Buy/sell agreements for medical practices
by Reed Tinsley

Abstract

Key words: health facilities — buy/sell, integration

Every group medical practice needs a buy/sell agreement. This contract spells out the transition of a current physician owner out of the practice upon certain events and how a new doctor may be admitted into the ownership structure of the practice. History has shown that once executed, many of these agreements never get looked at again until a buy out event forces it. Most agreements were drafted in times when indemnity insurance prevailed, reimbursement rates were good and physician incomes were quite healthy. However, as the health care marketplace continues to reform itself and as managed care continues to grow, most buy/sell agreements have become out of date.

This article provides a basic overview of buy/sell agreements, with particular concentration on the financial aspects of these contracts. It is the financial issues that will most likely impact both the physician owner and the practice itself either positively or negatively. Events requiring a buy out will be discussed, along with how buy out prices can be developed and paid for by the group practice. Particular emphasis is placed on valuation issues. Related tax consequences will also be mentioned.

Any medical practice with more than one physician owner needs a buy/sell agreement. The buy/sell agreement spells out the manner in which an owner can buy into the practice and how the practice will buy out an owner. Corporations have buy I sell agreements, which are sometimes called shareholder agreements. Partnerships generally have similar provisions as a part of their partnership agreement.

Buy/sell agreements must be reviewed and updated to take into account any changes that may have occurred in the health care industry since their last revision. Every group practice should have its agreement reviewed at least once a year, generally at the end of the practice’s fiscal or calendar year. Health care reform, the continued attacks on service reimbursements, Medicare cuts and the adoption of the resource-based relative value scale (RBRVS) payment system by other payers are just a few of the changes that have an impact on buy/sell agreements. These issues have the ability to directly impact the “value” of a physician’s ownership interest in a medical practice. In addition, physicians forming group practices must be armed with knowledge of the specific issues in buy/sell agreements so that such an agreement can be properly drafted as the group is formed.

The practice’s buy-out amount
The most obvious issue to address in any type of buy/sell arrangement is what to pay a physician/owner should he or she leave the practice. Death, disability, retirement, voluntary termination or involuntary termination of an owner can result in a buy-out situation. Agreements generally value a departing physician’s interest on the basis of either an appraisal of the practice or some type of fixed-formula approach. A continuing problem with the appraisal approach is that the buy-out amount generally remains a mystery until a practice is faced with an actual buy-out situation. In other words, most practices are not willing to have an independent appraisal conducted each year just to see how much the practice would be obligated to pay a departing owner should a buy-out event occur. Waiting until the buy-out event occurs, however, may result in a physician’s equity interest being appraised at too high a value in the minds of the remaining owners, and they subsequently refuse to pay it. Such disagreements can and often do lead to litigation. Therefore, an accurate appraisal of the practice is needed if the agreement values ownership interests at appraised value.

Appraisals
If the physician buy-out will be based upon an appraisal, an accurate medical practice valuation will often depend on the qualifications and expertise of the person or persons preparing the appraisal. For example, many agreements name the practice’s accountant as appraiser. Not all accountants who have health care clients, however, have experience or expertise in medical practice appraisals. They may not possess the in-depth knowledge of the health care industry necessary to arrive at an accurate appraised value. Although valuation formulas are generally the same
for all industries, the techniques of applying and interpreting them are radically different from industry to industry. These factors can and do affect the ultimate outcome of an appraisal. In addition, if the appraiser is also the personal accountant or advisor to one of the owners, there may be a conflict of interest if he or she is asked to perform the appraisal. Specific techniques for appraising a medical practice are discussed below.

**Formula approaches**
The fixed formula approach generally pays a departing owner his or her interest in the net book value of the practice, plus a value for goodwill if the physicians agree that such a value exists in the practice. Whether by appraisal or by fixed formula, the practice’s accounts receivable and fixed assets will have to be valued. (See the section entitled “Valuing fixed assets and accounts receivable.”) Goodwill can be valued at a percentage of the physician’s or the practice’s collections for the prior 12-month period or for some other time period. For example, the agreement may set a physician’s goodwill value at 20 percent of that physician’s prior 12-month collections.

