Will the Past Become the Present? Physician Employment: Then and Now

WESTAGE
COMPANIES
HEALTHCARE REAL ESTATE DEVELOPMENT

Will the Past Become the Present? Physician Employment: Then and Now

INTRODUCTION

Hospitals are scooping up physician practices yet again, and it is causing some concern among analysts, many of whom fear that the results from the health maintenance organization (HMO) craze of the 90's will be repeated , causing hospitals to divest their interests in physician practices. In order to avoid a repetition of the outcomes from twenty years ago, hospital leaders are attempting to learn from the mistakes of their predecessors by approaching physician employment from a long-term, strategic standpoint.

Between 1993 and 1995, the number of hospital-owned physician practices tripled. From 1995 to 2002, these hospital-owned practices suffered significant operating losses and, as a result, acquisitions slowed and divestitures increased. From 2007 to the present, acquisitions of physician practices have begun to increase at a rapid pace yet again, causing the number of employed physicians to grow 34% between 2000 and 2010.

SO, WHAT HAPPENED IN THE 90'S?

The wave of physician practice acquisitions in the 90's was largely driven by the HMO model. HMOs are organizations that provide care for health insurance plans, self-funded benefit plans, individuals, and other entities. In the 90's, HMOs generally provided care on a capitated basis, meaning that the clinicians were paid a predetermined amount for each person in the plan who fell under their care, whether or not that person actually received care. Hospitals took defensive positions in response to the rapid growth of managed care, and began buying the physician practices providing care under the HMO model. Unfortunately, the vast majority of hospitals only had experience providing episodic, fee-for-service care, and did not understand the capitated model. Many hospitals did not have a long-term strategy in place and most had no idea how to manage a practice. Some were buying groups they could not afford, for the sole purpose of keeping a competitor from scooping them up. In the 90's, many physicians were salaried, which was unprofitable for hospitals because it took away any financial incentive when it came to promoting positive patient outcomes or volume growth.

WHAT'S DIFFERENT THIS TIME AROUND?

Today, the trend is driven by the shift toward payment for value and population health management, rather than volume-based care. With the introduction of the Affordable Care Act (ACA), hospitals and physicians have an even bigger incentive to work together to make patient care safer, more efficient, and more affordable. New regulations are impacting reimbursement, quality, and performance, which forces providers to adapt and join together in order to comply.

BIG DATA

Big Data impacts how healthcare administrators and clinicians are approaching operational changes in the post-ACA environment. Healthcare executives can now keep a closer eye on physician performance and identify productivity or quality trends early on, thus allow-

ing for timely intervention. Big Data is also helpful when determining physician compensation. It supports creative, sustainable compensation models, which are geared toward a "pay for performance" mindset and tend to boost motivation among employees.

THE SHIFT FROM VOLUME TO VALUE

The movement from a volume-based model to a value-based model makes hiring physicians a top priority for hospitals because without a broad base of primary care physicians, a hospital does not have a big enough patient population to manage profitability. In addition to primary care physicians, hospitals are also bringing specialists onboard to drive quality improvement and improve costs for key service lines. Some systems are even launching their own managed-care plans and are using employed physicians to offer a broader and more attractive network. They are also using this as an opportunity to reduce cost through the consolidation of practices and the disposition of redundant real estate.

STRATEGIC AFFILIATIONS

Hospitals no longer have to employ physicians outright; a number of unique affiliations have been developed that meet the needs of both parties without creating a hierarchical employer-employee arrangement and are much more viable in the long-run. There is more flexibility and autonomy associated with these types of strategic affiliations, such as hospitals enhancing their collaboration with physicians without directly impacting payroll.

Launching an Accountable Care Organization, an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the organization's traditional fee-for-service program, is one alternative approach to direct employment that some hospitals are taking. One example is St. Thomas Health's MissionPoint Health Partners ACO, which was introduced in 2011. MissionPoint offers independent, community-based doctors, who participate in the system's malpractice insurance pool, billing and collection services, electronic health records, and group purchasing. James LeBuhn, an analyst at Fitch Ratings, predicts that more health systems will move to these types of physician partnership and alignment strategies.

DESPITE THE CHANGES, BIG COSTS ARE PRESENT

The acquisition of physician practices often results in a short-term loss. For example, Bon Secours Health System in Marriottsville, Maryland, took $158 million in losses in fiscal 2013 as a result of its physician employment strategy, according to Moody's Investors Service. The increase in the number of employed physicians has caused a 5.2% increase in salary and benefit ex-

penses, as well as added costs related to renting and staffing office space.

Other costs associated with the absorption of physician practices by hospital systems include the cost of upgrading information technology and paying comprehensive benefits packages. Some analysts have predicted a pullback on physician practice acquisitions this year as costs have increased faster than revenue. Moody's called physician employment "a principal driver of hospitals' margin pressure," but saw no signs of a slowdown.

WHAT'S THE PAYOFF?

Health systems will begin to see a return on their investment in physician practices once a critical mass of payers finally shifts to a new payment model aligning financial incentives with patient outcomes. Hospitals should be getting ahead of the curve and preparing for this shift now. For example, Bon Secours has already reduced its readmission rates, improved palliative care for terminally ill patients, and brought down blood-sugar levels for its diabetes patients.

SUMMARY

When it comes to physician employment this time around, clearer goals and smarter strategies are making a world of difference. Hospital administrators are asking more questions and developing a long-term strategy. Administrators are evaluating the practice's culture and clinical role in its network in conjunction with its financial valuation. They are structuring a compensation plan that keeps doctors efficient, happy, and productive.

Flexibility, planning, patience, and strong management can make a world of difference when building a solid relationship with physicians. If hospitals can successfully take the lessons learned in the past and apply them to today's shifting marketplace, the results of the 90's will not be replicated.

By: Alexis M. Farfaro