

Managing Physician Practices: Issues Every Hospital Should Know

If you are not currently employing physicians, then you may be actively considering doing so in response to inquiries from community physicians, a strategic initiative, or a defensive move. A number of issues bring integration considerations to the forefront for physicians and hospital executives alike. Healthcare reform, Medicare solvency, bundled payments, Accountable Care Organizations are all buzz words in today's market that prompt this consideration. In light of numerous political (inside the health system, not Washington D.C.) and regulatory concerns, many have deduced that employment is the best strategy. After all, how hard can it be to manage a group of physicians?

For those who lived through physician employment in the 1990s, you know that many models were tried and many, if not most, discarded before 2000. Important lessons were learned during this period about managing an ambulatory/physicians' practice, including the following:

1) Compensation models must be structured to align with overall objectives



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as well as regulatory concerns. This was perhaps the single most painful lesson learned in the 1990s. Without incentives to produce, many employed physicians simply decreased hours worked and patients seen, yielding practices operating in the red. While somewhat addressed from a regulatory perspective through Stark laws and anti-kickback regulations, a great deal of thought and planning is required to determine an appropriate compensation structure.

2) Many decisions center on the legal structure through which physicians and hospitals integrate. Some systems consider the employed physicians as a department of the hospital, while others form a new entity for this purpose. Before making this key decision, consider implications with regards to negotiating contracts, tracking revenues, access to employee benefits (and associated costs), management infrastructure, and strategic objectives.

3) Successful employment does not happen overnight, even if the systems and structure are already in place. It takes time to ensure that both parties are on the same page in terms of compensation, supervision, autonomy, and degree of

integration. Additionally, it takes time to onboard a physician in terms of credentialing, installing new systems, executing contracts, and conducting orientation for physicians and staff on system policies and procedures.

4) Physician billing is not the same as hospital billing. Professional fees, which are critical to the physician's livelihood, are often considered as collateral items to a biller who is more intent on working those outstanding, high dollar DRG claims. If the physician's compensation is tied to collections, then professional fee billing should be someone's top priority from a staffing, supervision, information systems, and insurance contract negotiating perspective.

5) Most physician practices do not use committees to evaluate and address problems. They tend to react quickly and swiftly to address the issue and move on – the last thing they will do is determine which department they should call for assistance. Your practice management team should have the latitude to make operational decisions, within reason of course, without requiring legal, human resources, asset management and the CEO to weigh in every time.

6) Speaking of practice management team, experience has shown that having professionals seasoned in the operational

and financial management of medical practices is an asset for the system. Physicians must also be a part of the management team. Regardless of the structure you choose, these individuals serve to liaison the culture and operations between a hospital and the practice/physician entity and help "translate" items which often get lost in differing communication styles.

7) Get ready to explain accrual accounting...and explain...and explain. Successful systems learn early that there is benefit to maintaining financials on both a modified cash and accrual basis. Modified cash financials are most often used for compensation calculations since physicians understand the notion of receipts (collections) and expenses in determining net income. Accruals, however, especially those for earned time off, are looked upon with great distrust.

Obviously, a number of factors affect the successful integration of hospitals and physicians. The more that are considered and addressed on the front end, the fewer hurdles to be overcome after the fact.

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