Another approach is to value the buy-out amount at a multiple or percentage of the departing physician’s average yearly compensation for an agreed number of years.

The advantage of any type of fixed formula approach is that the owners can quantify the buy-out amount at any time. Many practices calculate the amount at the end of their tax year so that each owner can determine whether the buy-out amount is fair. If any owner feels it is not, all the owners should get together to discuss and resolve the matter. Thus, at the end of each year, the buy-out amount should be calculated and the following questions asked of each owner: if you were to be bought out today, do you feel that the calculated buy-out amount is reasonable; and, if you had to pay a departing physician the calculated buy-out amount, do you feel it is a reasonable amount to pay?

**Accounts receivable**
The question often arises whether accounts receivable should be included as part of the buy-out amount. The answer is yes, but how it is structured is the important issue. The goal of the practice is to structure the accounts receivable as a form of deductible deferred compensation to the practice. This would enable that the practice to deduct the payments on its business federal income tax return. Accounts receivable are, in reality, an income asset. They are not an equity asset. In other words, the practice reports income and pays out compensation to the physician as receivables are collected. Therefore, accounts receivable should be part of the physician’s employment agreement and be paid out over time as deferred compensation.

Whether to include accounts receivable when a physician buys into the practice, however, is an altogether different issue. The inclusion of accounts receivable only inflates the value of the buy in, and therefore should not be included as part of the new physician’s buy-in. Rather, existing accounts receivable should be declared a bonus to the owner or owners of the practice and paid out to them over a period of time (generally three to five years) as a regular overhead disbursement. The reason a bonus is declared is because the owners of the practice are the ones who really own the practice’s accounts receivable. This way, all the new physician actually buys into is the practice’s net fixed asset value and goodwill, reduced by any debt. When determining the buy-in for any new physician, it is important to realize that he or she will be concerned mainly with the dollar amount of the buy-in. Rarely will the new physician concentrate on what makes up the buy-in value.

**Appraising a physician owner’s interest**
Many buy/sell agreements provide that a departing physician’s ownership be valued on the basis of an appraisal of the practice. Usually the practice’s outside accountant or other professional qualified in medical practice appraisals is engaged to perform the appraisal.

Although the following discussion applies mainly to appraising a physician’s interest for the purpose of a buy-out, appraisals are needed for a variety of other situations, such as divorce or outright sale of the practice, and can be adopted accordingly. The principles discussed here should apply to most medical practice appraisals.

**Excess earnings**
The first step in a medical practice valuation is to calculate the common valuation principle of excess earnings. Excess earnings represent the portion of the practice that creates the true value of the practice. In other words, excess earnings are the earnings above a reasonable level of physicians’ compensation for a particular medical specialty. It represents the true amount of “profit” the practice actually earned. Having special attributes allows the practice to
gain these excess earnings. This is what creates value. Excess earnings are calculated as follows:

- Step 1 — Gross collections - Overhead = Net income
- Step 2 — Net income + Addbacks - adjustments = Excess earnings

**Addbacks** include owner compensation, extraordinary expenditures and optional expenditures which are not connected with the normal operating overhead of the practice. The best example is a physician cost that is more personal than business in nature. For example, a physician may spend $15,000 on extravagant CME for a year, whereas the norm is around $2,500 per year for CME. The difference should be added back when calculating excess earnings. **Adjustments** include comparable owner compensation and extraordinary revenue items. Extraordinary revenue is revenue that is nonrecurring or would not stay with the practice if the practice were sold outright. Examples are expense subsidies and one-time, non recurring contract payments. Another example is free rent. If the practice was receiving free rent but will shortly have to begin remitting rental payments, this will impact the practice’s future income stream. Therefore, most appraisers will subtract an amount for reasonable rent for the years used in the appraisal calculation. This reflects economic reality.

Generally, excess earnings should be calculated for the current year and the prior four years of the practice. Net income can be derived from either the practices’ corporate tax return or the partnership tax return. Extraordinary expenditures and revenue are then added back or subtracted from the excess earnings calculation.

