Strategies for Avoiding the Hospital Buyout

BY RICHARD M. KIRKNER

EXPERT ANALYSIS FROM THE ANNUAL MEETING OF THE AMERICAN SOCIETY OF NUCLEAR CARDIOLOGY

PHILADELPHIA – With hospitals buying up physician practices, many physicians are tempted to take the bait, but Alice G. Gosfield, an attorney who specializes in physician practice ownership strategies, called this the "employment delusion" and the "acquisition fantasy" during the meeting.

Many physicians don't recognize that "the common law term for the employer-employee relationship is 'master-servant,' " she said. "It's a one-on-one relationship [in which the] master gets to tell you who, what, where, when, and why and how, and if you think that a contract can prevent that from happening, you would be wrong."

Regarding the myth about how selling out to a hospital group can guarantee financial security, she said "The hospital is getting paid under the same stupid reimbursement formula that you are. The only way that revenue stream ends up being more than what you're getting in your practice is if they are paying you for doing other things besides clinical work."

Another delusion is that the contract is a safeguard, according to Ms. Gosfield. "A contract is only as good as the will of the parties to abide by it," she said.

She singled out two strategies for selling a practice to a hospital: the sale of physical assets, including diagnostic "toys and weapons," in her words, but not the practice per se; and noncompete covenants. "It has to be fair-market value under the Stark regulations," she said of the latter, "and somebody – not a lawyer – has to do a valuation."

For self-preservation, she implored physicians to adopt the quality improvement measures that will provide the basis for Medicare reimbursement in 2012. "Now is the time to change your clinical and administrative processes," she said. "We all know what the conditions are." That information is already available from the National Quality Forum, she pointed out.

Cardiologists are in a particularly strong position to deal with hospitals, she said. "Hospitals cannot function without cardiologists," she said, citing the "20/80 rule" in which "20% of the doctors generate 80% of the medical staff's billings." She added, "They know that they make money on it, and they pay attention to you because you are cardiologists."

Among the alternatives to selling the practice offered by Ms. Gosfield were leasing the practice to the hospital, entering into comanagement contracts, having the hospital place a new physician in the practice, gainsharing, giving the hospital the right of first refusal if another entity offers to buy the practice, having the hospital provide continuing education for practice physicians and ancillary staff, leasing practice staff to the hospital, and having the practice provide contract services (such as billing and claims processing) to the hospital.

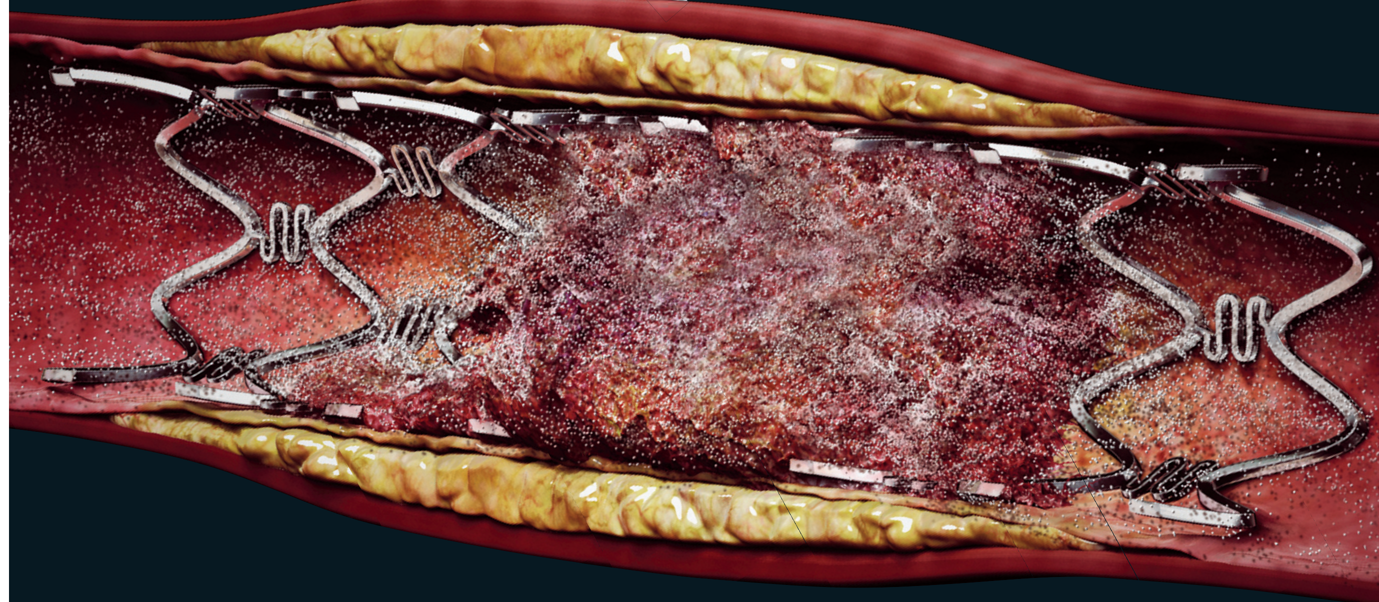
Ms. Gosfield described how a hospital would lease a practice: "Your group stays as your group," she said. "In essence what you do is, you reassign your right to get paid to the hospital. They pay you a salary. They will require some kind of productivity measures, but they can pay you irrespective of whether they get paid."

A comanagement contract involves the physician providing on-call services or advising the hospital on its care delivery systems. This could include performance bonuses when the hospital achieves specified results, she said, but she advised against getting paid an hourly fee. "Swapping an hour in your office for an hour of their time – you can't make it up," she said.

Having the hospital place a physician in the practice should be carefully structured, Ms. Gosfield said. Her preferred arrangement would have the hospital subsidize the up-front costs with a loan, then forgive the loan for each month the doctor stays in the community after the subsidy ends. One problem with this approach, she pointed out, is that "you can't then have a restricted covenant which prohibits this young doctor that you brought in and introduced to your patients from opening up next door," Ms. Gosfield said.

She reported no disclosures. ■

LOW LEVELS OF PLATELET INHIBITION MAY HAVE
SIGNIFICANT
CONSEQUENCES*[1-5]



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- **Concomitant medications** (eg, certain proton pump inhibitors or other drugs that inhibit CYP2C19)[9-11]
- **Pre-existing conditions that may impact platelet activity** (eg, diabetes, obesity)[12-14]
- **Patient noncompliance**[15-17]

*The level of platelet inhibition needed to reduce thrombotic cardiovascular events has not been defined.

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