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Sell Your Practice to a Hospital? Read This First

Neil Chesanow, Jeffrey J. Denning | May 22, 2013

Introduction

With the future of healthcare uncertain and many physicians, particularly soloists and those in small groups, feeling vulnerable, this may seem like the perfect time to sell your practice to a hospital or insurer. Both are in the midst of a shopping spree for physician practices.

In 2011, a survey sponsored by MedSynergies found that 70% of responding national hospitals and health systems planned to employ more physicians in the next 12-36 months.[1] Physician groups being snapped up by community and regional hospitals have become a staple of local news.

What's going on? And what -- if anything -- should you do about it? For answers, Medscape spoke with practice management consultant Jeffrey J. Denning, a partner in the Practice Performance Group in La Jolla, California, about the risks and rewards for a small or solo physician practice in selling to a hospital in the current market.

Jeffrey J. Denning

Denning advises even doctors who are having trouble paying the bills to refrain from acting precipitously. Instead, he urges you to pause, take a hard look at why you want to sell, and take an equally hard look at who you want to sell to rather than allow yourself to be ruled by herd instinct, as happened in the late 1990s, with unhappy results for both the hospitals and the doctors involved. Here's his perspective on what to do today.

What Hospitals Seek in a Physician Practice

Medscape: Are many of the physician practices you represent seeking to sell to a hospital?

Mr. Denning: Yes, we are increasingly helping clients with their exit strategies. As it gets more difficult to sell space in a medical practice to a physician, they seek any reasonable alternative.

Medscape: What's driving hospitals to acquire physician practices at such a rapid pace?

Mr. Denning: They need a feeder system, and that's a pretty common motivation for a hospital. I worked for a hospital in the Central Valley of California. They're a 1-hospital town, but they're near a couple of other good-sized towns. They had to buy up as much primary care as they could to protect their specialists who do the admitting and the work. If the primary care people drift away or fail, they have no one to vet patients.

To sell a practice to a hospital, it has to be something the hospital wants and needs. That means it's better if the practice is a success story. But if it's a success story, the doctor should be reluctant to part with it. Where these deals are tricky is that the hospital will do anything to get the doctors in. They'll live with the situation for a year or two before they start making changes in the practice -- but that's all. So negotiating the physician compensation package is crucial to making it work for the doctors.

Medscape: Do some doctors go into this thinking they'll be semiretired and won't have to work as hard?

Mr. Denning: If you look at their behavior after they've joined, the answer is yes. Most physicians contemplating doing this are at that age anyway, so even if they're not overt about it, often they've already starting scaling back, which is contrary to our advice, which is to go out in a flash. If you're trying to sell your practice, sell it in your best year.

What Hospitals Are Paying Today

Medscape: In the 1990s, some hospitals paid 10 times what a practice was worth in order to own it, so fierce was the competition to expand or maintain market share. Do doctors have a realistic idea of what hospitals will pay for their practices today?

Mr. Denning: In most cases, the doctors involved have no idea what is reasonable to ask for. In other cases, they have an inflated idea. They get laughed out of the room. I have a family physician who's very angry with me at the moment because I did an evaluation of his practice and what I thought it was actually worth. He said, "This is nowhere near what I'm going to need. The hospital told me to get an appraisal, and they'll go along with any appraisal I get." So I revised the evaluation upward with some optimistic assumptions. The hospital looked at it and said, "You're nuts. Whoever valued this practice is incompetent and doesn't know what he's talking about."

Medscape: What about goodwill -- the nontangible assets of a practice -- like patient loyalty? In the 1990s, the inflated prices hospitals were paying for physician practices were often justified by their goodwill value.

Mr. Denning: Nobody disputes the reasonableness of buying the contents of the office or the medical records and lease improvements and that sort of thing. But when it comes to goodwill, hospitals get very chary. They really only pay for hard assets.

How Will Compensation Work?

Medscape: Do doctors have realistic expectations of what their compensation will be? Do they think they will get a straight salary, as was often the case when hospitals purchased physician practices in the late 1990s, rather than a base salary with bonuses based on a productivity formula?

