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healthcare financial management association hfma.org

hospital-owned medical practices gaining the benefits without the losses

By applying effective strategies and correct operating principles focused on 11 key areas, hospitals can leverage their owned medical practices to improve market share and downstream revenues and to maintain performance.

AT A GLANCE

- > Hospitals can correct most of the causes of reduced performance in hospital-owned medical practices by setting appropriate performance expectations and implementing correct operating principles.
- > Engaging employed physicians and executives as partners who provide principle-based direction and support to practice managers encourages performance improvement.
- > A critical determinant of a hospital's ability to successfully own medical practices is understanding and implementing the principles for success in this unique ambulatory business.

The forces shaping today's healthcare environment are pushing many hospitals and health systems to purchase medical practices and employ physicians and other providers. The use of employment as a physician integration strategy—often one of several strategies—may help hospitals capture increased market share, secure competitive service lines, prepare for narrow networks and risk-based payment, and better support recruitment of new physicians out of residency programs.

Unfortunately, hospital-owned medical practices and employed physicians generally do not achieve the same levels of performance as do their private practice counterparts in the same communities. Physicians hired by hospitals directly out of residency programs often fail to achieve the performance levels of private practice physicians. Declines in performance commonly occur when previously independent physicians sell their practices to a hospital and they become employees.

Annual losses per employed physician can approach \$175,000 (*MGMA Cost Survey: 2013 Report Based on 2012 Data*)—a large financial risk associated with an employment integration strategy, regardless of the frequently cited downstream benefits. A hospital that employs several physicians frequently provides millions of dollars in subsidies each year to those practices. The challenges inherent in plugging such money-losing assets into a population health management payment model should give executives pause.

Contrary to the belief of some healthcare executives, physician practice losses are not an inviolate cost of doing business. The use of performance-improvement strategies and correct operating principles can bring about dramatic improvements in the performance of most hospital-owned practices. Through such measures, employed physicians and practices can be motivated to match the performance of successful private practices in the same community.

In short, invested effort and capital to correct the factors that contribute to the poor performance of hospital-owned practices have the potential to yield a significant ROI.

No Secret Sauce

There is no secret sauce or simple solution that will prevent or turn around money-losing medical practices. But the careful, consistent application of several performance-improvement strategies and correct operating principles has consistently produced performance improvement among hospital-owned practices. CFOs should focus on the following areas.

Use of primary care to grow market share. The most important component of any successful integrated delivery system (IDS) is a well-implemented primary care practice strategy. Primary care physicians and other providers capture and maintain relationships with patients (market share or covered lives) throughout the entire healthcare delivery system. Adequate numbers of closely affiliated primary care practices referring to affiliated subspecialists and to the hospital facilitate the success of both. An adequate number of primary care physicians (and their associated market share) supports optimal performance downstream. Another advantage of securing an adequate number and geographic placement of primary care physicians is that they guarantee the IDS a place at the rate-setting negotiation table, since those physicians hold the payer's market share as well. Employing a percentage of these physicians also gives the IDS market leverage during negotiations with subspecialty physicians who attempt to push the IDS into bad deals.

Avoidance of "bad deals." Bad deals are unsustainable arrangements that hurt both the physicians and the executives who negotiate them. Instead of creating a lasting partnership focused on improving clinical care and caring, bad deals produce financial losses for physician practices that become the major focus of the hospital-physician practice relationship. Bad deals always become public and can complicate referrals from primary care physicians who are upset about subspecialists' real or perceived "special deals."

Hospital transactions with established private practice physicians typically require two main steps. The first step is to determine the value of the practice; an objective, third-party valuation company can perform the necessary assessment. The valuation also may include real estate if the physicians own their building. Keeping the purchase price within the range recommended by the valuation company protects both parties. CFOs and others who negotiate practice acquisitions should move toward the higher end of the valuation range rather than trying to use the employment agreement to close the purchase.

