

Exit Strategies: Planning For Practice Succession

Planning for your own retirement is not just a matter of building up a large sum in a 401(k) or a profit-sharing plan. In addition, you may have a substantial amount of equity in your practice—an asset that you can convert to cash for the years when the paychecks no longer are coming in. What’s more, if you develop a successful succession plan, you can keep your practice

going, providing healthcare to your patients and jobs to employees who desire to keep working.

The structure of your succession plan will depend on the type of practice you have. “If you’re a solo doctor, you’ll need to find a buyer or a merger partner,” says Joseph Gallagher, vice president and assistant secretary, Health Care Law Associates, in Plymouth Meeting, Pa. “If you’re in a group practice, a buyout agreement will determine how you’ll be compensated when you retire.”

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For sole practitioners, an exit strategy should involve some advance preparation. “If you’re on your own and you want to retire, you should plan as far ahead as possible,” says Jeff Sansweet, shareholder and officer in Kalogredis, Sansweet, Darden and Burke, a law firm in Wayne, Pa., that concentrates its practice in the healthcare field. “If you’re hoping to retire at age 68, for example, you shouldn’t wait until age 67 to begin looking for a successor.”

A few years ago, solo physicians might have had multiple buy-

ers for their practice. Hospitals and practice management companies were paying substantial prices. Now, though, some of the practice management companies are out of business, and hospitals are just as likely to be sellers as they are to be buyers.

Nevertheless, you shouldn't just walk away from your practice at retirement. Selling your practice may turn out to be easier than closing it. In addition, your practice may be worth a meaningful amount of money to a motivated buyer.

Who'll buy your practice, if not some local hospital or another

Staying Active Professionally After Retirement

If you find yourself with too much time on your hands after you retire from medical practice, the American Medical Association's Senior Physician Group offers the following ideas for worthwhile activities:

- **Volunteer at a local clinic.** You can find volunteer opportunities through Senior Corps (www.seniorcorps.org), which is part of the USA Freedom Corps, a Federal national service agency, or through the Volunteers in Medicine Institute (www.vimi.org).

- **Mentor a young physician or medical student.** The AMA's Virtual Mentor program (www.ama-assn.org/ama/pub/category/4199.html) registers physicians who are willing to act as e-mail mentors to pre-med and medical students, residents and other new physicians. Your medical school alma mater may also have a program in place.

- **Get active politically.** Medical organizations that lobby Congress are seeking physicians to assist in their grassroots advocacy efforts. The AMA's Website (www.ama-assn.org/ama/pub/category/13038.html) includes a number of ways that doctors can make their voices heard on issues that affect the profession.

- **Become a locum tenens physician.** Doing temporary medical work is a good way to scale back from full-time practice while traveling to new areas of the country. Contact the National Association of Locum Tenens Organizations (www.nalto.org) for more information on how to get started.

- **Get involved in public health efforts.** Contact the Department of Public Health in your state and offer your expertise in any of the special projects, awareness campaigns, task forces or events promoting disease prevention and wellness.

- **Join an advisory board at a local hospital or clinic.** Many hospitals would welcome your many years of medical experience.

er healthcare organization? Generally, you will have to find another physician to buy your practice when you want to sell.

Likely buyers include doctors in their late 30s, with a few years of experience, who want to have their own practice. Such physicians may have joined a group a few years previously, expecting to become partners. In some cases, though, these young doctors will find that the price of becoming a partner is so high that they'll do better buying a practice. The purchase price may be

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lower, and the potential income may be greater.

Even younger physicians—those just emerging from residency—might be potential buyers. Indeed, the chance of finding such a successor is one reason to start planning to sell your practice several years before you plan to retire. You might attempt to sell to someone coming out of residency this year; if that doesn't work, you can

try next year's group, or the one after that.

In any case, younger doctors are the primary candidates to buy your practice from you, according to Mr. Gallagher. "The classic deal," he says, "is to bring in someone three years before you want to retire. After a year or two, you can see how things are working out. If all has gone well, an arrangement can be reached for the successor to buy you out."

Although this may be the classic deal, a five-year head start may be even better. "By that time, the new associate may be an equal partner in the practice," says Mr. Gallagher. "Patients will be used to the new associate, so there will be a more natural progression when the older physician leaves. Patient retention is likely to be greater." Also, beginning the process five years in advance, rather than three years, gives you more time to start over if things don't work out with the first young doctor you bring in.

