amednews.com
AMERICAN MEDICAL NEWS

BUSINESS

Illustration by Chris Gash / www.chrisgash.com

Hospitals are buying, but doctors don't have to sell

■ Practices have many options to gain tighter relationships with hospitals without making an outright sale.

By SUE TER MAAT (HTTP://WWW.AMEDNEWS.COM/APPS/PBCS.DLL/PERSONALIA?ID=STERMAAT) amednews staff — Posted April 22, 2013

In 2012, the Frontier Cancer Center in Billings, Mont., was going into debt as it faced cuts in payments from Medicare and private insurers. The physicians began talking about options to solve their problems, but they rejected one increasingly common strategy: selling their practice to a hospital and become its employees.

"I knew some of our partners would never go for that," said oncologist/hematologist Patrick Cobb, MD, one of the partners in the five-physician practice. "They wanted to retain their autonomy."

Many practices struggling with issues such as finances, health reform and technology are deciding that selling to a hospital is the only solution. A survey of 118 hospital administrators by Jackson Healthcare, a staffing company in Alpharetta, Ga., found that 70% of their hospitals' practice acquisitions took place because the physicians came to them looking to sell.

However, giving up independent practice and becoming hospital employees doesn't have to be the first option. There are multiple alignment models for physicians and hospitals that can give each the perceived

benefits of closer alignment while allowing doctors to remain autonomous.

Some are fairly simple, such as arrangements in which a practice contracts to provide extra services to a hospital. Some are more complicated, such as selling the practice's assets to a hospital but contracting as independent doctors. Hospitals often are willing to work out such arrangements, analysts said.

For both sides, these agreements can solve a nagging issue and serve as a test run for a possible deal to buy a practice and hire the doctors as employees. Whatever the arrangement, analysts say physicians need to examine their options, determine their goals and approach a hospital with a plan.

"Employment has been all the rage in the last seven years, but now we are seeing other alignments more often," said Kevin Kennedy, a Seattle-based member of the board of directors for ECG Management Consultants, a strategic and financial consulting firm. Picking a nonemployment alignment "can be very time-consuming, and physicians have to be very methodical about choosing an alignment model."

Three levels of alignment

Physicians can select from dozens of alignment models that vary based on financial rewards and levels of autonomy, said John Redding, MD, a manager of physician-hospital alignment at Blue Consulting Services, a business advisory firm in Indianapolis.

Although there are many individual models, alignments fall into three categories — limited, moderate and full, said Aimee Greeter, MPH, senior manager at the Coker Group, a national health care consulting firm.

With these three categories, financial rewards are inversely related to levels of autonomy. Limited alignments give physicians more autonomy but modest financial rewards. With full alignment, autonomy is low but financial gains are likely to be higher. Moderate alignments fall in between. The more limited the deal, the easier it is to get out of.

Limited alignment model. One such model is a medical directorship where physicians provide specific clinical oversight duties. Another example is call-coverage stipends where physicians are paid for unassigned emergency department calls. The upside of limited alignments is that physicians receive additional compensation and hospitals get increased manpower. For instance, trauma surgeons can make about $2,000 a night with pay-for-call arrangements, and a medical director could make between $125 and $250 an hour, Greeter said.

Ideal candidates are physicians who aren't particularly concerned about finances but want to increase their bottom lines, she aid.

Moderate alignment model. In clinical co-management, hospitals and physician groups are working toward shared goals such as lowering costs for particular services. Historically, gain-sharing arrangements have been against federal law. But with the advancement of accountable care organizations, the concept has received more of a push as incentives are created to help physicians and hospitals save money and improve care.

Other examples of moderate alignment models include management service organizations. Practices pay a fee for business operations such as revenue-cycle management, human resources and information technology that are owned by the hospital but keep their clinical independence. Physicians save money by not paying for those services in-house. Other joint ventures, such as an imaging center, also could be considered a moderate alignment model.

These arrangements are implemented mostly by specialists who want to increase their revenue streams

but don't need partners because they have no major concerns about money, Greeter said.

Full alignment model. Here more control of the practice is shifted to a hospital, but it doesn't necessarily require physicians to be employees. Frontier Cancer Center ultimately chose this model. The group selected a full alignment model called a professional services agreement, which is the closest alignment physicians can enter into with hospitals but not be fully employed.

"A PSA is basically an arm's-length way to have an employment arrangement for a practice to maintain itself," Jacobs said. "It's for a group that wants to keep itself intact."