The main factors contributing to the excess earnings calculation are the addition of physicians’ compensation and the subtraction of comparable compensation. Most medical practices are said to have value when the physicians earn more than what is considered the norm industry for that medical specialty. For statistical information related to comparable compensation for a physician’s specific medical specialty, see the surveys produced by Medical Group Management Association, the Society of Medical Dental Consultants, Medical Economics, the American Medical Association and the American Group Practice Association. For a truly comparable compensation figure, compute the average of the physicians’ earnings from each of these surveys. If the appraiser has many clients in a particular medical specialty, including these compensation figures in the calculation might be beneficial.

**Time span covered by the appraisal**

Once excess earnings are calculated for each year, the appraiser must then make a decision on which years to include in the appraisal, in addition to what weight to give each year. Ask and answer this simple question for every medical practice appraisal: Will the future mirror the past for this particular practice? In other words, will the practice continue its past gross and net earnings trend? For example, what will be the future reimbursement trend for the practice? Could insurance demographics change? Could patient demographics change? Will there be a strong switch toward managed care? If the future looks like it may not mirror the past, does it make sense to include any past activity in the appraisal? Instead, should the figures be restated on the basis of current reimbursement and economic conditions? The main point here is not to rush out and perform, nor rely upon, an appraisal based mainly on past performance. This is especially true when the future may indicate a decline in earnings. By carefully studying the health care industry, and the practice’s particular service area, one should be able to determine a practice’s future income potential. Therefore, higher weights are usually placed on the most current year, with declining weights placed on prior years if they are included in the appraisal calculation.

**Capitalization rates**

Each of the valuation methods described below requires the use of a capitalization rate. This rate is used to convert an income stream into some indication of a value for the medical practice. It is generally defined as the sum of (a) the annual rate of return currently available from investments offering maximum security and the highest degree of liquidity (the Treasury Bill rate is often used for this rate, as are rates on certificates of deposit), and (b) a risk premium, taking into account the risk that the predicted amount of future income will not be realized by the medical practice and the risk of unforeseen changes in the health care industry in the area in which the practice is located. In addition to these, the appraiser may want to add his or her own adjustments when building the capitalization rate. Primary care medical practices have lower capitalization rates than do other medical specialties, generally because their earnings are not expected to be as negatively affected by any changes that may occur in the future, as are the earnings in other specialties.

Figure 1 is an example of building a capitalization rate for a family practice.
<table>
<thead>
<tr>
<th>Risk Factor</th>
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<tbody>
<tr>
<td>Risk free rate</td>
<td>6.25 percent</td>
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<tr>
<td>Small business/medical specialty risk</td>
<td>4.00 percent</td>
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<tr>
<td>Competition risk</td>
<td>3.00 percent</td>
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<tr>
<td>Medicare fee impact</td>
<td>1.00 percent</td>
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<tr>
<td>Management</td>
<td>2.00 percent</td>
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<tr>
<td>Managed competition impact/change in reimbursement risk</td>
<td>2.00 percent</td>
</tr>
<tr>
<td>Capitalization rate</td>
<td>18.25 percent</td>
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Valuation methods
A number of valuation methods should be used when appraising a medical practice. Most of these are common methodologies used in the valuation of other industries. The key issue for medical practices is determining which ones to use and what emphasis to place on each formula. In other words, weights should be placed on each formula, rating its respective importance in the valuation process. Weights will differ depending on a variety of factors, such as the medical specialty being valued and the demographics of the practice’s area. The following are the most common formulas used in medical practice valuation.

Capitalization of weighted earnings
The theory of the capitalization of weighted earnings method is that the ultimate value of the medical practice and its assets is the earnings the practice generates over and above the average medical practice in the same specialty. Under this method, excess earnings are capitalized by using a capitalization rate which represents the rate of return required to compensate for the inherent risk in the medical specialty being valued.