When a junior physician is brought in with the expectation of buying the practice, a schedule for the gradual takeover may be in the employment agreement. Instead of a set purchase price, there might be a formula to set the terms of the deal. Often the

contract will allow either party to decide against going through with the transaction if the arrangement proves unsatisfactory.

“Another possibility,” says Mr. Sansweet, “is to sell your practice to a competitor, someone who feels his or her practice isn’t big enough and wants to add more patients. For years, the trend has been towards larger practices, to benefit from economies of scale or increased negotiating power.” You also may find a buyer who has a practice in another part of town and who now wants to expand into your area.

No matter who the potential buyer may be, an independent appraisal can help you to set a fair value from which negotiations can begin. Ideally, you should have the appraisal done just before talking to potential buyers, so that it will be current. The appraisal should be done by someone who specializes in medical practices because medicine is different from other businesses and professions.

Alternatives to a formal appraisal may be practical. “You might ask your CPA to give you a valuation of the practice prior to approaching potential buyers,” says Cheryl Holland, a financial planner in Columbia, S.C. “There also may be medical publications within your specialty that can provide you with a thumb-nail valuation of your practice.”

If you’d rather not handle all the details of selling your practice on your own, you might do well to hire a consultant. Such a consultant may be able to help you modify your practice in order to maximize its sales appeal; a consultant also may be able to line up a buyer. Contact your local medical association for leads to consultants who are familiar with your area. “In any case,” says Ms. Holland, “it is critically important to engage an attorney to handle the actual transition documents.”

What’s Your Practice Worth?

Valuations of medical practices usually take the following three factors into consideration:

- **Accounts receivable.** Often the sale of a practice calls for receivables to go to the seller. That is, you’ll eventually collect the money coming in from the treatment you’ve provided to patients.
- **Value of the equipment and office furnishings.** Such items may be relatively easy to value, and that value will be included

in the purchase price. For most medical practices, though, the value of these assets will be relatively modest.

■ **Goodwill.** This refers to the more intangible aspects of your practice that make it successful. That is, the buyer is relying on patients to keep returning even after a change of physicians.

“Goodwill is the worth of having a practice that is fully operable,” says Mr. Gallagher, “with a trained workforce, properly configured computer systems (hardware and software) and office space.” Other assets associated with goodwill include medical charts, patient lists, phone and fax numbers, practice location and perhaps even the practice’s name.

“The value placed on the goodwill typically will be a percentage of the practice’s profit,” says Mr. Sansweet. “One year’s average net income might be the price, although that will vary from practice to practice.”

Alternatively, goodwill might be valued as a percentage of your recent collections rather than profits. Generally, you might expect to receive 25 percent to 35 percent of collections, although that may vary in selected areas. Thus, a practice with \$300,000 in annual collections might sell for \$75,000 to \$105,000, plus the

Goodwill Value Often Controversial

Determining the value of goodwill is the area that generates the most controversy in practice valuations, according to Keith Borglum, a practice management consultant with Professional Management and Marketing in Santa Rosa, Calif.

“The value of intangibles, often described in a valuation as goodwill, generally includes a favorable location; going concern value; use of seller’s name; favorable leasehold; covenant not to compete; compensation for past managerial and entrepreneurial services; patient lists; credit records; patient care contracts; employee contracts, as well as assignment of future incomes from the practice,” Mr. Borglum writes, in an article on his firm’s Website (www.medicalpracticeappraisal.com/appraisal_of_medical_prac.html).

Mr. Borglum warns that goodwill values are often abused, “at the risk of legal and tax complications to the buyer and seller.” For this reason, he advises that goodwill value is best determined by an “impartial third party,” such as a professional appraiser.

value of its equipment and other furnishings.

Income trends count, too. If your practice can show a steady increase in revenues month by month, you're more likely to get a larger percentage of your collections. On the other hand, the appraised value of the goodwill might be a smaller percentage of collections if income has been dropping.

Thus, you may want to take steps to increase your income, such as putting in a few extra hours each month, before you have your practice appraised. If you've cut back to three days a week, getting ready for retirement, you may want to work four or even five days a week in order to bring in more revenues and get a higher appraisal.

Indeed, the best thing you can do, in order to get the best price for your practice, may be to avoid slowing down in anticipation of retirement. That is, don't retire before you retire. After you've dramatically reduced the number of patients you see, you can sell only your practice's assets; on the other hand, when you sell a practice that has substantial recurring revenue, you'll receive a higher price. If a practice has few active patient charts because the physician has slowed down, there's little or nothing to sell.

What's more, if you cut back on seeing patients, your revenues will drop, but your expenses probably won't fall quite as much, so your net income will shrink, making your practice less attractive to a buyer.

