

Economic Models for Physician–Health System Partnerships

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This column is the second in a series that is exploring physician–health system relationships. In this issue and the next, we will discuss specific partnership models for physicians, hospitals, and health systems. This column will focus on economic models; the next column will focus on partnerships that, while grounded in economic realities, pursue initiatives with other goals for the affiliation.

The overriding theme of the economic models is one of alignment, collaboration, and mutual benefit between hospitals, systems, and physician practices, rather than full integration (e.g., acquisition and employment). However, one could argue that formation of a partnership model whereby the economic performance of the hospital and physician practices are interdependent represents a significant degree of integration.

Partnership models focused on economic relationships that balance risk and reward are the only way to create value, interdependence, and motivation to provide cost-effective, high-quality care. Nevertheless, the application of any particular model must be tailored to specific practice needs and interests and a hospital's or system's particular strategic initiatives and priorities.

Historically, one of the primary failings of physician–health system partnership models was that only one model was developed (i.e., "one size fits all"). The best illustration of this practice is the acquisition and employment of primary care physicians. A better (but more time-consuming and complex) approach is to build specific but different relationships and extend opportunities for physicians to participate in various integration models. The approach is threefold:

1. Only offer affiliation opportunities that have a high likelihood of success (i.e., offer only what can be delivered as intended and promised);
2. Determine strategic priorities and extend partnership opportunities that help hospitals, systems, and physician practices achieve strategic priorities, such as securing additional primary care physicians for underserved geographic areas and strengthening specialty programs; and
3. Establish consistent guidelines for application of partnership models rather than striking deals in a haphazard and reactive manner.

ECONOMIC MODELS DEFINED

For the purposes of this column, an economic model of physician–health system partnerships is a structure that creates some shared financial risk and reward between and among hospital and physician participants. The degree of shared risk and reward can be extensive or limited, depending on the depth of the partnership, but is commensurate with the level of investment and commitment. The key element is interdependent financial performance.

PAST MISTAKES

Many attempts have been made to create meaningful economic models, but few have been sustainable in terms of financial performance. Following are examples of models that have been commonly implemented but generally deemed unsuccessful because most are being abandoned or substantially restructured.

Physician-hospital organizations (PHOs). PHOs were initially and primarily formed for two reasons: (1) to serve as a vehicle for physicians and hospitals to contract with managed care plans; and (2) to serve as a platform for other integrated partnerships, such as information systems or other practice management services, when and if they were developed by the PHO. PHOs have generally been failures because of a lack of incremental or better contracts with payors. Most PHO-payor contracts have been structured as the same contracts for physicians and hospitals, less a fee paid to the PHO to cover administrative costs.

Practice acquisition. The practice acquisition initiatives of the past decade that focused on primary care practices have now shifted from acquisition to restructured relationships or transitioning employed physicians to private practice (i.e., divestiture). Practice acquisition strategies failed because incremental earnings to recoup practice acquisition costs rarely existed. Losses have often exceeded \$100,000 per physician annually. Also, in most markets, practice acquisition resulted in no net change in referral patterns, the often-cited rationale for practice acquisition.

Global risk assumption. With global risk sharing, physicians and hospitals together assume risk for the utilization of health services, usually at a prepaid (capitated) amount. Although many physician practices and hospitals have entered into individual capitated contracts with managed care companies, joint contracting is a rarity, with only about one in ten dollars paid out by HMOs appearing in the form of global capitation or risk for health utilization and expenditures assumed by provider networks (Institute for the Future 1998). The concept is admirable—by assuming risk providers should be motivated to reduce excessive utilization of healthcare services. But global risk assumption has been unsuccessful because the tools to measure and manage utilization and costs are usually not built into the provider network. Hospitals and systems assumed full risk, then were unable to control utilization, or, in the worst cases, were unable to link costs associated with utilization.

