The physician enterprise model: A nonemployment alternative

Note: MGMA-ACMPE does not endorse any solutions put forth in this column. We urge readers to explore the legal issues – federal, state and local – that might arise from a particular course of action.

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Hospitals are seeking new and innovative ways to affiliate with physicians that differ from tactics used in the 1990s, when hospitals often purchased physician practices to compete with publicly owned physician practice-management companies. These new relationships involve a more formal type of relationship with physicians, which might reflect lessons learned through previous less-than-satisfactory relationships.

Most hospitals have physician-integration strategies as part of their long-range plans, but because physicians employed by hospitals lose approximately $156,000 per year, according to the MGMA *Cost Survey*,[1] hospitals and health systems must explore alternatives to physician affiliation aside from the traditional employment model.

Beyond employment

Affiliation is sought for various reasons. Large hospitals seek a wider reach into communities, while small and rural hospitals seek help with physician recruitment, which has been troublesome over the past few years due to 84 percent of senior medical residents desiring to practice in communities with a population in excess of 100,000 people.[2]

Integration between hospitals and specialists is occurring at a growing rate — in part because more hospitals recognize that successful partnerships with specialists are lucrative, according to experts.

"Specialists have higher incomes than primary care physicians, and they have money to invest in joint ventures for specialty centers," says Daniel Beckham of the Beckham Co., Whitefish Bay, Wis., a strategic planning group for hospitals and physician organizations. "In some instances, the relationship involves employment. When hospitals directly employ some specialists, the question becomes, what is the inevitable evolution of that model?"

A customer focus

When developing new affiliation models, hospitals should focus on their most important customer: the physician. Hospital executives have had various employment arrangements with physicians, but they are re-examining those arrangements because of performance issues, particularly regarding operating losses sustained by hospital-owned practices. (For more information on this topic, read the Data Mine article in the April issue of MGMA *Connexion*.)

What's more, some hospitals have discovered that it is not necessary to own a medical practice or employ physicians to develop meaningful

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relationships; they have learned that mergers do not necessarily strengthen business relationships. In the 1990s, reports showed that hospitals lost money after purchasing physician practices because doctors didn't work as hard once they became employees instead of owners.

There are many reasons why hospitals encounter financial losses when they acquire practices, including increased employee benefit expenses, administrative cost allocations and an inability to receive credit for the technical fee portion of ancillary services provided by practices.

As a result, hospital professionals are showing an interest in realigning incentives by developing alternatives to physician employment, known as the physician enterprise model or practice leasing, as reported by national publications and anecdotal experience.

A nonemployee alternative

In this structure, hospitals and medical practices enter into nonequity joint ventures, which help hospital professionals develop relationships with key physicians through a sustainable private-practice model. It establishes a centralized mechanism for both parties to be involved in improving patient care, enhancing information technology and using collective expertise. Some of the benefits:

- Hospitals agree to operate the practice at a fixed percentage of collections, which gives both parties an incentive to produce results;
- No capital expenditures are required;
- Hospitals benefit from stronger alignment with physicians in a less formal manner;
- Physicians preserve the private-practice model and autonomy;
- Physicians achieve the balance of security and independence; and
- The arrangement is much easier to unwind than a practice acquisition.

Due diligence

When hospitals and health systems embark on more formal organizational strategies with physicians, all parties should follow due diligence procedures to ensure regulatory compliance and fiscal responsibility. The hospital or health system should also take all deliberate steps to ensure that the new hospital/physician affiliation model is consistent with the Stark Law, anti-kickback statutes and, if applicable, regulations governing reasonable compensation for tax-exempt organizations.

Although hospitals are pursuing a number of alternatives to physician employment, such as co-management agreements and clinical integration, the physician enterprise model offers an integration strategy for both parties. After the appropriate due diligence is performed, a hospital can offer the practice a reasonable arrangement for ongoing management. Take, for example, a two-doctor internal-medicine practice that collects $1 million annually with operating expenses of $500,000. With this model, each physician would make a $250,000 annual income.

During due diligence, the hospital discovers it can improve practice performance with coding compliance improvement and enhancement of billing, collection and accounts receivable management. As a result, hospital professionals believe they can increase collections by $1.1 million annually.

The hospital is also prepared to offer ways to streamline operating expenses with group-purchasing arrangements, centralized staffing and simplified employee benefits so that operating expenses equal $450,000 annually. Using this example, the two internists could increase their incomes to $325,000 annually.

Through these types of models, hospitals can develop partnerships with physicians and, at the same time, doctors can achieve an elusive balance of security and independence.

Notes:

1. MGMA 2011 *Cost Survey* .
2. 2011 Survey of Final Year Medical Residents: A survey examining the career preferences, plans and expectations of physicians completing their residency training, Merritt, Hawkins and Associates, access: merritthawkins.com/pdf/mha2011residentsurvpdf.pdf.

A chart diagramming the potential financial impact of physician enterprise models is available as an online exclusive; visit www.acmpe-executive-view.com to see it.