A pre-appraisal checkup by a consulting firm may help you boost the appraisal that you wind up with. Adding a new care component or ancillary services may be a good idea. Some lab tests that require only a simple machine may help you increase the practice's revenues.

"Planning for three years in advance may help you sell your practice at a reasonable price," says Ms. Holland. "One step you can take is to maximize the revenues and net income from your

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practice for the next three years. The more cash flow your practice produces, the more attractive it will look to a buyer.”

However, last-minute revenue boosts may be seen as window dressing and thus not add much to the selling price. Appraisers often look at three years of tax returns in order to get an idea of the revenues and net income a buyer may expect. That’s yet another reason to begin preparing for a sale long before the practice actually is sold.

In some ways, selling a practice is similar to selling a personal residence. A little pre-sale sprucing up may enhance its appeal to buyers. It’s important to have your practice look attractive and modern; painting and putting in new carpeting, for example, can pay off.

One proven strategy for doctors who wish to sell their practice is to take home everything from their office, leaving the shelves bare. Then, bring back only what you actually use. You’ll wind up with a spare, clean, spacious look. Buyers will be able to picture themselves in such an office, which will improve your chances of making a sale. Moreover, buyers will project that image to your clinical practices, so they probably will think more highly of your professional abilities and the practice you’ve created.

Negotiating Sales Terms

What terms should you request? Sellers usually prefer an all-cash deal. Banks generally are willing to lend money to allow physicians to buy an ongoing practice. Then the seller will have that money in hand.

Often, though, a buyer’s first offer is to pay a certain percentage of revenues over a period of years. Sellers may be wary of this kind of transaction because they’re bearing all the risk if things go wrong.

“An outright sale for cash is less risky,” Mr. Sansweet says. “If you take back a note for the sale, and the buyer defaults, you’ll have to reclaim the practice and go back to work, which may be the last thing you’ll want to do.” After a year or two away from practicing medicine, and perhaps a move to a different area in retirement, returning to your practice may be impractical—that is why a cash sale is so attractive.

If you do negotiate a sale to a younger physician, the agreement probably will call for you to stay on from three to six

months. This will allow you to properly introduce your successor to your patients, helping to maximize the number of patients who'll stay with the practice. In addition, you may need that much time to get the new doctor enrolled in Medicare, Medicaid and all the various insurance plans in which you participate.

"Generally, the buyer will want the seller to stay around and work at the practice," says Mr. Sansweet. "The longer the seller stays, the more likely there will be a smooth transition for the physician who's taking over. Just having the retiring physician write a letter to the patients won't do very much for patient retention. In some cases, the buyer also will want some assurance that the office staff will stay around, too."

Even though you may prefer to "take the money and run," you might be making a costly mistake if you refuse to stay in the practice for a transition period. If you don't

stay around, the value of the practice might disappear. Just because Dr. Adams replaces Dr. Baker in the office, there is no guarantee that the patients will trust Dr. Baker enough to keep coming. If Dr. Adams is on-site to make the introductions, patients will be reassured.

Real estate also can be a vital factor in the sale of a solo practice, Mr. Sansweet notes. "If the physician who's selling the practice owns the building, the buyer will want to know if the building is for sale, too. Otherwise, a lease will have to be negotiated. In case there is a third-party landlord, the buyer will want to know if there will be a new lease or if the buyer is just taking over the existing lease. If there's only one year left on a lease, and the landlord hasn't agreed to terms for a renewal, buyers may be reluctant to make any commitments.

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Group Practice Buyouts

Succession planning may be much different for physicians in a group practice. If a patient has been coming there for years, al-

ternating among Doctors Carter, Davis and Edwards, the departure of Dr. Carter may not make a huge difference to that patient. Nevertheless, when Dr. Carter leaves the practice, which she has helped to build over the years, she naturally will want to receive some reward for her career-long contributions.

This reward should come through a formal buyout arrangement, sometimes known as a buy-sell agreement. If there is no such provision, you should ask to have one drawn up, preferably several years before you retire. It's always better to negotiate from strength, and that won't be the case right before you retire.

"You should take a good look at your buyout deal well before the actual departure date," says Mr. Gallagher. "Unfortunately, many buyout agreements are drafted and signed, then put away in a desk until retirement is imminent."

Your buy-sell should be a formal, written agreement that iden-

Review Insurance Coverage Before Retirement

Before you leave your medical practice, it is a good idea to review your insurance policies, both those that are provided by your business and your personal policies. Perhaps most important is your health coverage, especially if you are retiring before age 65, when Medicare coverage kicks in.

