Selling Your Private Practice to a Hospital

The sale of physician practices to hospitals is a growing trend in the health care market in Texas and throughout the United States. The NY Times noted earlier this year that in 2005, more than two-thirds of medical practices were physician owned, while now it is less than fifty percent. The shift toward hospital based physician practices is increasing every year.

There are a number of reasons for this change in the ownership of medical practices:

There is the changing priorities of the new generation of physicians. Physicians who are in their 60’s today may have viewed weekend call as a fact of life; the doctors of today see it as a nuisance. Many young doctors do not place much value on being a partner. Personal quality of life is more of a consideration for this new generation of doctors. Younger physicians are satisfied not to have the benefits associated with owning their own business. Many prefer the flexibility that comes with being part of a large group and prefer to avoid the risks of opening their own practice.

Those risks have increased with the decline in reimbursement rates. Doctors are realizing that, in an independent practice, they have little negotiating power against the mammoth insurance companies. As a part of a hospital based physician practice group, the physician avoids the risks. The hospital system will be the party negotiating reimbursement rates. The hospital system will have better leverage to negotiate managed care contracts and hopefully the increased collections will result in a benefit to the individual physicians in the form of salary. One physician recently told me that he had an epiphany when he had spent most of his day first negotiating a dispute between two employees and then on the phone with an insurance company arguing about reimbursement. He said to himself, “This is not the reason I went to medical school.”

Ever increasing burdens for regulatory compliance is another significant impetus for change. For example, the introduction of electronic health records is a large burden for an independent physician practice. The computerized systems are expensive and time-consuming for doctors to install and maintain. Their substantial benefits to patient safety, quality of care and system efficiency accrue almost entirely to large organizations rather than small ones. The economic stimulus plan Congress passed early last year included $20 billion to spur the introduction of electronic health records. This is certainly the way of the future.

A final reason for the change may be the feeling that the tide is turning and therefore it is wise to exit now in a timely fashion. Currently, hospitals in Texas have to employ physicians through their 501a physician
organizations, but many people believe that corporate
practice of medicine doctrine will get overturned in the next
legislative session. If that occurs and hospitals are able to
employ physicians directly, it is reasonable to assume that
more physicians will be employed by hospitals rather than
private practices, as it will be more economically feasible
for the hospital. At that point, one can assume the
purchase price will decline from what it is today, as the
supply will exceed demand.

Of course, there are some disadvantages for the physician
to consider as well when making the change. Physicians
who have sold their practices report they have trouble
adjusting to the slow decision making of a large
organization. For example, in your practice it would
require a simple partners’ meeting vote to decide to buy a
new piece of equipment. As an employed physician of a
large hospital system, you would likely have to get the
equipment included on the budget in advance before any
purchase is made. Changes in personnel also move slower
than they do when you are on your own. This slower pace
and need to constantly anticipate and get “permission”
from others can be a source of frustration for a physician
accustomed to being his own boss.

Typically, in effecting a sale, the first step will be on the
part of the hospital; the hospital will do due diligence to
determine the purchase price for the assets of the practice
and the salaries of the physician. Invariably, there will be
a gap between the price the hospital proposes and the
price the physicians think it is worth. The valuation will be
based on the net present value of the hard assets of the
practice minus the long term debt of the practice. There is
little or no value given to the goodwill of the practice.
Patients will switch practices over a $20 co-pay so the idea
that there is any sort of patient allegiance is a
misconception. That generally is a thing of the past. This
fact of no value being assigned for goodwill is hard for
some selling physicians to handle, but it is the reality.

As in any other business transaction, the parties must plan
for the divorce at the same time they are planning the
wedding. A heavily negotiated part of the transaction is
often the non-compete agreement. A physician will
typically want the provision to be limited to only the time
when he or she is an employee of the hospital. If things
fall apart, he or she wants to then be able to go back to
the old way of business. The hospital wants the doctor
restricted and does not want the physicians able to leave
and be in direct competition if they quickly find that being
an employee is not suitable to them. The Texas statute
requires that in order for a non-compete provision with a
physician to be valid, the language must contain a buy-out
clause for a “reasonable” price. Often, the notion of what
is a reasonable price will be debated. All non-competes
must be limited by time, scope and location so when
drawing up a contract representing the physicians, we try
to make it as narrow and specific as possible. Sometimes
with group practices it is feasible to negotiate a separate
option under which the group, after a period of time has
been in effect, has the option to buy back the practice.

A hospital employing the physicians also wants to assume
that the physician’s referrals for ancillaries are made to the
hospital. Therefore, the non-compete will typically prohibit
ownership in entities that compete with the hospital
system, such as ambulatory surgery centers, imaging
centers, and radiation therapy centers. When representing
the physician, any such current investments should be
grandfathered. If that is not possible, we negotiate to
have a grace period to find a suitable buyer for the investment.

The non-compete agreement will also usually include a covenant providing for a non-solicitation of hospital employees. It is important to ensure that any employees of a current practice who move to the hospital practice or new employees who work exclusively or primarily with the practice are able to leave with the physician if the group decides to part ways with the hospital.

Each employment agreement compensation model will be slightly different depending on the physician, the hospital and the nature of the practice. There are some constants, however. The physician will want the salary guaranteed as long a time as possible while the hospital will want the physician to quickly transition to an "eat what you kill" formula. Hospitals will often include minimum production thresholds; if the physician does not meet this level, the compensation can be adjusted negatively. It is very important to negotiate how production is measured and what are the threshold targets. There may be some amount of production of the physician that could be adversely affected when the physician becomes a hospital employee.

The purchase agreement will contain the standard representations and warranties and the requisite disclosure schedules that go along with them. This process is tedious and time-consuming, but is important to protecting the interests of all the parties involved.

Finally, it is important to remember that this process does not happen quickly. The transactions that go the smoothest have an office administrator or one point person to respond to the hospital and attorneys’ requests for documents and other matters. In this way, the physicians can focus on seeing patients rather than on closing deals.