The second key step in a practice purchase is development of the employment agreement, which is frequently the source of problems. As in most professional corporations, a private medical practice is usually a breakeven enterprise. Physician owners pay the bills, pay taxes, and take home what is left. Hospital-owned medical practice networks usually are not as cost efficient as a private practice. The reasons driving the decrease in cost effectiveness after a sale include frequent improvements in employee benefits and increased benefit costs. Other common costs include new computer systems, often-promised leasehold improvements, and new equipment. The cost of improved regulatory compliance also has a negative impact on the bottom line.

Frequently, the biggest variable affecting practice success is physician compensation relative to individual productivity. Even the busiest physicians usually expect a salary increase when they go to work for a big corporation. Previously

independent physicians also expect to take paid vacations, which physician owners avoid. Unfortunately, there are no simple ways to produce additional income for busy practices to offset the costs of increased compensation and increased vacation time. Often, relieving physicians of the ongoing pressure to meet their practice's payroll tends to decrease physician productivity in employment settings. The financial realities of physician costs and productivity after moving to hospital employment should temper any impulse to increase the compensation burden on the purchased practice. CFOs should avoid purchase agreements that include compensation increases based on future productivity increases. Projected productivity and revenue increases rarely materialize and should not support a bad deal between hospitals and physician practices.

Physicians consider acquisitions based on both the business valuation and the employment offer components of the proposed hospital transaction. In negotiations, it is critical for both parties to remember that the business valuation should reflect the wealth a physician has built in his or her private practice. Hospitals should not offer, and physicians should not expect, an employment compensation offer that exceeds reality, undercuts a sustainable partnership, or raises regulatory concerns.

Engaged physicians. Organizations can “buy” knowledge and skills by paying market compensation rates. Motivating and winning the hearts of highly trained physicians and other knowledge workers, however, requires more. Hospital employers should engage physicians in the development of a compelling vision, strategies, and tactics that enhance the lives of their fellow physicians, staff, and patients. Organizations that treat physicians like employees usually have physicians who act like employees, whereas organizations that manage to engage clinicians as business partners have found the source of a sustainable competitive advantage.

Physician engagement in IDS settings must occur on two levels. First—and most important—engagement is required at the individual practice level. Physicians in successful private practice

groups traditionally meet once or twice each month to effectively govern their group practice. Together, the physicians devise solutions to problems in the practice and then provide implementation directions to their office manager. The physician leaders in turn support the office manager during the implementation process. Engaging employed physicians as leaders means arranging for them to provide similar oversight, with a qualified operations executive—usually the office manager's boss—acting as a partner. Establishing such practice councils can further networks' efforts to achieve the private practice performance standard one practice—even one physician—at a time.

The second level of physician engagement that IDSs with a network of several hospital-owned practices should attain is among key employed physicians working as partners at the system level. Four to six key physicians should serve on a network council that acts like an operating board. The network council also should include the hospital CEO, CFO, and chief medical officer (CMO), who will serve as the management partners. The network council should establish the systemwide direction, strategies, and initiatives that will support the success of the IDS. The network council also reconciles issues that rise beyond practice-level councils. The hospital CEO is the IDS's board-appointed fiduciary who has the ultimate authority, which is why the CEO's attendance and participation in the network council's decision-making processes is crucial. The CFO's role is to bring an understanding of the financial realities affecting performance to the network council's discussions. The CMO plays a key role as translator between the business experts and the clinical experts and also usually provides significant support to a quality subcommittee.

Performance expectations. Performance expectations, targets, measures, and improvement should focus on five areas:

- > Clinical quality, as defined by physicians, evidence-based medicine, and payers
- > Service quality, as defined by referring physicians, their patients, and payers

- > Productivity of physicians—the IDS’s most expensive resource—and others
- > Sustainability of operating processes in supporting performance
- > Financial viability of individual practices (a potential drain on precious capital) and of the IDS as a whole

Decisions at the integrated system level and at the practice level should maintain or enhance—and certainly never detract from—the IDS’s performance in all five categories.