Goodwill calculation as a percentage of a practice’s collections
Under the goodwill calculation, as a percentage of a practice’s collections method, the multiplier is taken from the Goodwill Registry, published by the Health Care Group®. The Health Care Group® has tracked medical practice valuations for a number of years for each medical specialty in an attempt to define goodwill as a percentage of a practice’s collections. This method should be used only if there is a sufficient number of valuations in the Goodwill Registry related to the medical practice being valued.

Under this method, the weighted average collections generally are multiplied by the mean goodwill multiplier to arrive at estimated goodwill. This number is then added to the fair market value of the practice’s net assets to arrive at the total value of the practice.

Income approach
This method focuses on incorporating the specific operating characteristics of the seller’s business into a cash flow analysis. Cash flow that could potentially be taken out of the practice without impairing operations and profitability is estimated. The cash flow available for distribution is then discounted to present value at the indicated discount rate and totaled. The discounted cash flow method is based on the fact that a sum of money expected to be received some time in the future has a lower present value than the same amount of money in hand today. Thus, a valuation will project the cash flows of a business for some future time period to determine present value.

Valuation by start-up method
The start-up method is an approach that estimates the cost to establish a business, or to duplicate the medical practice being appraised. In this method, it is necessary to consider the current market condition relative to competition, and to estimate the capital costs and cash flow requirements to reach the same level of income and capacity as in the current medical practice.

It is implicitly assumed that such an approach can help the potential purchaser decide if it is a better economic
decision to buy the existing medical practice, or to “create” a new one. It is a “make/buy” decision concept. This method should not be used alone, but should be viewed in context with other methods which should in some regard “validate” the reasonableness of the cost to start and develop a practice to this point. In no case can the risk to establish a medical practice that could duplicate the current practice be measured.

Valuing fixed assets and accounts receivable
In a medical practice appraisal, fixed assets and accounts receivable may need to be valued. Fixed assets may be valued in any one of a number of ways. If assets are substantial, an independent appraiser may be engaged to value the assets. Value could be based on book value amortized over a reasonable time period, such as five to 10 years. If the assets are not material to the practice, the appraiser may take an inventory and ask the physician or physicians what the assets could be sold for on the open market. If real estate is involved, an independent appraiser should always be engaged. Accounts receivable must always be valued as closely as possible to the amount that actually will be collected in the future. Thus, net realizable value for accounts receivable should be based on the following:

1. insurance receivables multiplied by the practice’s gross collection percentage for the prior 12-month period;
2. patients’ receivables that are 90 days old or less; and
3. patients’ receivables more than 90 days old when the patient has consistently made installment payments.

The practice’s gross collection percentage is calculated by dividing collections by all gross production. The appraiser may also want to multiply the patients’ receivables by some percentage (e.g., 90 percent) to take into account potential bad debt write-offs.

Weighing the methods
After making the calculations for each method, the appraiser must decide which ones to use and the weights to place on each method. The result is a weighted average value for the medical practice. After calculating the weighted average value, the appraiser needs to assess whether or not the amount is reasonable. This is normally done by seeing if, after paying out reasonable physicians’ compensation, the practice’s excess earnings are sufficient to pay out the value of the practice over a number of years. To perform this calculation, first figure the yearly amount due if the practice’s value were financed over five years at an interest rate close to the prime rate. Compare this to the practice’s excess earnings. If the excess earnings are sufficient to cover the installment amount, the calculated value should be reasonable.

It is critical for the appraiser to assess, however, whether the excess earnings of the practice will remain close to the same in the near future. If not, recalculate excess earnings on the basis of the expected earnings potential of the practice and compare this number to the practice’s calculated value. If the practice is one that has potentially high risk, the appraiser may want to calculate the installment amounts on the basis of a period of less than five years. A high risk medical practice might be one for which earnings could fluctuate substantially some time in the future. In this situation, one would want to pay out the value as quickly as possible before the practice is affected economically.

