

# Restructuring Employment Relationships Between Healthcare Organizations and Primary Care Physicians

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**H**ealth systems have expended substantial energy and financial resources to create lasting and meaningful partnerships with primary care physicians. One of the most common strategies in the 1990s was the purchase of practice assets and employment of primary care physicians.

Numerous rationales have been used to justify the acquisition and employment of physicians, rationales such as protecting core markets, maintaining or expanding market share, securing the referral base for inpatient and ancillary services, and improving the organization's negotiating position with managed care payers. But the outcome of this strategy can be defined by a single common denominator: severe financial losses. Post-acquisition financial performance of employed physician practices has been far lower than expected and, in some instances, financially disastrous. A study by Coopers & Lybrand found that hospitals lose, on average, \$97,000 per physician per year for acquired practices, much of which results from inferior performance in volume, revenues, and costs (*Wall Street Journal* 1997).

As recently as two to three years ago, these losses could be offset by surpluses in other components of operations, but this approach is no longer an option. The Balanced Budget Act of 1997 severely reduced reimbursement to healthcare organizations. As a result, many hospitals and systems are facing operating budget deficits that must be funded from nonoperating revenue. Financial deficits from employed physician practices have become intolerable for most healthcare organizations because financial performance from operations no longer serves as a cushion. Two approaches address deficits incurred from practice ownership and physician employment: restructuring the arrangements or transitioning the practices back into the private sector. These approaches, discussed below, are complex processes that raise a number of legal issues. In fact, the legal considerations for restructuring and transitioning the practices are as complex as those involved in the original purchase. Healthcare organizations must address, among other things, fraud and abuse, the Stark Law, and the private inurement and private benefit aspects of the arrangement. In addition, the transitioning of a practice involves employment law issues and, potentially, litigation considerations.

**RESTRUCTURING EMPLOYED PHYSICIAN RELATIONSHIPS**

The restructuring process usually starts with implementing networkwide and practice-specific initiatives to improve financial performance. This approach may also include the transition to new models or compensation arrangements, many of which were discussed in the previous two columns in this series.

Restructuring typically entails a three-year to five-year process outlined in a performance improvement plan. Some of the highest return initiatives that have been used successfully in the industry include:

- Revise physician employment contracts to incentive-based arrangements that are linked to productivity as measured by collections performance rather than office visits or relative value units;
- Reduce or eliminate administrative overhead costs and bureaucratic management of practices;
- Improve charge, receipt, and production capture;
- Right-size practice support staff to provider levels and workload; and
- Consolidate practices to achieve economies of scale.

When healthcare organizations opt to restructure employment and ownership arrangements, legal issues may already be on the table as a result of significant losses from physician practice operations. Government agencies may view such losses as an indication of overpayment for practices and overpayment for physician compensation. Therefore, as part of the restructuring process, healthcare organizations that employ physicians must address the legal questions of whether losses will continue and, if so, must decide how to reduce the legal risks associated with such losses. Healthcare organizations will be required to analyze the reasons for losses and move toward resolving these financial issues in the restructured arrangement. Failure to do so can result in continued or greater legal risk under the new arrangement.

Healthcare organizations must also analyze what ability they have to impose changes in compensation or the underlying arrangement. For physicians with long-term agreements at fixed compensation levels, it is difficult for the healthcare organization to force a change. Instead, a mutually acceptable amendment should be negotiated. If physicians are unwilling to accept a new compensation arrangement or model, the employer is forced into either breaching the arrangement or trying to terminate the agreement because of legal considerations. This latter approach is fraught with danger in that the employer must allege that the agreement is illegal in order to void it. Most organizations are obviously reluctant to do so because it is tantamount to admitting to participating in an illegal arrangement to avoid financial losses. If physicians agree to an amendment or healthcare organizations are able to change the arrangement, compensation must be set at reasonable levels

consistent with fair market value and that satisfy the Stark Law's requirements with respect to production incentives.

When establishing the new arrangement, healthcare organizations should take into consideration the knowledge gained from their practice operations. Specifically, healthcare organizations should use historic production levels to set compensation for physicians. Base salaries or guaranteed compensation levels that are not set with realistic productivity in mind can increase an employer's legal risk.

### **TRANSITIONING BACK TO PRIVATE PRACTICE**

Many healthcare organizations are finding that divestiture is the only viable option for cutting overwhelming financial losses. This transition process does not inherently need to be harsh and painful. If it is, the aftermath will leave physicians feeling bitter and resentful and will affect their future relationships with the healthcare organization. Following are four important components of the transition process:

1. Choose a selection process for divestiture that is objective and uses measurable criteria to evaluate historic and potential performance such as magnitude of operating losses, years in practice, productivity trends, and practice location relative to the healthcare organization's strategic and geographic priorities.
2. Determine practice requirements (e.g., information systems, funding accounts payable, benefits transition) that serve as the foundation for developing transition packages and factor in physicians' tolerance for risk and motivation for independence.
3. Agree to transition packages that include detailed financial terms and conditions and address issues such as potential employment contract buyout, repurchase of practice assets (e.g., medical records, real estate), future sale of the practice, continued inclusion of physicians in provider panels and other practice promotion initiatives, and restrictions on disparaging commentary by either party.
4. Follow logical transition steps to ensure a smooth transfer of responsibility for operations and systems or arrange for the hospital to continue to provide services to the practice at fair market value. Transition steps need to be outlined for payer and vendor contracts, leases, benefits, staff employment, print and electronic communication material, and myriad other services and relationships.

For those organizations that choose not to continue employment arrangements, the most important legal consideration is determining the organization's ability to terminate the arrangement. In some cases, employers are able to terminate agreements by not renewing them or exercising "without cause" termination rights. In such cases, the legal issues relate largely to the transition services offered to the physicians. Healthcare organizations must ensure that they are not improperly benefiting the physicians by offering services that are priced below market

value or that are intended to induce the physicians to continue referrals to their former employer.

The more difficult legal issues are faced by organizations that do not have the right to terminate the arrangements. In such cases, employers must either reach a mutually acceptable termination and settlement with the physicians or terminate the agreement and risk litigation. Because most employers would like to avoid litigation, offering a structured settlement is a common approach. The settlement offer, however, must be reasonable in light of the contract terms, the assets transferred to the physicians, and the value of any other services offered as part of the transition. Offering settlement packages that include excess value for the physicians creates significant legal risk. The Office of the Inspector General has commenced investigations into practice transitions, so settlements should be structured with legal oversight.

The choice of whether to restructure relationships with employed physicians or transition them back to private practice will be difficult to make and implement, but it is a choice that must be made. Christopher Howard, executive vice president of Healthfirst Inc., in Oklahoma City, voices the opinions of many executives facing this dilemma. "The old system of trying to prove that there is a benefit to owning a physician practice, even though it is losing \$50,000 a year, is going by the wayside. In the future there simply isn't going to be \$50,000 sitting out there to be lost."

### Reference

*Wall Street Journal*. 1997. "Hospitals that Gobbled Up Physician Practices Feel Ill." June 17: B4(W), B4(E).

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