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Between a rock & a hard place: Physician markets create new strategic problem for hospitals

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The U.S. hospital sector's initial foray into physician practice acquisition was a painful and expensive journey. And unfortunately now, before the wounds have even healed, economic circumstances are conspiring to force hospitals back into the physician marketplace. Why is this, what can reasonably be done about it, and when would a hospital need to consider such alternatives?



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The painful past

In anticipation of regional, sole-source contracting with health plans, and in response to the proliferation of physician practice management companies, hospitals experimented during the late 1980s and '90s, for the most part unsuccessfully, with acquisition and management of physician practices. Most hospitals discovered that

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this strategy created neither bargaining leverage nor market share gains, as health plans moved back to open panel, fee-for-service payment.

The typical hospital-affiliated medical group was a highly inefficient delivery system, in which the costs greatly outweighed benefits. The average hospital-affiliated physician group lost \$70,000 to \$85,000 per physician per year.

The employment strategy also generated tremendous ill will between hospital management and the remainder of the medical community, because it altered the traditional boundaries between the hospital and medical practices. So for the past five years most hospitals have been endeavoring to reduce their losses, political and economic, from this misadventure, and to focus on their traditional clinical services missions.

Now a new pinch

But now, recent evidence suggests, a second leg of the physician strategy journey is about to commence.

Hospitals are finding themselves caught between the Scylla of EMTALA—the federally mandated 24-hour physician coverage obligations related to emergency services—and the Charybdis of a depleted and angry cadre of specialty physicians, increasingly unwilling to provide call coverage without compensation.

At this writing, physician income is under severe pressure, even in the face of growing specialty physician shortages. From 1995 through 2000, physician income declined relative to that of other professional and technical workers. Given the modest increases in the government fee schedules, and physicians' limited negotiating clout with managed care organizations, physician revenues have not kept pace with the costs of running a practice.

And now with their practices at capacity, physicians are seeking alternative sources of revenue in order to main-

tain their income. These alternatives include:

- Owning and operating office-based and/or free-standing services that were traditionally referred to the hospital, and
- Demanding payment for services that the physician traditionally provided the hospital for free.

In either case, the economic impact on the hospital of their physicians' search for alternative revenues is significant.

A supply shortage

Meanwhile, the balance of supply and demand in the physician services market has tilted decisively in the past three years, toward a seller's market. Hospital-based specialty groups such as anesthesiologists and radiologists, as well as key hospital-focused specialists such as cardiologists and trauma surgeons, are having increasing difficulty filling their groups' vacancies, and are turning to hospitals for increased subsidies and recruitment support.

The Council on Graduate Medical Education recently confirmed this reality by declaring a physician shortage, and endorsing both expanded residency training and larger medical school class sizes.

But market conditions are likely to worsen faster than new supply can address them. Repeated surveys of the existing practicing physician cadre have revealed widespread work dissatisfaction. These surveys suggest that as many as 30% of the cadre of practicing physicians over age 50 plan on leaving practice in the next five years. The extent of this exodus may be "NASDAQ"-related: A significant further recovery in the stock market that helps physicians rebuild their 401K and retirement plan portfolios would facilitate withdrawal from active practice.

And GME training programs for the 24-hour specialty practices are not filling, leaving shortfalls in the ranks of retiring physicians' replacements. A situation that's exacerbated by a trend among physicians to begin limiting their practice. Research suggests this reflects partly the increasing percentage of medical school graduates who are women and wish to lead a more balanced life than their male colleagues or elders. As one chief medical officer put it recently, "specialty physician care is becoming shift work."

Bottom line: Specialties such as trauma and general



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surgery, cardiology, anesthesiology (which has recovered somewhat from a year 2000 trough) neonatology, and emergency medicine all face the prospect of not generating physicians at a pace sufficient to replace retiring physicians in specialties central to the hospital's mission.

Deer in the headlights

In most markets, one does not have a shortage of anything valuable for very long before the price goes up.

The cost of recruiting these scarce specialists is soaring. Thanks to EMTALA's service mandates, hospitals have become the *de facto* "residual" buyer in these tightening physician specialty markets. And the results include dramatic increases in hospital subsidy payments and relocation support to physicians.

Several hospital CEOs told us recently that physician subsidies have become their most rapidly growing and least controllable expense line. Meanwhile, the FBI has identified physician relocation assistance as a rich target for investigation. So many hospital executives are like deer in the headlights: They feel intense pressure to support their physicians in order to maintain their current business, but because they fear regulatory scrutiny, they do not take action.

