SPECIAL REPORT

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Challenges and opportunities in physician practice succession planning

A special report from Kaufman Hall, a Vizient company

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Background – the succession planning challenge

Joint venture structures have long been used in ambulatory care settings to align the strategic and financial interests of physicians and other partners, which may be health systems or other corporate entities with applicable facility or specialty specific operating expertise. Facility types in which this approach has been common include ambulatory surgery, dialysis, radiology imaging and infusion.

In these partnerships, generally the physicians and their joint venture partner or partners invest fair market value capital in exchange for equity, with the goal of improving clinical care and generating annual cash distributions for all shareholders. There are some instances in which physicians create joint ventures at the medical group level, but oftentimes physicians purchase shares as individuals. Participating physicians may all be employees of a single medical group or may come from a range of medical groups and private practice.

While each situation is unique, when the business and clinical case is sound these joint ventures can create a mutually beneficial value proposition for all parties. The structure aligns the clinical and economic interests of physicians, whose clinical expertise is critical for the strategic success of these facilities, and their business partners, who often bring capital, business expertise and other important resources.

Joint ventures have been most successful when the physicians and their joint venture partners have aligned goals and are all active participants in the success of the facility. Each shareholder brings unique capabilities and relationships that are critical for delivering high-quality, high-value care in a financially sustainable model. In these arrangements, the corporate partners are going concern entities that are designed to outlast individual leaders. However, if physicians are investing as individuals, each physician will eventually retire or otherwise leave the practice and will cease to be an active contributor to the success of the venture. Given that active physician participation is critical to sustain strong clinical and operational performance, these transitions present a succession planning issue that joint ventures must address to continue to be viable over the long term.

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In some cases, joint venture organizational documents clearly define what happens when a physician retires from active practice. In some facility types (e.g. certain types of ambulatory surgery centers [ASCs]), regulations effectively require retired physicians to divest their shares. However, in other instances there are no such requirements, and it is common to see retired physicians continuing to own shares and receive cash distributions.

In these cases, a portion of facility cash flow serves as retirement income for non-practicing physicians. Distributions to retired physicians leave less cash flow available for actively practicing physicians who contribute to the facility's clinical and operational success.

If the number of retired physicians receiving distributions is small, there is often little motivation to address the issue. However, over time and as more physicians retire, a tipping point emerges and the number of actively practicing physicians aligned with the joint venture becomes insufficient to support the facility's clinical and operating goals.

WHEN A GOOD JOINT VENTURE AGES OUT

A decade ago, a group of 10 physicians from a respected specialty practice formed a joint venture with a corporate partner to operate an outpatient facility. The venture was successful from the start: aligned incentives, strong clinical leadership, steady financial performance. But over time, quietly and unnoticed at first, fissures emerged. Today, that JV has become a source of strain.

The original 10 physicians invested as individuals. In the intervening years, the practice grew and welcomed more than 10 additional partner physicians. But without a mechanism for transitioning equity, the joint venture's ownership never evolved. Two of the founding physicians have since retired, yet they continue to hold equity and receive distributions. Several more are planning to retire within the next 5 years.

Meanwhile, the newer partners are locked out. There is no defined process for share redemption or admitting new shareholders, and no shares have been made available for purchase. Three promising physicians left last year to join a competitor offering joint venture investment opportunities; the practice has not yet filled those roles. The CEO now fears more departures are coming.

What was once a strategic asset has become a recruitment risk. Without action, the facility's ownership model will be increasingly misaligned with its active clinical base. The solution isn't simple. It may require negotiating with retired physicians, amending legal agreements and building consensus among active partners. But one thing is clear: the longer they wait, the harder the fix becomes.

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Each situation is unique, and a number of factors will define whether and when these issues demand attention. Factors that impact when this dynamic becomes unsustainable include:

1. **Percentage of distributions going to retired physicians:** If only a handful of physician shareholders are retired, the issue may not be sufficiently material to drive a willingness to change. However, as the percentage grows, the imperative will likely increase.
2. **Timing of retirements and recruitment:** Although unusual, there may be cases in which timing of physician retirement matches harmoniously with new recruitment such that internal share buy-outs and buy-ins proceed without friction. This presumes that retiring physicians are willing to sell, but if that is the case it is possible that a carefully planned (or highly fortuitous) cadence may allow for the issue to be addressed naturally without changes to the joint venture documents or other intervention.
3. **Materiality of joint venture distribution income to physician shareholders:** If physicians in the practice are able to earn satisfactory compensation from professional activity alone, there may be less urgency to admit new physicians to the joint venture.
4. **Affordability of shares for new physician shareholders:** New physician shareholders will be required to invest fair market value capital to buy in. These physicians will need to assemble the required cash or borrow to support their purchase. If new physicians do not feel that the buy-in is affordable, there may be less demand to purchase shares.
5. **Willingness of the joint venture partner to buy or sell shares:** In some cases, the corporate entity with which the physicians have partnered is able to buy and/or sell shares as needed to assist with physician shareholder succession planning.

