Integration: A Business Perspective

hfma healthcare financial management association

Strong collaboration with physicians is critical to a hospital's ability to drive evidence-based improvements in quality of care, reduce costs, and protect financial viability under healthcare models with performance-based payment. For this reason, many hospitals are weighing business strategies that would lead to tighter physician engagement, including employment—an area where many hospitals experienced financial loss in the past. With this issue in mind, this HFMA Executive Roundtable, sponsored by Bank of America, focuses on current trends in physician employment, lessons learned over the past decade, and solutions for effectively integrating physicians into the hospital's business operations.

How is your organization managing physician employment in the current market?

Keith Moore: We're putting together processes in line with a formal strategy. We have 13 CEOs with differing reasons for employing physicians. So it's good to have a plan we can reference, particularly in situations where someone wants to hire without a compelling reason: When a CEO requests new hires, we may ask, "Will your patient population of 10,000 really support three orthopedic surgeons?" It's really about establishing criteria and maintaining processes for communication and dialogue.

Mark O'Connor: We've seen far fewer practice acquisitions and more recruitment of new physicians to address access issues, where patients can't get into the practices of our long-time employed physicians. It's a win-win situation, because we're able to get the new physicians up and running pretty quickly, but we're not overpaying for their services either.

PARTICIPANTS IN THIS ROUNDTABLE

David Bolen, FHFMA, CPA, is vice president and CFO, Passavant Area Hospital, Jacksonville, Ill.

Bryan Coffey is CFO, Lakeland Regional Hospital, Springfield, Mo.

Paul Doelling is director, specialty practices, Saint Francis Medical Center, Cape Girardeau, Mo.

Loren (Nick) Fjone is leader of regional payer relations and contracting, Sisters of Mercy Health System, Chesterfield, Mo.

John Katsianis, CPA, is CFO, Christian Hospital, BJC HealthCare, St. Louis.

Gregory Meier is executive director, finance, Resource Optimization & Innovation, St. Louis.

Keith Moore, FHMA, is CFO, HSHS Medical Group, Springfield, Ill.

Mark O'Connor is vice president of finance, joint ventures, and physician organization, SSM Health Care, St. Louis.

Ted Saul is senior vice president and senior client manager, Bank of America, Chicago.

John Katsianis: In the late '90s, my organization lost money with a staff-model HMO that it acquired. This loss drove the need to have a more formal review process with our physician network today, so we know how we will review performance, determine need, and evaluate the opportunity financially.

Developing a strong primary care base is a particular priority for us right now. Last year, we had a very good year in recruiting primary care physicians, so my CEO was surprised this year when we couldn't find them. Availability ebbs and flows, so sometimes you have to keep your eyes on second and third priorities until other opportunities arise.

Also, the role of ACOs [accountable care organizations] is likely to shape our strategy into the future. Although the ACO model under healthcare reform is still not well-defined, examples of best practices the government has been showcasing—Mayo Clinic, Kaiser Foundation, and Geisinger Health System—show strong integration. I think we can anticipate that they want hospitals and physicians to collaborate considerably more in the future.

Paul Doelling: Back in the '90s when I was consulting, hospitals across the country were acquiring medical practices as a defensive strategy. But today, I think we've learned that we gave away the store a little bit while we were trying to shore up our defenses, so now it's more about aligning hospitals and physicians around quality and efficiency.

As people try to determine what the ACO strategy is going to look like, they're trying to build up primary care to ensure they have a referral base for specialists. I agree that it's the truly integrated physician-hospital organizations like the ones you just mentioned that are going to succeed.

What is the current trend in practice subsidies?

Doelling: I see hospitals determining payment in different ways. As far as employment agreements, many hospitals are using RVUs [relative value units], percentage of collections, or salary. I think RVUs are a good standard because you're actually looking at an objective measure of physician productivity.

Katsianis: I think the big change from 10 years ago is that in those days, we paid physicians on a straight salary and therefore took their productivity incentive away. Many physicians felt they had a guaranteed income, so they relaxed their hours. Since then, we've learned that we do need to have some form of incentive that ties to how hard they work. Of course, there are exceptions: Sometimes a surgeon the organization needs works really hard, but isn't generating the cash desired because of a high percentage of self-pay patients. You need to have some strategy for managing these types of situations.

