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Understanding Hospital Buyouts of Physician Practices

by Steven Podnos, Md, Cfp • Feb. 15, 2016 • 1 min read • original

Part 1 of a two-part series on physician buyouts

In a world where physicians are fleeing independent private practice to join the corporate and institutional world of medicine, it is important to separate the different opportunities in the marketplace for physician employment.

Most commonly, I'm seeing hospitals buy physicians' practices. The deal is usually structured as a small buyout of fixed assets and equipment, sometimes a small payment for goodwill, and then a salary offer that matches or exceeds the usual income the physician was making independently. The appeal is the corporate protection of patient flow, relief from managing staff and overhead, leasing of physician owned office space, and some benefits paid for by an employer. These buyouts are relatively fair from a business standpoint, and are especially attractive to physicians in the late stages of their career. The downsides include the onus of working for a corporation and increased focus on compliance.

As many of these hospital buyouts are relatively new, it is not clear how well they will work out. Until recently, it has been common for the hospital systems to show "losses" on the cash flows of their physician groups. They sometimes add a variety of administrative fees and are rarely as efficient with staff as are individual practices. However, some recent Federal whistleblowing lawsuits against hospitals allege that if they are losing money on

running a medical practice, they must be making up the loss by gaining referrals (which of course they are). Although this may be permissible for physicians that are individually employed by a hospital system, it is somewhat dicey for other type associations with physicians and medical groups.

It has been somewhat jarring to see the somewhat rapid transformation as more hospitals take control of physician practices. It has allowed hospitals to control primary care flow via either direct employment or group contracting with ER physicians, hospitalists, and often the majority of primary-care physicians in a community. Specialists are then similarly employed or at least controlled by these facts, on the ground. The rise of hospitalist medicine alone over the last ten years has completely changed the physician/patient relationship for the first time since hospitals became a prevalent mode of health care delivery.

An uncomfortable effect of hospital employment is the loss of patient advocacy by physicians. It is hard to complain to the hospital that can fire you about patient care issues. This further loss of autonomy and practice control is something to consider carefully.

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