

Physicians Again are Opting to Sell Practices to Hospitals

By SHARON H. FITZGERALD

This is supposed to be a story about practice management. What it is instead is a story about what physicians today, particularly those under 40, think of practice management. The bottom line? Most would prefer not to think about it at all.

That's one factor driving the growing trend of hospitals and hospital systems purchasing medical practices. "Doctors are tired of trying to be business executives and clinicians, and this provides them the opportunity to turn their practice over and let somebody else run it," said Kevin Boggs, a senior vice president of PivotHealth, a Brentwood-based contract management company that specializes in bringing practices into the hospital fold and ensuring a smooth transition. Then PivotHealth helps hospitals, on a full-time or interim basis, manage day-to-day office operations such as scheduling, coding, billing and claims. "We focus wholly on the physician-hospital relationship," Boggs said.

When asked if doctors are more will-

ing today to sell their practice to the local hospital, Boggs responded, "Absolutely, and we're seeing that nationwide. There's not one reason; there's a litany of reasons." Motivation to sell includes:

- Rising costs, from supplies and salaries to malpractice insurance premiums,
- Declining reimbursements,
- Claim hassles,
- The growing need for continued electronic sophistication,
- The desire for more family time and a more predictable schedule,
- The stress of personnel management and
- Stress in general.

Boggs said practices are operating on razor-thin margins, adding pressure to physicians who don't necessarily have the requisite business skills on top of their clinical expertise. "They want to be a doctor and go home. Particularly physicians coming out of training today, they are willing to let someone else take the risk," he explained.

Wait a minute. Isn't this sounding like the late 1980s and early 1990s? Look how *that* turned out. Boggs said this time it's different. Hospitals have wised up, he said, and aren't "building doctors' Taj Mahals and then wondering why they are los-

ing their shirts. Hospitals are a lot smarter about this now. They are not going in and buying good will in a practice. They're not throwing their cash around."

In fact, today's hospital-practice deals revolve around the fair market value of the hard assets and perhaps a flat fee per patient chart. "Once they buy that practice, they have no guarantee that that patient is going to stay with that practice and continue to provide a downstream revenue, so they're not willing to pay for something that they're not sure they're getting," Boggs said. "We're seeing hospitals that are not awash in cash – they're having some struggles too because of the poor economy and a higher self-pay population, but they recognize that they have to make sure their physicians stay with them and continue to admit and order ancillary tests."

With healthcare reform, accountable care organizations – provider partnerships forged to increase efficiency and improve patient care – are in the offing, and hospitals see the advantages of casting a net and pulling in a variety of providers to establish continuity of care and the strongest array of services possible.

But what about physicians in a community who stay independent – a large

group practice or a fiercely independent doctor duo? "When we work with hospitals, we try to help them build a model across all the physicians in the community," Boggs explained. "Hospitals are going to have to work with every physician within that continuum. We work with hospitals to help them run their own practices more efficiently, help them with their billing and operations, but we also help them set up, for lack of a better term, the old MSOs, management service organizations." In that scenario, hospitals offer independent practices administrative services such as electronic health records and billing and charge them a fair market value. "Ultimately, what happens is that once you develop that relationship and that bridge, when the physician becomes ready to align more closely, you already have that relationship with them," Boggs said.

Another option for a hospital-practice relationship is for the physicians to hold onto the real estate and the hospital enters into a lease, thus offering the doctor a long-term tenant. "You structure it along the line that you're not tripping any of the issues with anti-kickback or the Stark regulations," he said. "You're just buying

(CONTINUED ON PAGE 14)



Kevin Boggs

Physicians Again are Opting to Sell,

continued from page 9

the real assets of that practice.”

Last October, the Medical Group Management Association released the results of a survey that revealed that physician compensation and revenue are negatively affected by hospital ownership of a practice. According to the report, the medium total medical revenue for a multispecialty hospital-owned practice was \$448,597 per full-time physician, \$350,011 lower than in not-hospital-owned groups. Specialty-care physicians in hospital-owned practices earned 19.85 percent less in total compensation than those in not-hospital-owned groups. Primary-care physicians fared better in hospital-owned practices, earning about \$12,000 more than independent primary-care doctors.

Boggs said today's typical arrangement establishes a market-competitive base salary for physicians, usually with a factor added for production. Yet a bonus isn't based on a patients-through-the-door count. More likely, bonuses are accrued based on relative value units. Again, Boggs added, hospitals are approaching practice purchases more pragmatically this time around.