David Bolen: In the rural market, it's often simply you get what you can get and try not to overpay. It's unfortunate, but if a needed surgeon wants a particular level of compensation, then you provide it.

One of the things we're doing to improve our situation is to recruit using other organizations. So instead of being a small, rural hospital in the physician business, we'll recruit with larger clinics that specialize in placing physicians in rural areas. They are more efficient at recruiting and can provide benefits that we can't, such as better rates on malpractice insurance.

Moore: I recommend short contracts—such as a one-year employment guarantee—so that if the physician doesn't work out, your organization is protected from further financial loss. I've completed multiple deals between health systems and hospitals regarding physician practice acquisitions all over the Southeast. In 12 to 15 cases, there wasn't any goodwill paid. The only money exchanged was for hard asset purchases. I believe we are doing better fair market valuations than in the past.

Instead of buying practices, we're opting to grow them. It's a whole lot safer to hire an individual physician than to buy a practice of three people who would be placed on guaranteed salaries and can pose a major concern with productivity, current and future. I recommend as close to a 100 percent productivity contract as you can get, so that you incentivize much of the income opportunity for those who want to work.

Loren (Nick) Fjone: Physicians, particularly in a lot of larger markets, just can't live on what they're getting paid. They're losing a lot of money on Medicare and Medicaid. Integration is one of the few avenues they have to enhance their revenue stream from commercial insurance companies. As a result, a lot of physicians are asking hospital leaders, "What can you do to help me with my reimbursement phase?" It is a defensive strategy for physicians that is also working very well for health systems in term of integration, growth, and controlling the market presence.

O'Connor: I think two things are contributing to physician interest in integration: electronic health records—because physicians can't afford to do that on their own—and frustration with payment denials as they cope with managed care's increasingly complicated processes for obtaining authorization. Most physicians would rather practice medicine and let someone else run the business for them.

Understanding the current business concerns of physicians is important. What are some of the most common issues that you're hearing from physicians?

Katsianis: Physicians are unsure of what tomorrow means and are under new financial pressures. For example, the government has quashed many of the physician joint ventures that used to be profitable. Now with Medicare cuts to compensation, many physicians are looking for a certain amount of stability.

O'Connor: Physicians don't want to be left out of ACOs. A successful ACO is designed as an employment model to control the flow of patient care. As such, referrals are more likely to go to a cardiologist who is aligned with the hospital than it is to equally skilled competitors who are not.

What are some of the key business concerns for hospitals when it comes to physician relationships?

Moore: One factor is the new generation of physicians. Younger physicians want a greater work/life balance than those before them. They expect to work a shorter work week and not be on call. So when your 65-year-old cardiovascular surgeon who performs 400 cases a year retires, you had better plan to hire two replacements.

Along these lines, younger physicians prefer an employment model to taking on the business demands of building a practice.

Bolen: I agree. The first question asked by the last two physicians we hired was, "Do you have a hospitalist program?"

Katsianis: Is a hospitalist program inherently a bad thing? From a resource utilization and quality-of-care perspective, our hospitalists have a one day shorter length-of-stay.

On the other hand, I remember my dad telling me back in the late '80s that he drove from Chicago to Mayo Clinic because everything was "team-oriented." There was a lead physician who would coordinate care for my dad with all the other specialists the physician chose to work with him. That's a different situation from having a hospitalist who writes three consults with physicians who round at different times, and who doesn't want to put in the effort to ensure those physicians are communicating effectively. In such an instance, patients are likely to complain that no one knows who is in charge and physician collaboration is poor.

Physician billing and collections priorities can significantly differ from those in a hospital setting. What difficulties are you encountering with integrating physicians into your revenue cycle, and what solutions have you deployed to achieve effective integration?