Mr. Denning: It's almost never a flat salary anymore because if the hospital sets the base too high, the doctors quit working. The ambitious doctors who want to make a lot of money are not usually attracted to these deals. It's quite often frankly failed practices or practices that are nearing failure looking for a bailout. We see a lot of those cases. If the doctor owes a ton of money, has not saved anything for retirement, and he's 71 and has an 11-year-old son -- that scenario is very common.

Medscape: So it's worth it, at least in some cases, for a hospital to buy a practice that isn't doing well.

Mr. Denning: What's worth it to a hospital is to have an ability to control the practice and to recruit additional physicians. Recruiting a new doctor to settle near a hospital used to be pretty easy, but now, because of antikickback regulations, the Stark Law, and the IRS breathing down their necks, there's a very strict limit on what hospitals can legally defend in terms of private inurement of not-for-profit money to physicians. Hospitals that ignore that are playing a "sweat-the-statute" game. Maybe nobody'll look. But most hospital administrators are not up for that risk.

Who Will Manage the Practice After You Sell?

Medscape: Many doctors feel that if they sell the practice, they will no longer have to manage it. It will be the hospital's headache.

Mr. Denning: It's true that some doctors go in with that attitude. There's another large group, though, that's used to calling the shots, and they try to convince a hospital to let them continue to do that. And there are plenty of hospitals that say, "We want you to have this practice however you want it. So you can run it." That works until you try to buy a photocopier. Then you have to contend with the hospital's budgetary process.

What I tell doctors is: "If you're hopeless at managing your business and you're begging someone to bail you out of it, then it might actually be better to go with the hospital. The hospital is much more likely to be in a position to hire a degreed professional in business who might be better at this than you are."

However, hospitals almost always do a poorer job of running a physician practice than doctors do. That's because doctors sign every check. Every dollar belongs to them. They're very aggressive about collections.

Medscape: Speaking about controlling the money, does it become a problem when you take billing out of the practice and replace it with the hospital's centralized billing system? Then you no longer have a dynamic between the practice billing department and the front office staff that energizes the practice, and the doctors are divorced from the money as well.

Mr. Denning: Yes, it does happen that way, and it's predictable. It also happens in practices where they run out of room in the office and rent 850 square feet of space upstairs and move billing up there, and bingo: All of a sudden it does them in. A symbiotic relationship exists between the billing people and the front-desk staff. Each motivates the other to do a better job. When that interaction is prevented, the accountability and communication that both groups need to succeed may suffer. It's generally a mistake to move the billing department off-site.

Negotiating Your Compensation Package

Mr. Denning: When it's a centralized billing operation servicing a half-dozen hospital-owned practices, collections tend to suffer even more. We tell our clients going into that mix, "If you negotiate your compensation package correctly, you don't need to care whether they collect what's owed or not."

The best way to negotiate the compensation package for both the hospital and the doctor is to price every relative value unit the doctor produces and give the doctor the money as it's earned. If accounts receivables are later uncollected, that's not the doctor's fault or problem. The doctor no longer owns the business. Negotiating the correct rate is all you have to do.

Medscape: Hospitals are receptive to negotiating on these terms?

Mr. Denning: Yes, in concept. With my clients, we tell them, "It's the only way it's going to be." There's no logical argument against it. But where the rubber meets the road is on negotiating the rate. We'll bring the hospital MGMA [Medical Group Management Association] compensation numbers. We've got reams of data on this: what doctors in this specialty and region actually earn per relative value unit. And the hospital will say, "Fine, we'll give you half of that." When the doctor is desperate, it works. The hospital is almost never desperate to buy the practice. So a lot of deals break down in negotiations.

By owning a clinical operation, an outpatient operation, the hospital now has an organization that is in a position to recruit doctors to a larger entity. If I'm coming out of ENT training and joining 2 doctors in their 50s and 60s, that's a risky job for me to take. At least it's contemplated that way by people coming out of training. Whereas if I join a hospital, I know they have endless money, and they really do.

The hospital always says they're losing money on physician practices. That's like Hollywood accounting. The fact is, an office visit for a family physician goes up in value about 4 times when a hospital does it. That's because their lab and imaging referrals go to inpatient units where the cost is much higher than outpatient unit imaging.

