Dissolving a Medical Practice Partnership

A medical group isn’t a marriage, but it’s similar in many ways — especially when it comes to breaking up a practice relationship. Staying together may not be an option, but dissolution doesn’t have to result in open warfare.

Put it in writing
Just as a pre-nup can help pave the way for a more amicable divorce, a partnership agreement can help ensure a cordial separation. Draft the agreement when you first form the practice and update it as new partners are brought in.

The partnership agreement, which may include exit fees or buyout provisions, should specify how key issues will be handled while the partnership is together (such as compensation arrangements), as well as when it dissolves (such as the division of assets and liabilities, distribution of patients and employees, and the timing of the separation).

Split assets and liabilities
Your assets run the gamut from accounts receivable to cotton swabs, and a departing physician will want his or her fair share of them. Physicians who are leaving to start solo practices may want to buy their current equipment. If so, you may need to enlist an equipment supplier or consultant to determine a fair value for these items, which would be deducted from the departing doctor’s share of the practice value.

If the entire practice is being dissolved, asset allocation will likely depend on each partner’s plans. Retiring partners may want their share of the assets in cash; younger physicians who are likely to continue to practice medicine may wish to take equipment with them. In either case, distribution must be based on fair market value and each partner’s percentage of ownership.

Liabilities must enter the picture as well. Ideally, when a partner leaves, they will owe a fair share of the remaining debt. If there’s nothing left but more debt, the liabilities must enter the picture as well. Ideally, when a partner leaves, they will owe a fair share of the remaining debt.

Understand the human element
Splitting up assets and liabilities is one thing; splitting up patients and employees is quite another, because of the human element. It’s a little like determining child custody when a marriage breaks up. Through it all, remember that patients come first. Be sure patient care isn’t interrupted or shortchanged.

In addition, try to keep the breakup as amicable as possible so your employees don’t feel alienated from the doctors—or each other. Don’t get involved in bidding wars for top employees, which can only lead to hard feelings. Also, keep in mind that, because of the breakup, your staff may find themselves without jobs, which introduces a whole new dimension to the human element.

If a single physician is retiring, the group should keep all patient records and notify that physician’s patients about his or her departure and ask the patient to make future appointments with others in the group. If a patient wants to continue seeing that physician, however, it’s your duty to provide the departing doctor’s contact information. If the entire group is dissolving, notify your patients at least 30 days in advance and offer to forward their patient records either to a departing physician’s new practice or to another practice.

Know when to get help
When you’re splitting a practice, emotions typically run high. That’s why it’s essential to draft a partnership agreement from the outset that includes breakup provisions. Contact our office for assistance. Breaking up may be hard to do, but it doesn’t have to be painful.

Electronic Health Records

In 2004, President Bush issued an executive order mandating that a comprehensive national health information network (NHIN) be fully operational by 2014. The core of the system will be individual patient electronic health records (EHRs), linked through regional information systems to form the NHIN.

Docs slow to implement technology
According to the Physicians Practice 2007 technology survey, although 39% of practices have fully implemented EHR systems, another 27% have no intention of getting them anytime soon. Why all the foot dragging? The main reason is cost.

There’s little disagreement about whether a well-designed EHR system can improve quality of care. A 2005 RAND Corporation study estimates that EHRs could trim $80 billion off the nation’s health care bill.

Unfortunately, according to the Physicians Practice survey, you can’t expect an EHR system to pay for itself through efficiency and revenue. Three out of five respondents said they hadn’t seen an excellent return on their investment, though many reported being able to reduce or reassign staff because of their EHR systems.

High cost of progress
EHR systems can run as high as $100,000 for an individual practice and more than $50 million for a large hospital. You’ll

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Will EHR systems pay-off?
As practices nationwide start adopting EHR technology, the question is whether or not the roughly $35,000 investment per physician will return proportional benefits to their group practices. Here are some answers to that question in four key areas:

1. Billing. Appropriate charges for medical services will be generated and sent to connected billing applications, so the practice will save time and money.

2. Transcription services and costs. EHR systems eliminate the need for these services, so you could save thousands of dollars a year in support staff.

3. Coding. EHR systems track procedures by sending you a prompt if an evaluation and management code isn’t entered accurately, helping minimize downcoding and improving charge capture.

4. Prescribing meds. Staff will spend less time communicating prescription orders and refills. Plus the clinical support component of the system can cut the number of adverse drug events while suggesting alternative medications.

There are some bright spots, though. The IRS has agreed to allow hospitals to offer subsidized EHR programs for medical staff members without fear of violating the Stark or anti-kickback statutes. Following the lead of the Department of Health and Human Services (HHS), the IRS agreed that EHR subsidies won’t constitute Section 501(c)(3) violations if the subsidies are permissible under HHS regulations. Any subsidy arrangements must ensure long-term compliance with HHS EHR regulations, and the hospital must have access to the records physicians maintain on the systems, to the extent permitted by law.

Additionally, hospitals must make subsidies available to all physicians equally, unless the inequality is related to meeting the health care needs of the community. That contrasts with HHS regulations, which allow hospitals to offer different levels of subsidies to different physicians so long as the distinctions aren’t directly based on referrals.

Creative solutions
To increase their buying power, some practices are joining forces to obtain group-purchasing discounts; others are using affordable EHR systems as an enticement to lure solo practitioners to join their practices. Such solutions may not be appropriate for every situation, but they demonstrate that many physicians aren’t going to wait for the government to back up its mandate with cash.

Steve Williams, CPA, received his BS degree in Accounting from California State University, Long Beach in 1977. After a year as a staff accountant at Disneyland and another year with a large local accounting firm, he joined the staff of HMWC CPAs & Business Advisors in 1979, and became a partner in 1985.

Steve has worked extensively with physicians and other high-income taxpayers for over twenty years. He specializes in consulting services to medical practices, as well as tax and financial planning. He is a member of the American Institute of CPAs, the California Society of CPAs, the Medical Group Management Association, and Affiliated Healthcare Advisors. Steve is a frequent speaker on medical consulting and tax issues.

EHRs (continued)
find a wide range of prices partly because of varying software features. Pricing may also vary according to the fees vendors charge for licenses. Prices could vary greatly based on the training and support services required. Software that offers a wealth of features a large multispecialty practice might require may also necessitate more training than is likely to be needed for less complicated software in a small practice.

Vendors’ approaches to training may differ, as well. Some provide on-site training for all users; others use a train-the-trainer approach, teaching one or two people in the office who then are responsible for training the rest of the staff. Similarly, support pricing may differ if one vendor has invested more in technical support staff to guarantee support when you need it.

Financing EHR systems
You can buy an EHR system loaded with options. Or perhaps a bare bones, entry-level version is a better fit for your practice. Some serious comparison shopping is in order before you make any decisions. Comparing products may get you the best deal, but that doesn’t necessarily translate to an affordable product. The federal government and many states have some funding available to help, but competition for that money is stiff.

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For Further Information
To learn more about any of our services, see our website at www.hmwc CPA.com or check the boxes below and complete the name/address information on the right and mail this cut-off form. Or fax to Steve Williams at (714) 505-9200.

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