O'Connor: One challenge is to help physicians understand how reimbursement works in the hospital setting and recognize the importance of taking steps to ensure appropriate authorization for services provided. Many managed care plans set up a path of least resistance to encourage choosing low-paying care. Even though an overnight inpatient stay may be clearly indicated for a procedure, physicians can easily obtain an authorization for an outpatient procedure instead of spending 30 to 45 minutes on the phone to get an authorization for an inpatient stay. I think we need to work with payers to change some of the requirements and also with physicians to understand the effects on payment.

Fjone: Sometimes there is a benefit to taking certain functions out of the physician office—such as authorization—and centralizing them.

For example, if a primary care physician wants to make a referral to specialist X, then the referral can go directly to a clerk out of the office, so staff at the physicians' office no longer need to spend 45 minutes on the phone trying to obtain the authorization. Such arrangements can make physicians happier and more productive.

Katsianis: The issue goes beyond authorization. It's also about fostering an appreciation for thorough and accurate documentation and its effect on coding.

How well is your physician documenting comorbidities, for example? Are your physicians capturing all of the services they are truly providing in a way that ensures appropriate reimbursement? I think for most hospitals, accurate physician documentation means the difference between making and losing money.

Bryan Coffey: In rural hospitals, centralized business offices seem to be popping up to facilitate physician billing. Not having to manage this function is a key factor driving physicians toward the employment model.

Managing the business side independently can be difficult. First, they get hit on the reimbursement side. Then staff at many physician offices don't have the knowledge and skill set to get procedures billed without denials.

Moore: One of the mistakes I've seen in the past is that the hospital or health system pulls all of the billing staff out of medical practices and tries to handle the billing with hospital staff. It's important to leave that front-end piece in the practice to ensure ownership of the front-end revenue cycle for collecting copays and coinsurance. Otherwise, the hospitals will experience unexpected lower collection rates and higher practice losses.

Despite the desire to disengage from financial aspects of the practice once the physician is employed, I think we have to help him or her understand that, "You have to collect up there. The revenue cycle in your practice needs to work." When non-urgent patients have a large balance, physicians need to stop care until they can pay it down.

Katsianis: Actually, in some ways, physicians seem to be much better at collecting copays than hospital departments. They all have signs posted: "Your copay is due."

O'Connor: I think it depends on market dynamics. When most people go to the emergency department, they fully expect to be asked for a copay. And yet, locally, we've seen imaging centers that do not collect any payment at time of service. So it becomes a patient dissatisfier when they are asked for a $50 copay at our hospital.

Coffey: It can also be hard to get a true picture of patient deductibles with the way patient benefits are structured right now. But I think that as health care migrates toward these integrated efficiencies, we'll see a better front-end process develop so hospitals and physicians will know right up front how much of the patient out-of-pocket obligation has been met regardless of care setting.

How are physicians aligning with hospital and health system leadership?

Fjone: Ten years ago, we employed physicians and expected them to work in our office and stay out of our business as hospital administrators. Now it's just the reverse. We're trying to involve physicians starting at the governance level throughout the organization. It's truly a physician-led organization, not just in name.

If we as hospital administrators try to say, "We want you physicians to sit down as a team," it's met with skepticism. But if a physician suggests to peers that they need to think about things differently, then they tend to be receptive. Of course, the physician leadership has to be empowered to speak for the hospital. That's one of the fundamental differences from 10 years ago.

Gregory Meier: At my organization, we have separate boards for the hospital and the physician group. Membership is overlapping, so some of the physicians are involved in what is happening at the hospital.

Doelling: While I was at a different hospital a few years ago, administration started a physician leadership group where 10 physicians met every two months with the administration to discuss hospital-related issues. One of the successes to come out of the physicians' continued support of the hospital was the development of a bone and joint center, which made a huge difference in patient and physician satisfaction. In my current position at Saint Francis Medical Center, physicians are an integral part of strategic planning and capital budget planning. Administration and physicians work hand in hand. Physician satisfaction is at the 99 percentile for "relationship with leadership" and it is the medical center's goal to continue this close partnership.

Ted Saul: It's clear from everyone's comments that while there are several different approaches for effective physician alignment, getting that alignment "right" for each health system will be critical for their future success.