Comprehensive management services organizations (MSOs). Hospitals have built MSOs to provide full-service practice management services for private prac-

tice physicians. The management services often provided include all "back office" (other than clinical) functions including clerical staffing, human resources, billing and collections, medical records, and information systems. Fees are usually based on level of service or a percentage of net medical revenue. Comprehensive MSOs generally fail because hospitals have done a poor job providing the same or better level of service at the same or less cost. The billing and collection performance of most MSOs has been inferior, and provision of support staffing has been costly, reflecting the sentiments of many physicians that hospitals do not understand the physician practice business.

EMERGING MODELS

The emerging economic partnership models are tailored to specific practice needs and enable hospitals, systems, and physicians to design alternative relationships and earn and build trust, provide added value to partnership participants, and address the interests of both primary and specialty physicians. Some emerging models include the following:

Joint ventures. Although the concept of joint ventures is not new, the programs and services that are included in joint venture arrangements are much broader than they were five to ten years ago. Today's joint ventures between physicians and health systems include ambulatory surgery centers, ambulatory care centers, imaging and other diagnostic centers, wellness programs, occupational medicine services, and others. Successful joint ventures provide risk and reward commensurate with the level of investment and commitment, with neither joint venture partner dominating the relationship. Most importantly, there is economic and strategic value for each partner.

Joint operating agreements (JOAs). Since the recent ban on gainsharing arrangements, JOAs have increased in popularity as an alternative for securing physician participation in clinical or operational initiatives. JOAs borrow the most attractive aspect of gainsharing—alignment of hospital and physician clinical and operational incentives—without fostering reductions in patient care. Where physician commitment needs to be significant, reimbursement of physicians is tied to measurable and documented market rates and is commensurate with the amount of effort required.

À la carte MSOs. Physicians can benefit from selection of individual practice management services provided at fair market value rather than package deals providing full practice management services. Commonly selected services include access to group purchasing of health insurance, managed care contract evaluation and negotiation strategies, information systems, answering services, and back office staffing services. Physicians generally show little interest in billing and collection services because hospital performance in this area historically has been poor.

Management contracts. In return for providing specialty or program-specific administrative services to a hospital, a physician practice or group may receive a contract (and reimbursement). The practice usually is given the advantage of an

exclusive relationship with a hospital and a contractual (but not employment) relationship. Hospitals and systems usually benefit from these relationships by securing coverage of a service (e.g., radiology, anesthesiology, pathology, emergency services). In successful management contract relationships, performance expectations, such as specified full-time equivalent physician coverage on-site and medical staff and patient satisfaction levels, are clearly defined.

Right of first refusal contracts. As an alternative to practice acquisition and employment, many physicians have entered into right of first refusal agreements with hospitals. In this relationship, the hospital has the right to exercise an option to purchase a physician practice should that practice receive an acquisition offer from another entity. In return, physicians generally agree to exclusive participation in managed care contracts negotiated by the hospital, sign a noncompete agreement with the hospital, and receive a cash payment, usually in the range of \$10,000 to \$30,000. In today's market, right of first refusal options are exercised infrequently but represent tacit agreements of the need for physicians and hospitals to develop mutually beneficial noncompetitive relationships.

Line of credit guarantee. This model is applicable to the private practice physician group that requires capital for practice expansion or program development. Some hospital systems have earned the goodwill of physician groups by serving as a guarantor on the loans or lines of credit secured by the physician group. The physician group is primarily responsible for the loan or line of credit repayment, but the hospital, through its guarantee, helps the physician group secure a loan. Protection for the guarantor (i.e., the hospital) needs to be specified clearly to avoid false expectations by either party.

These examples illustrate just a few of the economically grounded partnership models that show promising signs of the financial benefits of alignment and collaboration, although the success of these models will depend heavily on the ability of the hospitals and physicians to deliver on their promises, the needs and interests of physician practices, the degree of trust between the parties, competitor initiatives, and many other market-specific and practice-specific factors. Innovative and creative examples of economic integration between hospitals and physician practices will continue to emerge as hospitals and health systems face the harsh reality that they can no longer sustain the financially draining physician relationships that have prevailed over the past decade.

Reference

Institute for the Future. 1998. *A Forecast of Health Care in America*, 48. New Brunswick, NJ: Robert Wood Johnson Foundation.

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