

FORMING A MEDICAL GROUP: WHAT YOU NEED TO KNOW TO GET STARTED

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For purposes of this discussion, a “group”-two or more physicians in an integrated medical practice-does not include expense sharing arrangements, “clinics without walls,” or joint ventures.

Varied reasons cited for the steady rise in group practice include:

- # greater patient convenience and competitive advantages of multi- and single-specialty groups
- # enhanced access to managed care contracts
- # greater access to contracts with hospitals, such as exclusive, hospital-based contracts for anesthesiology services, medical-director agreements, and joint ventures
- # increased revenue and potential profit from the ability to keep referrals within the group
- # greater ability to afford expensive new medical equipment
- # improved quality of care and physician resources
- # greater operating efficiency through a group’s ability to spread costs (economies of scale), hire professional managers, and diversify revenue sources
- # reduced “on-call” time for each physician
- # perceived “safety in numbers” in an increasingly hostile and difficult health care environment

Physicians who are considering forming a new medical group or merging two or more existing groups need to understand that the process is complex. To succeed, physicians must handle group formations with great care. A common and costly mistake is to create the group without proper planning and preparation. This article will discuss what physicians need to understand about the four crucial steps to form a group: identify goals of forming the group; assemble the planning team; identify, discuss, and resolve key strategic, organizational, and operational issues; and form the group.

Identify and agree on realistic goals

It is sometimes surprising how poorly physicians have defined the reasons to form a group. Some physicians might be seeking reduced call and the collegiality a group practice offers, while others want to aggressively pursue managed care contracts. Such goals are worthwhile, but if prospective group members don’t share those goals, the seeds will have been sown for conflict and problems.

Having identified their goals, physicians should consider whether they could achieve such goals without spending the time and taking the risks associated with a fully integrated group practice. Initially, a better approach might be an office expense-sharing arrangement that could later evolve into a group practice. The parties, in effect, would have an “engagement” before committing to

“marriage.”

Finally, the physicians’ goals need to be realistic. To use an extreme example, if a number of pediatricians practicing in an area with few young families and an unusually high percentage of senior citizens simply form a group, they will not reverse the demographic problems. Forming a group should be a means to an achievable end, not the end itself.

Assemble the planning team

The formation process requires the skills and talents of a number of professionals. A planning team should include some or all of the physicians involved, one or more office managers or practice management consultants, a certified public accountant, and an attorney who specializes in medical practice and health care issues. Physicians should assemble the planning team at the beginning. Doing so will help them avoid costly mistakes. A question may arise as to whose office manager, accountant, and attorney to use. One approach is to allow each physician or group to consult existing advisers, but to hire neutral consultants whose loyalties will be to the proposed group.

Resolve key organizational and operational Issues

When the proposed group has established its goals and assembled its planning team, the next step is to identify, discuss, and resolve key issues concerning the group’s organizational structure and operations. Because the key issues are various and complex, such as in the tax area, the following is intended only as a general guide.

Choice of entity. One of the first decisions is the type of legal entity through which the group will conduct business. There are two basic choices: a general partnership (formed pursuant to California Corporations Code Sections 15000 et seq.), or a professional corporation (formed pursuant to Corporations Code Sections 13400 et seq.). A variation is to form a partnership of one or more individually owned professional corporations. Limited partnerships, although theoretically possible, are seldom used.

The professional corporation model is the increasingly popular choice. Among its advantages over a general partnership are that a professional corporation’s owners (the physician share-holders) generally are not personally liable for the professional corporation’s malpractice obligations, debts, and other liabilities. Physician shareholders will always be liable for the consequences of their own malpractice, and the corporation will also be liable for its agents’ acts, but other shareholders’ personal assets, such as homes, bank accounts, and automobiles, will not be at risk. An exception to this rule is if the corporation has not been properly organized and maintained, thereby allowing a “piercing of the corporate veil.”

In contrast, physician partners in a general partnership are personally liable for all liabilities, debts, and obligations incurred in connection with partnership business.

One way to reduce the liability problems of physicians in a partnership is for each physician to

form a professional medical corporation, and then create a partnership composed of all the corporations. This arrangement should limit each professional corporation/partner's liability for the other partners' conduct to the professional corporation's assets. A partnership of professional corporations also might be helpful when physicians want greater individual control over fringe benefits and perquisites. However, a partnership of corporations will no longer allow each physician to maintain individual pension and medical expense reimbursement plans.