Clinical quality. Most network councils quickly form a subcommittee to help define and enhance performance on clinical quality and service quality, which IDSs frequently struggle to measure and improve. Although most medical professionals believe they already provide high-quality clinical care, many are surprised to find that they do not *consistently* meet the standards increasingly set by payers, which define “quality” and enforce it through payment. The quality subcommittee should ensure adequate expectations, targets, measures, and transparency for key clinical processes and outcomes, which are increasingly essential to the success of individual practices and IDSs as they prepare for value-based payment.

Service quality. Primary care practices should focus on meeting the needs, wants, and priorities of patients. Subspecialty practices should meet the needs, wants, and priorities of referring physicians, which include treating referred patients very well. Access, communication, and patient experience drive future referrals—and all three drive the value proposition for the IDS’s patients and referring providers.

Productivity. Successful private practices have always set the standard for provider productivity. The most successful private practices tend to require more than the median productivity for the specialty. Setting the expectation of higher productivity among hired physicians (new or established) and newly acquired practices is essential to the success of hospital-owned practices, as maintaining or achieving desirable levels

of patient volume remains critical, even under healthcare reform. Acquired practices should modify or eliminate systems, tools, processes, policies, and procedures that adversely affect their productivity—including poorly performing or poorly implemented electronic health record systems.

Operations processes. Many IDSs have access to process improvement experts, who work to improve quality while reducing costs in hospital settings. Although cost control is the key to success in the acute care business, success in a medical practice is determined by revenue. Applying the principles of Lean management, total quality management, and continuous quality improvement to ambulatory medical practice are effective if they focus on improving clinical quality, service quality, and productivity. Simply cutting costs in a medical practice will have a deleterious effect on all three critical success factors. On the contrary, a common tactic to improve the performance of a money-losing medical practice is to add staff to improve physician productivity and customer service.

Financial viability. Hospital-owned primary care practices can operate just as well as successful private primary care practices, if given the opportunity and expectation to do so. The success of subspecialty practices, which have added significantly to the average annual loss per hospital-employed physician, is heavily dependent on potential referrals. An IDS with a strong primary care market share through both employed and independent physicians should expect its subspecialty practices to achieve private practice performance levels.

Effective implementers. Engaged partnerships of employed physicians and executives should receive support from a team of qualified implementers, or managers, at the network and practice levels. An experienced network executive also is essential to council success. Some organizations prefer to hire a physician as their lead operations executive, while others have hired experienced nonphysician leaders. Knowledge

workers are generally impervious to management pressure—even from another physician—so the key characteristic of a successful network executive is the ability to engage the practice councils, which provide strategy, policy, and expectations, and to hold the management team accountable to effectively implementing council decisions. In larger hospital-owned systems, the network executive is frequently supported by other operations executives who serve as members of practice councils and who support office managers. Many small practice office managers adroitly handle daily operations but require additional close support to implement practice council initiatives to improve performance.

Organizational will. Although the principles for improving performance and effectively governing a hospital-owned medical practice network are clear, implementation of those principles depends on the willingness of executive and employed physician leaders to support the required changes. Change management is complex, especially when valuable human resources have ready employment alternatives. However, such changes are increasingly important due to the growing pressure for successful integration.

Improvement Without Losses

Working together, hospitals and physician leaders can correct most of the reasons behind performance challenges by establishing appropriate performance expectations and implementing correct principles. Ultimately, the organizational will to change⁷ previous expectations and operating results is critical to the organization's success. Engaging employed physicians and executives as partners who provide principle-based direction and support to managers, both within each practice and at the practice network level, encourages performance improvement. The result is hospital-owned medical practices that achieve the anticipated benefits of improved market share and downstream revenues without financial losses. ●

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