If you don't have coverage through a spouse's employer, you'll need to bridge the gap before Medicare eligibility by extending your practice's health coverage under COBRA, which can last up to 18 months. If you're still shy of 65 when COBRA runs out, you will need to convert your group coverage to individual coverage or buy a separate individual policy.

Even with Medicare coverage, however, the average 65-year-old couple will spend \$190,000 on medical costs over the next 15 to 20 years, according to a recent survey by Fidelity Investments. The estimate includes Medicare Part B and D premiums, cost-sharing provisions (copayments, coinsurance, deductibles and excluded benefits) and prescription drug out-of-pocket costs. It does not include other health expenses, such as over-the-counter medications, most dental services and long-term care.

So you may want to take out some additional insurance to cover some of these costs. Medicare supplemental insurance, commonly called Medigap insurance, can fill that need. Medigap policies come in

tifies the seller, the buyer, the trigger events and the terms of the sale. Here, you would be the seller (of your interest in the medical practice) while the buyer probably would be the medical group itself.

The trigger events might be your death, disability, retirement or voluntary withdrawal from the company. Thus, a buy-sell agreement not only is important for retirement planning, it can protect you or your family if your career is ended prematurely.

Such a possibility provides even more reason not to delay the creation of a buy-sell, with some mechanism for keeping it current. If one of the partners in a medical practice died, for example, his or her estate would be in no position to negotiate with the surviving partners. The group would buy the decedent's interest in the practice from the estate at the agreed-upon price.

That price would be the amount you'll receive when you leave

10 standardized versions, with each version offering different degrees of benefits. While plan benefits are standardized among insurers, prices are not, so shop around carefully.

The Financial Planning Association (www.fpanet.org) offers the following advice on other types of insurance that you may or may not need in retirement:

■ **Disability.** Once you retire, you don't need disability coverage. Besides, most disability policies won't cover you beyond normal retirement age.

■ **Long-term care.** If you haven't already bought LTC insurance, you may want to consider it now: the cost of coverage climbs rapidly as you age. Your risk of not qualifying because of health reasons also accelerates over time.

■ **Life.** You may need minimal or no life insurance at this stage, perhaps just enough to cover any debts you have and to be certain your spouse will be financially secure after your death. Larger amounts may still be necessary if you want to pass the death benefits on to your adult children or to pay for potential estate taxes. With large amounts, it's often wise to shift ownership of the policy out of your estate in order to reduce any potential tax bite.

■ **Property/casualty.** Retirees often can get a discount for homeowner's coverage, and they may get a discount for auto insurance until they turn 75.

the practice at retirement. “Usually the buyout price is set by some kind of a self-adjusting formula,” says Mr. Sansweet. “That may be a better arrangement than having the partners re-set the value each year. A formula also may be better than using appraisals, which are expensive and can be subjective.”

The pricing formula probably would be keyed to your productivity. “Although agreements can vary,” says Mr. Sansweet, “a common arrangement calls for a retiring partner to get one year’s compensation, which might be an average of the prior two or three years. This amount might be paid over two or three years.”

You probably will have some obligations of your own, too. “Buy-sell agreements usually require a departing physician to give six months’ notice,” says Mr. Sansweet. This gives the practice time to bring in a replacement and allows you to introduce the newcomer to your patients, facilitating the transition.

Gradual Exits

Although the above discussion assumes that a doctor retires from a group practice and stops practicing medicine, at least with that group, that’s not always the case. Many physicians would like to take early retirement, but they have not yet accumulated the retirement wealth needed to support a desired lifestyle.

“In other circumstances,” says Mr. Gallagher, “a potential early retiree really does not want to check out completely; she wants to gradually exit the practice and gradually phase in to full retirement.” For a variety of reasons, partial retirement from group plans is becoming popular, which means that some arrangements must be made.

In order to make partial retirement work effectively, there should be a game plan that addresses scheduling, compensation and ownership of the group. “Coming up with a satisfactory work schedule will mean determining in advance how much time the partially retired physician wants to devote to the practice, what type of patient services she is willing to render and how long she intends to work under the partial-retirement arrangement,” Mr. Gallagher says. Some physicians may work full-time but increase vacations to 10 or more weeks; some work four months on and four months off; some work full-time but only three days per week, and some work the regular schedule

but only until two o'clock each afternoon.