Possible alternatives?

It is worth asking now—What alternatives are there to steadily increasing the physician subsidy line in hospital budgets?

There are only a couple that we can think of. One of them is to "outsource" the services currently supplied by volunteer or partially paid private attendings, to firms that specialize in contracting for physician specialty services.

Examples of these firms include Pediatrix, in neonatal care, and Sheridan Healthcare, in anesthesia and critical care. Such outsource firms are among the most rapidly growing businesses in health services today. They hire physicians on salary, and contract with hospitals to supply them with clinical services.

Since these firms hire out of a national talent pool, contracting with them effectively shifts the market risk of specialty recruitment to the hospital's competitors.

These firms have an easier time recruiting physicians because they can offer stable and predictable hours,

career advancement opportunities, geographic flexibility, and stock options not available to private practice or hospital-employed physicians.

However, in contracting with specialty outsource firms, the hospital will be delegating control of key departments to an outside enterprise whose business interests do not perfectly overlap with those of the hospital. This can create problems with respect to acceptance of managed care contracts, adherence to hospital-mandated quality protocols, and other control-related issues.

Many of these outsource firms are public companies, so they may focus on short-term objectives that are inconsistent with the long-term objectives of the institution.

Also, use of an outside firm does not necessarily mitigate the demand for call pay and other hospital subsidies to physicians.

And importantly, many of these outsource firms are public companies. To a large extent, their future capital access depends on consistently meeting Wall Street's quarter-to-quarter profit growth targets. So they may focus on short-term objectives that might be inconsistent with the long-term objectives of the institution.

Most of these companies are survivors of the physician practice management company debacle of the '90s, and their future is complicated by the same environmental factors discussed above.

Specialty care division

A second alternative—which, if appropriately executed, also avoids many of the fraud and abuse problems—may be to create a hospital-salaried or tightly affiliated "specialty care" division, which employs the physicians who provide 24-hours-a-day coverage to the hospital.

A brief editorial aside is appropriate here. One of us—Goldsmith—was an outspoken opponent of hospitals'

hiring their physicians under any circumstances; and the other—Kaufman—was a cautious advocate of employing physicians in some circumstances, and has spent the past six years helping unwind many physician employment deals that suffered from poor structure and/or implementation.

Our experiences have taught us that the employment option is fraught with both economic risk and dangerous political complexities. And, like the primary care practice acquisition strategy, the specialty division strategy risks being hijacked by entrepreneurial healthcare attorneys before CEOs can sort the politics out completely and make the correct strategy call based on local conditions. Remember the “Foundation Model”?

Hiring specialists directly would permit the hospital to meet its EMTALA obligations with salaried physicians, and relieve community-based specialists of the need to cover specialty referrals from the hospital’s ER.

It would also enable the hospital to organize the practices of intensivists, hospitalists, and others who provide 24-hour coverage of the hospital’s inpatients in a group practice corporate structure, for billing and practice management purposes.

In addition, as long as compensation is at fair market value, the fraud and abuse and tax risks associated with recruitment or physician subsidy payments moderate or disappear altogether.

The children’s hospital precedent

There is precedent for this approach in the way children’s hospitals cover their subspecialty needs.

Historically, pediatrics has been organized into two distinct but interdependent physician practice spheres—community-based primary practice, and hospital-based subspecialty practice. With the exception of pediatric surgery, most admitting and consulting pediatric subspecialty disciplines require a large enough population/demand for services to make private practice in those disciplines economically infeasible.

Though this division of labor has not been without friction, successful hospital-based pediatric subspecialists regard their community-based colleagues as customers and partners in the care process. We see this division of labor emerging ad hoc, and at varying paces in different parts of the country, in adult physician services.

And potential issues in adult services

There are numerous points of contention in implementing this type of model for adult services, where physician incomes are larger.

Foremost among these is the issue of how inpatient-related consultation is divided up between hospital salaried and freestanding adult subspecialists who depend on consults for a portion of their incomes.

The hospital’s salaried specialists may not wish to confine their practice only to the uninsured and Medicaid populations. Hospitals might wish them to consult broadly to offset their salary expense. In many communities, this issue could be a political minefield.