Payout terms
Should a buy-out occur because of a shareholder’s death, the amount is usually paid as soon as the proceeds from a life insurance policy are received. Most medical practices obtain insurance on the lives of each physician owner, with the practice named as beneficiary under the policy. If the practice has owners of a relatively young age, analyze whether or not it makes sense to have buy-out life insurance. Often times, it is cheaper to borrow the money when a buy-out is required. If life insurance on each owner does not exist, the payout will have to be paid through installment payments, unless the practice decides to borrow the money from a financial institution. Depending on the amount of the buy out, however, the practice may want to pay out the buy out immediately rather than in installments. Not only the result of an owner’s death, buy-outs also occur in the event of disability, retirement and voluntary or involuntary withdrawal. Payments related to these events are almost always paid out by the use of installment payments, generally over a five-year period at the prime rate of interest. The interest rate is sometimes capped at 12 percent to protect the cash flow of the remaining shareholders.

S and C corporation status
Upon the death of a physician owner, the buy out is usually paid out in one lump sum to the estate, generally from
the proceeds of a life insurance policy. If the practice is a beneficiary under the life insurance policy, and if the practice is incorporated as a regular C corporation, its business tax return should indicate a nondeductible line item generally labeled “officer life insurance premiums.” Severe tax consequences could result, however, if the practice operates as a regular C corporation under the tax law and is the beneficiary of the policy’s proceeds.

A C corporation is its own tax paying entity, as opposed to an elected S corporation, in which the practice’s net earnings are passed directly to the shareholders. When a physician owner dies, the medical practice corporation may have to pay an unexpected alternative minimum tax, which is currently embedded in the Internal Revenue Tax Code. The alternative minimum tax, however, applies only to medical corporations that have not elected S corporation status. As a way to avoid the alternative minimum tax, the owners of the practice may want to consider restructuring the officers’ life insurance into the form of cross purchase agreements. In this situation, the owners of the practice have life insurance on each others’ lives. The cross purchase agreement provides that should an owner die, the other owners have the right to acquire his or her shares. Another way to avoid the alternative minimum tax is to operate as a partnership.

**Covenant not to compete**

Related to payout, the buy-out agreement should specify the procedure to follow should a physician leave the group and practice medicine in competition with the practice. Generally, this is covered by a “covenant not to compete” provision in the agreement. For example, the provision may provide that should a physician compete against the practice some time in the future, the installment payments cease immediately if the buy out has not been paid in full. The inclusion of such covenant will depend mainly on the laws of the state in which the practice is located. Also, many physicians believe that the covenant is not worth the time and money necessary to enforce it.

Whether a covenant not to compete is in place or not, if a physician leaves the practice and immediately competes against the practice, the practice should consider placing limitations on the buy-out amount. Since the departing physician will probably take patients, and thus revenue, away from the practice, it is not fair to pay out his or her full share of the ownership. Many buy/sell agreements include a clause stating that if a physician leaves the practice and immediately competes against the practice, the physician will be entitled to receive only his or her share of the practice’s fixed asset value. In other words, the physician’s share of accounts receivable and any goodwill would be forfeited. Always consult an attorney, however, before executing such a strategy.

**Tax deductibility of buy-out payments**

It is important for the remaining physician owners to maintain the tax deductibility of the buy-out payments. Otherwise, the remaining owners not only must pay out cash to the departing owner but also face an additional economic burden if they are not deductible. Never assume that buy-out payments are deductible as currently written in an existing practice’s buy/sell agreement. Payments to repurchase a physician’s ownership interest are generally not deductible by the practice. For example, payments to buy back a physician’s stock in a professional corporation are not deductible. These payments will be classified as treasury stock. This is why structuring the buy-out payments is such a critical issue. In fact, the Internal Revenue Service has been cracking down on group practices that try to deduct nondeductible buy-out payments. Amendments to the tax code were enacted in 1990 to make it mandatory to report the specific details of a buy-out transaction to the IRS. Under Section 1060 of the Internal Revenue Code, if a departing physician owns 10 percent or more of the practice and, in connection with the buy out, enters into an agreement with the practice, then the transaction must be reported to the IRS by both the departing physician and the practice.

