The Care and Feeding of Physician – Hospital Alliances

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Overview

• What’s the motivation?
• With whom should we do it?
• What model shall we use?
• What will we need to know?
• What will it look like?
• Will we both be happy?
• Cultural / communication challenges
In the Spirit of Good Contract Legalese:

“Whenever used herein, the masculine gender will include the feminine, the feminine will include the masculine, the neuter will include...the neuter. There shall be no presumption against the presenter and this presentation shall be construed as if drafted by some who knows the difference!”

Motives for Proposal

You’ll take care of me

Oh Boy! Vertical Integration!
Motives. . . .

• Fear
  - Physician – “private practice is doomed”
  - Hospital – To survive, we must control the healthcare delivery chain from start to finish

• Business acumen – you’re ones with the business degree, you can run my practice more efficiently

• Buyouts – No longer like the early ‘90s. (Goodwill?)

Motives. . . .

• ACOs – It’s necessary if we’re to participate in ACOs (Vertical Integration, here we go again)

• Physician fatigue – tired of hassling with business details, just want to practice medicine
  - Caveat – doctor, you’re still going to care very much about the business details!
With Whom?

- Good citizen?
- Respected by other doctors, nurses, medical community?
- Rounds completed timely?
- Charting completed and closed timely?
- Patient satisfaction
- Physician friendly hospital?
- Is Hospital over-recruiting?

Models...
Employment

• Hospital generally exercises greater control (i.e. No admissions to Crosstown Medical Center)
• Hospital is totally at risk for all cash flow – does all billing, pays all bills
• Generally, greater flexibility with physician compensation
• Production may not be as high (“profit is your worry, not mine”)
• Often less entrepreneurial interest
• Risk management more complex

Start-up Assistance

• One year guarantee period marks end of financial risk
• Physician are generally keen to be self-supporting at end of guarantee period. Entrepreneurial interest.
• Generally cost is limited to start up working capital with limits
• Physician on the hook for furniture and equipment via bank loan
• Books are kept by the practice and reimbursement reports are submitted
  - Who prepares the reports? Have they read the contract?
  - Do you audit the reports for accuracy?
• After 3-4 years, physician free to go anywhere
What do we need to know?

- Encounters – past volumes – and future expectations
- How many FTEs are we looking at here?
- Charges (RVUs might be better)
- Fee levels
- Collections
- CPT code utilization – E/M bell curves / surgical cases to office visits out of line with specialty peers?
- Chart audit?
- Ancillaries carved out? (Stark)

What do we need to know?

- Tax returns reconciled to practice management systems reports
- Employees – number, salary, duties, spouse; any who are “off limits” for termination?
- Compensation reconciled to W-2’s / 1099s/ K-1s
- Other sources of income that may cease?
  - On-call contracts (beware of double dipping)
  - Directorships
  - Remuneration from other hospital?!
Physician Needs to Know

• Typical patient volume of current successfully employed physicians
• Typical compensation
• Typical patient demographic breakdown
• Sample income calculation
• Expected duties besides seeing patients
• Benefits, professional expenses provided

Expectations

• Is physician required to be “Profitable”
• Physician comp – base + incentive?
• Decline in production?
• Increase in overhead?
• Expected patient volume, hours
• Trotting out MGMA stats
• Market value of physician
Incentives – What Was Good Enough is No Longer Good Enough

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<td>Other citizenship values</td>
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Profit Vs. Value

- Physicians Employed by Hospitals are Usually not profitable in a strict accounting sense.
- What about the receptionist? Nurse? File clerk? Are they profitable?
- What value does the physician bring beyond revenues minus expenses?
- Determine this value and back into measureable indicators
Communication & Cultural Disconnect

- Mom & Pop go corporate
- The practice lost its heart
- Admin off-site – who cares anymore?
- Centralized billing and front desk disconnect – impersonal working relationship – “Who cares if our demographics are bad – they’re so smart, they can figure it out!”

In Summary

- Right reasons
- Right parties
- Right information
- Right plan
- Right heart
- Right outcomes
- Right for the healthcare of your community
Questions?