In most cases, if retired physicians are retaining shares the issue will eventually rise to a level that requires intervention. The declining number of actively practicing shareholder physicians may impact joint venture quality and performance. There may also be discontent among newer physicians practicing who have not been given the opportunity to buy shares. If the shareholder physicians are all members of the same affiliated medical group, as is often the case, discontent among younger physicians waiting to buy shares may spill over into that medical group and hamper its ability to recruit and retain physicians. If the issue is not addressed, particularly in highly desirable “ambulatory prosperous” specialties, the newer physicians will have no shortage of alternatives for joint venture participation and will go elsewhere.

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Lessons learned

There is no one-size-fits-all solution to address all issues that will emerge among a diverse range of equity partners, but certain leading practices have developed over time.

1. **Mandatory share buy-backs:** Many organizations require physicians to sell their shares upon retirement or departure, either immediately or within a previously established time frame (e.g., 12 to 24 months). This keeps shares concentrated among active physicians and maintains clinical and operational alignment without requiring potentially challenging or even acrimonious negotiations to address succession planning issues.
2. **Standardized valuation formulas:** A defined formula for share buy-backs and new purchases, often based on a valuation that is calculated as a fixed multiple of facility EBITDA, is used. This approach seeks to balance the affordability of share buy-ins with providing a reasonable return on investment to selling shareholders. If there is no defined formula, a new valuation may be required every time a shareholder buys or sells shares, creating a longer, costlier and more challenging process. This dynamic could also result in the purchase price of shares rising rapidly and becoming unaffordable for early-career physicians.
3. **Access to financing:** Medical groups and corporate partners can support new physician partners by introducing banking relationships to provide a source of funding to support physician buy-ins. Younger physicians may not be able to afford the purchase price of shares. Providing easy access to financing at attractive terms will make the buy-in process feel more approachable, equitable and affordable.
4. **Joint venture and/or corporate partner participation:** If permitted, the joint venture may be able to issue new shares and/or buy back shares to be held in treasury to facilitate transitions in physician share ownership. In some cases, the corporate partner may also be willing to act in a similar capacity. Because new physician hiring and retirement dates are not always easily coordinated, having the joint venture partner or the joint venture itself facilitate the transaction can ease the friction caused by differences in timing.
5. **New joint ventures:** Although not a permanent solution, some practices that are growing have bridged the succession planning issue by opening new joint venture facilities to create new pathways for physicians to purchase shares. As the practice matures this will not be a long-term solution, but some practices have been able to leverage lessons learned from initial joint ventures to build mechanisms into the new joint ventures (including many of the above) that more directly address these issues. Ultimately the succession planning issues in the original joint venture(s) will need to be addressed, but the magnitude of the issue may not be as large.

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As succession planning issues emerge, some of these tactics may be achievable without requiring changes to initial joint venture agreements. However, others generally cannot be implemented without changing the foundational documents—which may be met with resistance. In particular, requiring physicians to sell their shares upon retirement is a key lever and potentially the most important tool. But if this provision was not included in the original agreements, it will require changes to the documents to be implemented.

The ease of implementation (or lack thereof) will depend on the specifics of the circumstances. Each situation is unique. But the following series of questions and accompanying examples may help frame the options.

1. **Is there enough support to implement the desired change?**

   Example: A single-specialty medical group with a joint venture analyzed the age distribution of its shareholders and realized that a majority of its physician shareholders were still early to mid-career. Through a carefully managed communication process, the group aligned those physicians around a shared objective and secured enough votes to implement a requirement that physician shareholders be actively practicing in the medical group.

If not, then...

2. **Can a compromise be reached to gain the necessary votes?**

   Example: A single-specialty medical group with a joint venture performed a similar shareholder age distribution analysis but did not have sufficient support among early to mid-career shareholder physicians. The group developed a compromise approach in which retiring physicians would be required to sell their shares over a 2-year period, with 50% of shares sold back after the first year and the rest sold after the second. This allowed retiring physicians to benefit from additional income for a transitional period and was sufficient to secure the remaining votes needed to approve the change.