**Examples of how Section 1060 applies to a physician owner’s buy-out**

Example 1: Dr. Brown owns 100 percent of X corporation. As a step toward semi-retirement, Dr. Brown sells 90 percent of her X corporation stock to Dr. Jones and enters into an employment agreement with X corporation. Although there has been a transfer by a 10 percent or greater owner, there is no reporting requirement because there is no transferee.

Example 2: Dr. Kim owns 50 percent of Y corporation. He sells half of his shares to Dr. Tyler, and Dr. Tyler enters into an employment agreement with Y corporation. Although an owner of 10 percent or more of an entity has transferred an interest in the entity, there is no reporting requirement because the owner (Dr. Kim) has not entered into the employment agreement with Dr. Tyler.
Example 3: Dr. Miller is the sole shareholder of Z corporation. Z corporation issues new shares to Dr. Delgado and enters into an employment agreement with him. The reporting requirement applies. Under section 318(a)(3)(c) of the Internal Revenue Code, if any person owns 50 percent or more of the stock of a corporation, the corporation is considered to own such person’s stock by attribution. Accordingly, Z corporation is deemed to be a 100 percent shareholder in itself for purposes of section 1060(e), and it has transferred an interest in itself and entered into an agreement with the transferee (Dr. Delgado).

Keep in mind that if Section 1060(e) of the Internal Revenue Code applies to the buy-out or buy-in transaction, the corporation and the shareholder or buy-in partner will have to attach an IRS form to each of its tax returns.

Other provisions in the buy/sell agreement
There are many other provisions in a buy/sell agreement that must receive attention. Many of these will need the assistance of and review by an attorney. Besides the obvious legal issue, one goal is to assess what impact these provisions would have on the daily and continuing operations of the practice. The practice must be protected from harm. Another goal is to achieve fairness among the parties.

Involuntary removal
Any buy/sell agreement should address how an owner can be involuntarily removed from the practice. Termination of employment is different from termination of a physician’s ownership interest in the practice; if a physician is dismissed from the practice, he or she will also need to be removed as an owner of the practice. Some agreements provide that an owner be removed if a certain percentage of the other owners (usually two-thirds or three-fourths) vote to do so. Other agreements state the physician’s ownership interest is terminated immediately when his or her employment or compensation agreement is terminated. If a vote to remove a shareholder is not an option, the agreement should state specific instances in which an owner can be involuntarily removed from the practice’s ownership. For example, a physician owner must automatically surrender his or her ownership interest in the practice if the physician loses hospital privileges, loses medical licensure, becomes uninsurable for malpractice coverage or is convicted of a crime. Involuntary withdrawal also occurs when a physician becomes permanently disabled, often as defined in the disability policy. Generally the issue of permanent disability will be addressed separately in the agreement.

Temporary disability
The buy/sell agreement should discuss when an owner can be removed from ownership in cases of a temporary disability. Situations of temporary disability occur much more often than situations of permanent disability. For example, suppose a physician contracts multiple sclerosis and is out for long periods of time. What about the physician who has heart surgery and is out for 10 months? Many agreements have also failed to address the issue of HIV contraction by a physician owner. This could lead to a potentially explosive situation if the other owners feel it is in the best interests of the practice for the physician to leave, but the infected physician refuses to do so. Before addressing a situation such as this in the buy/sell agreement, make sure any provisions are not in violation of the Americans with Disabilities Act of 1990. Generally during a period of temporary disability, the physician remains an owner but his or her compensation will be reduced at some point during the temporary disability period.

Adding a new owner
The agreement must also include a provision about the process in which a new owner is added to a practice. Generally, admitting a new shareholder requires the unanimous vote of the existing owners of the practice. Internal disharmony might arise if a physician is admitted who some of the other physicians do not want as a fellow owner. The agreement should not state specifics about how the buy-in amount would be calculated for the new owner, however. Generally gives the practice the flexibility to design a buy in on the basis of changing economic and market conditions in the health care industry. Thus, the agreement should state that the buy-in amount will be determined by the practice at the time a new physician owner is admitted.

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