As a practical matter, the hospital takes over the practice, puts their logo on the door, and everything stays pretty much the same -- at least for a while. When the hospital has enough practices, they move them into a clinic building that the hospital owns.

But in the first year or two, what the patient or payer pays for an office visit goes up 3 or 4 times, even when there are no ancillaries ordered. That's because the hospital bills the physician component separately from the facility

component. And a hospital's facility component is much higher than Medicare allows for doctors.

Should You Be Selling at All? And to Whom?

Medscape: Say the lead doctor in a 5-doctor primary care practice comes to you. "Our expenses are going up," he says. "The cost of the EHR has eaten into our budget. The cost of maintaining the office is going up. Medicare rates are being chipped away. All this consolidation is happening. I'm afraid we'll be left out or squeezed out of it. All these hospitals are buying up practices. Is this something I should do?"

What do you say?

Mr. Denning: I get this call once a week: "Come help me figure out how much my practice is worth because I need to sell to the hospital." I'll ask, "Why do you need to sell?" And if the answer is, "Because my overhead's going up, my fees are being ratcheted down, and it's becoming economically untenable," I know as a consultant that is often not the case. That is what the doctors have been telling each other. But they're complaining with assertions rather than facts.

I tell these doctors, "I'm happy to help you with this transaction, but I'm going to begin with the question of: Why do it? Then I need to learn how your practice is actually working compared with what it was doing 10 years ago. And if what I learn is that the doctor is working 67% of what he was doing 10 years ago, his assumptions are wrong. That is often the case.

If a doctor is doing this because he is unable to keep his practice profitable, and the consultant agrees -- "You're just not good at this," or, "Nobody could do it" -- you sell your horse before it dies. But doctors tend to negotiate transactions serially. First they try to look for somebody to join them. When that fails, they go to the hospital or the hospital approaches them.

An early question I have is: "Who else are you talking to about buying the practice?" A practice with a family physician or 2 or 3 senior family doctors practicing together may have more value to the internal medicine and primary care group down the street that's already together but still independent of the hospital. It's very smart to build a small multi-primary care practice with pediatrics, internal medicine, family medicine, and OB/GYN: 12-14 doctors. If there are 2 or 3 hospitals in the area, and these doctors control a huge portion of specialty referrals, a practice like that can be really valuable.

When I talk to a doctor who's talking to a hospital, I ask, "Have you shopped this to the internists upstairs?" "No," I'm often told, "I'm dealing with the hospital. I've got a letter of intent that precludes me from talking to anyone else." I say, "Let's ignore that. It's much better to have a bidding situation. We don't know who might be interested until the end."

Evaluating a Hospital as a Prospective Employer

Medscape: In the late 1990s, the last time hospitals went on a buying spree, there were personality and cultural clashes between hospital administrators and doctors. Everyone had different expectations of how things should work. It was often like 2 warring camps. One consultant quipped that as businesses, the only thing hospitals and physician practices had in common was patients. How do doctors avoid a replay of that this time?

Mr. Denning: It's like residents going on job interviews. The question the resident needs to have answered at the end of the recruiting process is: Are these people qualified to hire me? They'd like me to build a career here. I need to build a career in a place where I can take root. I don't want to put my seeds in the desert. I want to put them in the loam.

The same question exists with hospitals. Among hospital administrators, turnover is commonly high. So the people you're negotiating with today to buy your practice may not even be the ones you work with next fall when you come on board.

Given this, the question I would ask is: What is this hospital's ability to retain good workers? Especially good midlevel managers -- if they have midlevel managers who have been there 8 or 9 years, that's a good sign. If the midlevel managers are clear and easy communicators, that too is a good sign. Speak with physicians who are already employees. If the hospital has a history of 10 years of acquiring physician practices gradually, progressively, and successfully, that's a good sign.

References

1. FierceHealthcare. Survey finds 70% of hospital and health plans will increase number of employed doctors. October 2011. http://www.fiercehealthcare.com/press-releases/survey-finds-70-hospitals-and-health-systems-will-increase-number-employed- Accessed May 8, 2013.

Cite this article: Sell Your Practice to a Hospital? Read This First. *Medscape*. 01Jan , .