PHYSICIANS PRACTICE
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Physicians Practice. Vol. 21 No. 10

Should You Sell Your Practice?

By Bob Keaveney | November 4, 2011

To sell or not to sell? That seems to be the question that so many physicians in independent practices are asking, as life in a reformed healthcare marketplace is shaping up to include a return to "capitated" contracts with global payments for "keeping people healthy;" quality requirements that can be met only with the aid of expensive technology; and the expectation of comprehensive care that smaller practices can't deliver alone.

Given all that, goes the thinking, *perhaps I should I sell my business to that hospital down the street. Or would I be selling my soul in the process?*

But that is not exactly the right question, says Justin Chamblee, a senior consultant with Coker Group who specializes in physician compensation plans and hospital/practice transactions. Chamblee, who spoke at the Medical Group Management Association's annual conference last month, chatted with me as part of our coverage of the event. Yes, he told me, practices will indeed have to find ways to *affiliate* with larger healthcare systems in order to remain viable in a reimbursement system that will eventually layer quality metrics atop a volume-based foundation. But an outright conversion to employment status is not the only way for such affiliations to occur, and physicians should remember "that there's always a tradeoff between the possibility of additional pay and the certainty of a loss of control."

Can you live with life as a worker bee? Don't be sure you'll have to.

Various co-management arrangements exist, in which the hospital gets what it wants (your services) and you get what you need (a degree of income stability, plus access to technological and administrative resources) while retaining some independence. "What we always tell groups is that even though hospitals are really looking in many instances for physicians to employ, don't make [employment] the end-all and be-all — the only option you consider," Chamblee says. For example, under a physician service agreement, or PSA, you'd work exclusively for the health system or hospital, and it would keep your revenue while paying you a flat rate. But you'd retain ownership of the practice. And when the agreement ends, it would be renegotiated, or not, at each side's discretion. It feels a lot like employment while you're working within it, but everything's negotiable and you needn't be in it forever, which is why Chamblee calls it "employment light."

A deal like that (as well as any of several types of other arrangements) would satisfy one of Chamblee's three must-haves for thriving practices in a reformed healthcare market — affiliation of some kind with

a deeper-pocketed healthcare network. The second, a strong group culture in which physicians are committed to working together for the good of the practice, is within your own control.

The third is access to data that will allow you to demonstrate the value of your services and the quality of your care to private and government payers. That means more than just having an EHR; it also means understanding how to leverage the EHR to get the data you need, then leverage the data to make changes to your practice to extract the results your payers demand.

Anyone mourning the decline of fee-for-service healthcare reimbursement should take a look at our data on physician income in this issue and online. The system has not been good to most doctors. Which is why I would add a fourth must-have to Chamblee's list: An open mind.

Bob Keaveney *is the editorial director of* Physicians Practice. *What are you doing to prepare for reform? Tell us about it in the comment box below. Unless you say otherwise, we'll assume that we're free to publish your comments in upcoming issues of* Physicians Practice, *in print and online.*

This article originally appeared in the November 2011 issue of Physicians Practice.