The professional corporation model's other advantages include the greater ease with which physician shareholders can join or leave the group. Furthermore, a professional corporation, acting through its board of directors and officers, may facilitate more effective, centralized management. By contrast, in a partnership, each partner has an equal right to participate in decision making, unless otherwise stated in the partnership agreement.

Nevertheless, professional corporations pose some potential disadvantages. If the corporation has taxable income after paying its expenses (including physician employees' salaries), there could be a "double taxation" problem. That is, the professional corporation would have to pay federal and California corporation taxes on such income. If the same income, minus corporate taxes already paid, then were distributed to physician shareholders as a dividend, the recipients would have to pay individual income taxes on the remaining amount. In a partnership, however, there is no taxation at the "entity level." Rather, the individual partners only pay taxes on the partnership's earnings.

As a practical matter, most professional corporations can avoid double taxation through "zeroing out" the corporation each year by distributing surplus cash to physician employees as bonuses. However, there is a risk that the IRS will determine the physicians' compensation is excessive and unreasonable, and recharacterize the excess compensation as a non-deductible dividend payment.

Alternatively, if there are 35 or fewer shareholders and other requirements are met, the professional corporation can elect to be treated as an "S corporation," for federal tax purposes. There are comparable S corporation rules for California franchise tax purposes. S corporations generally are able to "pass through" earnings to shareholders, avoid federal corporation taxes entirely, and pay only a modest California franchise tax.

Finally, a professional corporation, unlike a partnership, has to pay an annual minimum California franchise tax, and has more detailed statutory requirements and limitations on its operations.

Capitalization. Whether forming a new group or merging existing practices, it will be important to determine in advance:

- # how much each physician will be required to contribute in cash or property
- # how much money, if any, will be borrowed
- # how to value the contribution of existing practice assets

Although beyond the scope of this article, it is essential to structure carefully the contribution

or sale of existing practice assets to the group so as to minimize or eliminate taxable gain. Should accounts receivable be contributed? In most cases, this is probably a bad idea because of possible tax consequences, the potential for disputes over efforts to collect receivables, and the actual, as opposed to anticipated, collections. In general, no value will be assigned to the perceived “goodwill” of individual practices.

The amount and kinds of assets physicians will need to contribute to a new or merged group depends on what the group requires. This will necessitate preparing financial projections and developing capital and operating budgets. Physicians should calculate how much cash they will need to expand office space, purchase equipment, and pay rent, salaries, and other expenses until the new or merged entity sends out its first bills and starts to make collections. If some of the money will be borrowed, who will be obligated to repay it? Will only the group be indebted on a nonrecourse basis, or will each physician personally guarantee any borrowings? Will the group or the physicians be expected to assume any existing debts?

When costs will be spread among a number of physicians, it is important to resist the tendency to overspend on new or expanded office space, computers, telephone systems, furniture, and other items.

Ownership interest. Determining how partnership or professional corporation ownership will be divided among physicians is a sensitive issue. Will physicians have equal shares, for example, or will more experienced physicians or those with larger practices own a greater percentage? When considering this matter, physicians should understand the relationship between their stock or partnership ownership interest and their compensation. For example, a physician who owns 25 percent of the shares or partnership interests might end up earning more or less than 25 percent of the group’s annual “profits,” depending upon the compensation formula used.

On the other hand, if the group is ever sold or dissolved, the ownership percentage will determine how much of the net assets or sales proceeds each physician will receive after liabilities are paid. Furthermore, the ownership percentage will directly affect how much the physicians will be entitled to receive under the group’s “buy-sell” agreement (see “Withdrawal from the group” on page 35) if they leave the group. Finally, ownership interest affects physicians’ voting rights and powers.

Management and control. Legally, control is exercised differently in a professional corporation than in a partnership. Except for a few limited, albeit significant, decisions (such as election of directors, amendment of articles of incorporation, sale of the practice, or corporate dissolution), physicians in their capacity as shareholders do not control ongoing management and operation. In fact, if shareholders manage the professional corporation’s affairs, they could lose the protection of the “corporate veil” and become personally liable for its debts and obligations.