With this arrangement, practices can maintain their own boards, remain legal entities and divide payments from hospitals however they see fit, Greeter said. The model is for practices that know they need strategic partners but aren't ready for full employment. Many physicians use PSAs to test the waters with hospitals before entering into full employment.

In this model, hospitals may have the power to make major decisions for practices such as vetoing capital investments. For instance, if a practice wanted to buy an MRI machine or linear accelerator, a hospital could decide against it, Greeter said.

Selecting a model

When physicians conclude that they want to form some type of alignment, they first should determine their practice issues and common goals. This probably will take many meetings to refine what the physicians collectively want out of alignment.

At this point, the group should not discuss any particular alignment model, because it's important to focus on problems the practice faces and what might fix them, said Laura Jacobs, MPH, executive vice president of the Camden Group, a health care management and consulting group based in Los Angeles.

During the first meeting, physicians should discuss revenue, projections and competition with local hospitals to establish how financially stable their practices are. Then physicians should discuss their practices' ideal direction, Jacobs said. They should ask whether they will be able to grow, what is happening in their markets, what payers are doing, how aligning with local hospitals can help them, and what the additional revenue streams (or cost savings) might be.

After physicians have identified their practice problems and understand the basic alignment models, they should seek out other physicians who are aligned with local hospitals to learn about their experiences, experts said.

Physicians should meet with hospital CEOs to discuss what type of alignments are available. Redding said physicians should be wary of hospitals that have only one type of alignment, because it demonstrates inflexibility. Physicians should try to steer clear of conversations about compensation or whether they would fit in with a hospital's core value system. If they want to move forward with alignment, those conversations will occur later, Jacobs said. It is incumbent on hospital executives to explain their alignment models to physicians, she added.

Physicians shouldn't make any decisions about aligning with a hospital until after discussing core values, said Tom Atchison, head of Atchison Consulting, a health care financial consulting firm in Le Claire, Iowa. This should be a separate meeting where the two parties talk at length. If the values don't match up, physicians should not proceed with alignment, he said.

Watch out for these red flags

After learning about the models, defining their issues and meeting with hospital executives, physicians should meet again to determine the mode of alignment they prefer.

At this point, some physicians decide they rather would be employed, Kennedy said. That's because employment is more straightforward than other alignments like PSAs, which can take two to six months of negotiations. But others decide that they would like to remain independent.

"When you put it all on paper, it's really complex, with all those issues that have to be worked through," Kennedy said. "It doesn't mean it can't work out, but you're in it for the long haul."

If physicians feel they are culturally aligned with a hospital, they should have another meeting about contracts. Physicians should bring up the nature of hospitals' termination clauses. Financially punitive termination clauses that forbid physicians from practicing in the area if alignments don't work are red flags, Dr. Redding said. Another red flag, Greeter said, is if the hospital doesn't make its top executives available and allows meetings only with midlevel staff.

Dr. Cobb said it took about nine months for Frontier to hammer out an agreement with its new partner, St. Vincent Hospital. The practice formally began its new working relationship in December 2012. It resulted in a name change — St. Vincent Frontier Cancer Center.

"So far, the arrangement has been working out well," Dr. Cobb said. "Before we didn't have a sustainable business model, and now we do."

BACK TO TOP

ADDITIONAL INFORMATION

The finer points of physician-hospital alignment

When physicians decide to enter a business agreement with hospitals, they are faced with various business options. Such alignments fall into three categories — limited, moderate and full — that are based on financial rewards and levels of autonomy. Limited alignments offer modest financial rewards but have the most autonomy while full alignments have less autonomy but higher financial rewards.

Limited

- **Managed care networks:** Loose alliances of physicians, hospitals and other providers. Examples include HMOs and PPOs.
- **Call coverage stipends:** Physicians fill in for unassigned emergency department calls.
- **Medical directorships:** Physicians provide clinical oversight duties on an ongoing basis.

Moderate

- **Management services organizations:** Hospitals agree to provide business-related services, such as computer support for fees.
- **Provider equity:** Joint ventures unite physicians and hospitals under common enterprises, such as specialty hospitals and surgery centers.
- **Clinical co-management:** Hospitals and physician groups work toward shared goals such as lowering costs for particular services.
- **Equity model assimilation:** Model ties physicians to hospital partners or private groups into legal agreements. Physicians retain ability to contract with payers.

Full

- **Professional services agreements:** Physicians act as self-employed independent contractors.
- **Group practice subsidiaries:** Practices operate as stand-alone, wholly owned subsidiaries of hospitals.
- **Physician enterprise models:** Some physicians of a practice are employed in a subsidiary company, while the remainder stay within the practice.

Source: Coker Group

BACK TO TOP