If not, then...

(continued)

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3. **Can the joint venture partner assist with a solution?**

   A specialty medical group found itself in a position in which a majority of its JV shareholders were retired or near retirement. There was no feasible, near-term path to an internal resolution of succession within the group. In this case, the group's leadership asked the joint venture partner for assistance. A review of the JV operating agreement revealed that the partner, which was a majority owner in the JV, had the right to amend the document to require that physician shareholders must be in active practice. While this option may not be available in all cases, it illustrates that collaborating with the strategically aligned joint venture partner could reveal alternatives that the medical group cannot pursue on its own.

If not, then...

4. **What must happen to shift the dynamics? The pathway may be challenging, but what strategies can the practice pursue to create a burning platform for change?**

Note that in the examples above, the shareholder physicians were all members of the same affiliated medical group. In cases in which the shareholder physicians are in independent practice or members of disparate medical groups, similar strategies may still be available. However, in these cases there could be added complexity from having to coordinate across multiple groups, in which case the joint venture partner may have to play an even more important role.

Sometimes physicians recognize the problem but struggle to address it. In these cases, there are no easy solutions. Making the case for change may be a multi-year effort that requires listening, education and change management. Consider starting small. Begin with education and data-sharing, then introduce modest, non-binding policies—like encouraging retirees to sell their shares—before pushing for formalized change. Early steps help build momentum.

A few additional approaches to consider:

1. **Strategic planning as a tool for change:** Formal strategic planning can be a useful lever. Facilitated planning processes may include financial modeling, physician turnover and recruitment forecasting, and scenario analysis. One powerful tactic is to quantify the long-term impact of inaction on the facility's clinical outcomes and operational performance. Data can shift focus from emotion to evidence and create urgency around reform.

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2. **The role of medical group leadership:** If the affiliated medical group has strong administrative leadership, those leaders may play a crucial role in raising these issues and guiding the conversation. Because their role is to protect the medical group's overall health, they often have insight into any issue that could challenge the viability of the group over the long term. In some cases, their credibility and focus on group success, especially when paired with champions from physician leadership, may help make the case for change.
3. **Don't underestimate culture:** Culture often determines whether change is possible. Practices that value shared success and long-term thinking are more likely to reach consensus. In contrast, cultures centered on individual autonomy or income protection may get stuck, even when risks are clear. It's worth examining how culture is shaped. Messaging from leadership, policy consistency and how younger physicians are treated all play a role. Are new physicians viewed as future partners – or second-class stakeholders? Building a culture that values stewardship and shared investment can lay the groundwork for lasting change.

And what if the case for change is not successful? A few options of last resort are possible.

1. **Selling the entire physician share block:** Some groups opt to sell the entire block of physician shares, either to the JV partner or a third party, in one transaction. This offers liquidity and simplifies governance but removes a key alignment tool. Often this is a temporary solution, and these ventures are later re-syndicated to new physicians, at going concern value. The decision to sell isn't inherently wrong, but it should align with the group's broader strategic goals.
2. **Maintaining the status quo until it breaks:** Alternatively, the lack of alignment may result in no action. The structure remains unchanged while recruitment slows, morale drops and joint venture performance declines. Change eventually becomes unavoidable, but by then the practice may face fewer options and greater risk. Left unchecked, this dynamic can undermine both the JV and the affiliated medical group's long-term performance.

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Conclusion

There is no universal playbook for addressing complex succession planning. Physician joint ventures have been common for decades and there are industry best practices from which physicians may draw, but the solutions must be tailored to the unique dynamics of the situation, including the goals, constraints and culture of the practices. Physicians who establish and build a practice rightfully want to be rewarded for their risk and hard work; but, perhaps ironically, physicians who are focused solely on maximizing the value of their individual investment risk ultimately reducing that value over the long-term.

For those practices that must confront these challenges directly, the solutions will require making the case for change and aligning the interests of physicians with diverse individual goals and perspectives. In some instances, there may be a relatively frictionless path to resolution while others will require a multi-year education and change management approach.

This is why forward-thinking practices should consider succession planning long before they think they need to. Those that do will continue to grow, attract new physician talent, satisfy the needs of retiring physicians and, ultimately, continue to benefit their patients and communities.

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