By law, a professional corporation’s business and affairs must be managed by, and all of its corporate powers exercised by or under the direction of, a board of directors (Corporations Code Section 300). Although the board of directors can delegate day-to-day group management to its officers, a non-physician administrator, or others, the board is responsible for their conduct. In a partnership, on the other hand, all partners are entitled to participate equally in management, unless

there is an agreement to the contrary.

In a new or merged practice, a key issue will be to determine who exercises such control. If the group wants to be very democratic, it can create a sufficiently large board so that all physician owners can be directors. If this would be unwieldy, such as might be the case with a group of 10 or more, a smaller board could be created. Furthermore, the board of directors can delegate specific functions to an executive committee or to other committees of still fewer physicians. In a partnership, physicians could delegate day-to-day operations to a managing partner or a committee.

Whatever a board's size or the number of partners, the general rule is to take actions by a simple majority vote. To reduce the risk of majority "tyranny," the physicians might want to require that certain decisions need "supermajority" approval from two-thirds or even three-quarters of the directors or partners. Such decisions might involve spending or borrowing money in excess of predetermined limits; entering into important contracts, such as a capitated contract, a new office lease, or a major equipment purchase agreement; admitting or expelling a physician; and selling or dissolving the group.

Compensation and benefits. Along with control, one of the most important and sometimes difficult issues is physician compensation. The group should view compensation as a combination of salary, bonus, retirement plan contribution, and fringe benefits such as automobiles, disability insurance, and professional society dues. There are many methods to determine compensation. For example, profits (roughly, revenues minus expenses) can be divided equally among all physician owners. However, this might make it difficult to maintain high productivity and a fair workload.

Alternatively, the group can choose a "profit center" approach in which physicians are paid 100 percent of the profits generated by collections for their work after deducting the physician's expenses. This means the group must fairly allocate all of the practice's expenses. Expenses for office rent and general personnel might be divided equally among the physicians, but other costs, such as for lab and X-ray work, might be allocated according to usage.

The profit-center approach may be fairest for a single-specialty group. However, in a multi-specialty group that includes primary care physicians, surgeons, and other specialists, it might not reflect each physician's true contribution. Allowances also might need to be made if, for the group's health, some physicians are required to provide a disproportionate share of services to Medicare, Medi-Cal, or managed care patients where reimbursement is generally lower.

Another approach is to split profits equally from professional fees, and divide fees generated from certain ancillary services, such as X-ray, lab, and physical therapy, according to which physician generated the work. Still other groups divide ancillary and professional fees equally according to the "profit center" approach.

The situation is further complicated if the group forms separate corporations or partnerships to own the medical office building or equipment. The physicians must also decide, in advance, whether physicians who leave the group will be compensated for accounts receivable generated before their departure.

With respect to fringe benefits, physicians must agree on which benefits the group will pay, and which will be the individual physicians' responsibility. Some physicians might want the group to pay for car expenses, club memberships, travel and entertainment, disability and life insurance, and continuing medical education. Others might believe that some or all of such expenses should be the individual physician's responsibility. One way to deal with the problem is to deduct the cost of fringe benefits not provided to all physicians from the compensation of the physician receiving the benefit. The physicians also need to agree on maximum and minimum time off for vacations, continuing medical education, and illness.

Finally, the physicians will need to agree on the kind of retirement plan (for example, a pension or a profit-sharing plan), if any. This issue must be faced not only by physicians forming a new group who do not have preexisting retirement plans, but also when two or more physicians or groups with existing plans want to merge. The IRS has strict guidelines restricting physicians in the same group from having different pension plans, or from improperly favoring themselves over nonphysician personnel. This does not mean that the receptionist has to receive the same retirement benefits as the highest-paid physicians. However, it does mean that, subject to certain eligibility rules and vesting requirements, the physicians cannot exclude nonphysicians from retirement plans.

Furthermore, some physicians cannot choose to have a defined benefit plan, while others choose a profit-sharing plan, for example. Another potential problem may exist if older physicians who may have already funded their pension plans want to form a group with younger physicians who are just starting to plan for their retirement.

Personnel. An often overlooked issue is how to "merge" each physician's existing personnel such as office managers, nurses, receptionists, and billing and collection staff. Will all of the practices' personnel be offered employment by the group, or will some people have to be terminated? Because one goal of many group formations is lower overhead, it is unlikely that all personnel can, or should, be retained. The group must squarely address this difficult, often unpleasant, issue early. It is a mistake to form the group and rely on "natural attrition" or "survival of the fittest." Such a hands-off approach can be extremely disruptive and jeopardize prospects for the group's success.