Most groups cannot afford to carry an early retiree at regular pay. Often the workloads of the remaining full-time doctors must increase; increased compensation may be appropriate for their added duties, which means the part-timer will have to receive less.

According to Mr. Gallagher, groups that divide their income on a productivity basis typically do not face as difficult a problem when figuring out how to compensate partial retirees; the most severe problems arise within groups that divide all or a portion of income equally. "A primary benefit of productivity income division is its self-adjusting feature," he explains. "However, care must be

taken to properly account for how overhead expenses within the group will be allocated in light of the part-time status."

Groups with partial retirees also must decide how to adjust buy-out agreements already in place, with compensation pegged to full retirement. Often the buy-sell provides a payment to a retiring physician that is based upon her salary established for the last year or few years of working for the practice. Should this continue to be the case if the doctor works part-time those years?

Some groups have adjusted the buyout payment to correspond to the retired doctor's percentage of full-time activity before he or she completely stopped practice. "For example," says Mr. Gallagher, "deferred compensation to a departed member, who in her last few years of practice had phased down to 60 percent of a full-time contributor, might be paid on a two-tiered plan, with 40 percent of the pay-out based on her salary during her last fully active year with the practice and 60 percent based on her salary during the last phase-down year."

A partner in a medical group who opts for partial retirement also will need to resolve whether he or she should continue to have a vote in practice management or governance. In general, most groups decide that in order to maintain a voice in manage-

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ment, an individual must be involved full-time in the practice. Thus, it is customary for a partially retired doctor to sell his or her stock or partnership interest and resign from officer or director positions.

Whatever the determination, some group-wide structure is vital. Allowing each physician in a group practice to set his or her own partial retirement terms can develop into a logistical nightmare. If partial retirement is going to work successfully, the practice must deal with as many potential problems as possible before they happen, by establishing a formal, written partial-retirement or phase-down policy.

Such a policy might include eligibility standards (minimum age and service); advance notice of nine to 12 months, and limits (often three or four years) before “partial retirement” must become full retirement.

Closing Shop

If you leave a group practice or sell your solo practice, patients’ records need not present a problem. “The records belong to the practice,” says Karen Schechter, a consultant with Stone Carlie Wealth Advisors, an accounting and management consulting firm in St. Louis. The situation is different, though, if you close down your practice.

“As a physician,” says Ms. Schechter, “you have a responsibility to protect your patients’ health information while ensuring its availability for continuity of care.” During and after closure of your practice, you must be concerned with the retention and storage of those records.

In terms of the retention of patient records, either federal or state law may apply. State laws are generally the ones to follow while federal laws cover Medicare (five years are required for participating physicians) and patients treated for substance abuse (written authorization is required before transferring to another physician).

“If your state does not specify the length of time that records must be kept,” says Ms. Schechter, “you need to adhere to the state’s malpractice statute of limitations. We recommend you use the time period prescribed by the statute of limitations as a minimum; if the patient is a minor, records should be retained until

the patient reaches the age of majority, plus the period of the statute of limitations.”

Storage of patient records will be your responsibility unless they’re transferred to another physician. You can rent space (paying the storage cost) or store them at home. If patient records are transferred to another physician, you are responsible for ensuring that they are stored safely for an appropriate length of time. Therefore, you should request a written agreement that spells out the terms and obligations.

Ms. Schechter advises physicians who are closing a practice to notify their malpractice insurance carrier. “Make sure that your coverage continues even after the practice is closed,” she says. “Consult your attorney, too.”

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Once you’ve determined that all records are complete and unnecessary material has been purged, you should notify your patients, giving them an opportunity to obtain copies of their records or have the originals forwarded to their new physician. “At a minimum,” says Ms. Schechter, “send a letter to patients you have seen in the past 12 months, telling them of your plans 60 to 90 days in advance of your closure. We recommend registered mail in the case of high-risk patients.”

Such a letter should include the following information: office closing date, notification of where the records will be stored and how to access them, release-of-information form to be completed to receive a copy of their medical record, deadline for submitting record requests and information on how to locate a new physician.

“Place a copy of the notification in each patient’s chart,” says Ms. Schechter. “You also should place any returned letters, with the associated envelopes, in the appropriate patients’ charts.”

In addition, referring physicians and other professional associates should be notified, probably with a letter, and arrangements should be made for announcements of the closure to appear in

the local newspapers. You will need to establish a method for honoring requests for patient records before and after the practice closes. This might mean hiring or retaining staff to honor the requests for patient records within the time period established in your notifications.

When all of these procedures have been followed and you've satisfied these obligations, your retirement can truly begin.