There is also the issue of the quality of practice support and management, an area where hospital adventures in primary practice exposed systemic weaknesses. Hospital executives struggled to add value to the practices they acquired. They often failed to create the governance or management structures needed by a functioning medical group, and often assigned inexperienced personnel to the delicate tasks of billing, medical records management, information technology, and the hiring and compensation of support and nursing personnel.

In our experience, the keys to successful hospital-based medical group management are:

- Management of specialties in different “divisions”
- Physician-dominated executive committee
- Strong administrative team
- Consistent, reliable, and timely financial information
- Productivity-based compensation system
- Management of practice expenses to benchmark levels
- Dedicated infrastructure for practice operations
- World class business office.

It is truly depressing how many hospitals failed to do these things, and damaged not only their financial positions but their relationships with their affiliated physicians.

Finally, one has the problem of coping with the inevitable rush of specialists wishing to cash out of their practices and “vacation in place” on the earnout, as

their primary care colleagues attempted to do until the cash ran out. But the experience of the '90s provided several rules for the acquisition of physician practices:

1. Pay only asset value. Only pay for goodwill associated with technical services, for example if the group owns a nuclear camera.
2. Never guarantee compensation for more than one year, and have a "trap door" to reduce compensation if productivity drops dramatically.
3. Tie bonuses to net collections—that is, collections net of expenses. Many hospitals paid physicians bonuses even though the practice was losing money.
4. Every agreement should have a "prenuptial" section. Some professionals, ourselves included, are simply not employable, regardless of their economic circumstances. If employment is not working out, the hospital needs a predetermined, orderly process to repatriate the physician back into private practice.

Most important: Ability to "read the local tea leaves"

More importantly, given the herd instinct in this field, hospital managements must read the local tea leaves, have good political intelligence, and communicate openly and honestly with the medical staff about their strategic intentions.

Physician supply conditions differ significantly across the U.S. Each physician community also has its own unique sociology, mood state, and history of relationships with the hospital. The differences may be greater than the underlying similarities, making timing and communication, as well as regulatory compliance, vital components of an effective strategic response.

Having a broad base of physician support—but not necessarily consensus—for whatever subspecialty physician strategy the hospital may choose is an essential precondition of success.

As hospitals have merged, they have, wittingly or not, increased both their power with and potential threat to their physicians. Merely to move without communication from this position of power is exceptionally risky and dangerous for hospital leadership. Getting a broad base of physicians to understand and share in the hospital's strategic dilemma is vital to avoid repeating many of the mistakes of the past 15 years.

In our experience, it may be better to avoid employing specialists than to execute the strategy ineptly. Because of the close tie to ongoing hospital profit centers, particularly radiology and surgery, and the higher level of compensation of specialists, the business risks associated with a poorly executed subspecialty physician employment strategy are much greater than with primary care physicians.

We do not view this strategy as fraught with profit potential, or market share gain. Rather, decisions made in this area will be motivated primarily by damage control, and protection of the hospital's existing core service obligations.

Who should consider these alternatives

Overall, both strategies—outsourcing, or employment of hospital based or hospital affiliated specialists—pose strategic and economic risks for hospitals. Whether they represent a viable alternative to soaring physician subsidy payments will vary from community to community and institution to institution.

But the risk of *not* responding to the local need for subspecialists and/or the soaring physician subsidy payments poses an equally significant risk.

Hospitals that meet the following criteria should thoughtfully consider alternatives to subsidizing community-based subspecialists:

1. If the payments demanded by subspecialists are unreasonable and have no relationship to fair market value. In addition to creating a compliance problem, this can create an expensive precedent for other physician specialties.
2. If the majority of the medical staff supports the hospital's strategic alternative to subsidizing a particular private practice subspecialty group.
3. If the physicians in the target subspecialty are outliers relative to cost and/or quality benchmarks.
4. If the hospital's ability to provide a core service, such as ED, ICU, or surgery, is being threatened by the demands of physicians in a particular subspecialty.
5. If physicians in one or more subspecialties are developing a competing provider organization, such as a heart and/or surgical hospital, that will threaten the viability of the institution.

A hospital's ability to meet its obligations to the community is likely to become more complicated as regulators and courts scrutinize how it supports its tax exemption-related community service obligations—and physicians demand higher payments for providing it with essential services. Hospitals must weigh carefully the economic and political consequences of the strategies they choose to support their 24-hour service missions. ■■

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