Before terminating any personnel, physicians need to determine how much severance pay, accrued benefits, and possible accelerated vesting of pension benefits will cost. The group should also consult an attorney to reduce the risk of wrongful termination lawsuits by discharged employees.

For personnel who continue with the new group, the physicians need to agree on their compensation and benefits. Obviously, each physician's employees will have their own expectations based on their current situation. If possible, the group should avoid taking the best and most expensive aspects of each physician's current compensation and benefit plan and creating an unnecessarily costly group package. The group formation, in fact, can be an opportunity to trim compensation and benefits.

Withdrawal from the group. Groups in development often give inadequate attention to terms and

conditions governing a physician owner's voluntary or involuntary withdrawal from the group. This, too, can be a costly mistake. So called buy-sell terms need to be explained carefully in a written agreement that all of the physician owners and their spouses sign. A buy-sell agreement's principal goals are to control ownership in the group, allow for the orderly termination of physicians as owners, and provide payment to disabled and retiring physicians and deceased physicians' families.

A typical agreement limits physicians' rights to sell their partnership or stock interest in the group to another physician inside or outside the group. Rather, selling physicians must first give the group the opportunity to purchase their interest. This is known as a "right of first refusal." If the group elects not to purchase, some agreements allow other physician partners or shareholders to do so. The buy-sell agreement might require that the group or other physician owners match price and other terms offered by a prospective purchaser. In other cases, the group or other physicians are allowed to purchase a selling physician's interest at a bargain price.

The other key buy-sell issue is whether the group or individual physician owners have the right or the obligation to purchase the stock or partnership interest of a physician who becomes permanently disabled, retires, is terminated from the group, or declares bankruptcy. Under California law (see Corporations Code Section 13407), when a physician in a group organized as a professional corporation loses his or her medical license, the group is legally obligated to purchase the physician's shares within 90 days. If a physician shareholder dies, the group must purchase his or her shares within six months. In the case of a physician who leaves the group voluntarily or becomes disabled, the physicians might want an option to purchase the departing or disabled physician's ownership interest, but not be obligated to do so.

Of course, the group must also determine the purchase price and payment terms. In general, the buy-sell agreement must set a specific purchase price or formula for determining such. Establishing the price can create disagreements among older and younger physicians, because the younger physicians are more likely to purchase the ownership interest of an older physician who retires, becomes disabled, or dies. Life and disability insurance can be purchased to cover this risk.

To determine purchase price, the group might retain an appraiser to ascertain the partnership interest or shares' "book value," or the physicians might annually review and establish the price for the next year. An important consideration will be whether to include "goodwill" in the price and, if so, at what amount? If goodwill will be included, then the group might want a covenant-not-to-compete in the buy-sell agreement in order to restrict the departing physicians' right to compete with the group after their ownership interest has been purchased.

Physicians should also consider the payment's timing. Unless the price will be relatively nominal or covered by life insurance, most agreements provide that a portion will be paid at the time of purchase, with the balance, plus interest, during the next one to five years.

Agreement to form group. Assuming all parties agree on the issues described, they should prepare a written agreement or plan, and have each physician sign it. A prior, written agreement serves several purposes. First, it helps the parties reach a better understanding and consensus with respect to the key issues, as opposed to generally talking around the issues or perhaps avoiding them altogether.

Second, it helps reduce the risk of misunderstandings that would be created by oral “agreements.” Third, the development of a detailed plan or agreement simplifies its implementation, as well as the new group’s formation.

Group formation

- # The final step in the formation process is to create the new or merged group. This can involve:
 - # preparing corporate organizational documents (such as articles of incorporation and bylaws) or a partnership agreement, physician-employment and buy-sell agreements
 - # applying for a new group provider number and fictitious name permit
 - # establishing new books and records
 - # purchasing and leasing office space and equipment
 - # obtaining new stationery and telephone numbers
 - # securing malpractice and other insurance coverage
 - # establishing new bank accounts

The formation of a new medical group or the merger of existing groups is a complicated undertaking, with many important matters to be considered and resolved. Physicians should allow sufficient time for the formation process, which can take a few months if things go very smoothly, or as long as a year if they encounter difficulties. By following the steps described in this article, physicians should be able to significantly enhance their prospects for successfully forming a group.

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