Hospital-Acquired Physician Practices: After the Deal is Done

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Hospitals and health systems have been on a rapid course of acquiring physician practices in the 1990s. In a national survey published in 1995, Hill and Wild found that more than 36% of senior financial executives noted physician acquisition activities for their institutions, with over 50% for hospitals with greater than 300 beds. This trend is seen in all regions of the country [1].

Hospital executives give a number of strategic arguments for acquiring physician practices, especially primary care practices (PCPs). Preparation for managed care and for accepting global financial risk for populations are key reasons. To develop a fully integrated delivery system, ambulatory services—including physician practices—are seen as a critical element, and acquisition is seen as a viable approach. Defensive positioning to protect market share for inpatient and ancillary services as well as to preempt competitors from "stealing" aligned physicians are also common justifications for purchasing practices. And for some organizations, there is the hope that employed physicians will be more loyal and more easily controlled. Once an acquisition strategy is adopted, it is often given a target number of physicians considered necessary to achieve a critical mass to achieve the intended goals.

Enough practices have been purchased across the country to identify a significant problem: in the majority of cases, results are not meeting expectations. Hospital executives are experiencing financial losses on purchased practices far beyond their projections. In a 1995 survey, only 17% of finance executives reported a positive bottom line [1]. A report of a 17-hospital survey noted annual losses of $97,000 per acquired physician [2]. This article explores the underlying causes of why so many hospital acquired physician practices are not successful, and offers possible solutions, in the form of recommendations, for improving the performance of acquired practices.

The Initial Focus of Practice Acquisition

When most hospitals begin discussions with their physicians about possible purchase of their practices, the emphasis is on organizational and governance issues and on contract terms and language. Questions addressed include how will the physicians and the newly formed medical group be organized; what will their governance structure be; and what will be the structure and representation on the board of the medical practice organization? There are a number of questions physicians typically ask, such as will we also have representation on the hospital board; are we going to be told how to practice; what if we don't like the practice executive director; and will we be paid for administrative duties? Also, there is consideration of an array of legal opinions and organizational charts representing a variety of voting rights issues and organizational structures. It is important work that requires a lot of time and effort from everyone involved.

The other area that receives considerable attention is the actual contract with each physician. These are negotiated in detail for each practice, and, unless a disciplined approach is used, may result in a number of unique contracts that are difficult to administer or may lead physicians to wonder if they were treated fairly. Physicians are concerned with a number of issues in the contract, including which assets will be purchased and at what price (*eg*, "What about my building?"); will the office manager be guaranteed a job for at least a year; what salary guarantee is to be received and for how long; what vacation and other benefits will be received; and what type of noncompetition agreement is to be signed. Usually, the result is a salary guarantee for 2 to 5 years with a productivity incentive. PCPs have been purchased at a cost of anywhere from $10,000 to $600,000, most commonly between $100,000 and $150,000.

While the purchases usually begin with a targeted group of practices, once the process is in place and a critical mass is identified, there tends to be a speeding up of acquisitions which may lead to less attention to quality or "fit" as a good partner. In addition, operational issues that are categorized as management services organization (MSO) functions are often seen as relatively easy to do for an experienced group of hospital administrators. The complexity of performing these tasks well is often underestimated.

Expectations Versus Reality in Operating Acquired Practices

The reality of acquiring a practice is often at odds with the expectations. A typical scenario is that in the first 1 to 2 years it usually becomes apparent that managing acquired practices and forming a well-performing group practice is not going as planned. Hospital executives and their Boards of Directors have faced most or all of the challenges listed in Table 1.

Immediate financial losses

It doesn't take long after physician practices are acquired before financial reports begin to show significant losses. Some of this is due to amortization of the cost of the purchases. In addition, there may be new overhead allocations from the hospital administration that the practices never had to experience before. Also, the salary guarantees result in cash outflows before practice revenue is realized.

Overhead costs increase

Overhead costs to operate the practices often increase due to upgraded staffing and improved vacation and other benefits. Physical plant improvements and other capital purchases such as telephone systems, and medical and office equipment may be necessary to bring the practices up to the level that the hospital expects and that is necessary to have an integrated group practice.

Decreased physician productivity

Decreased physician productivity as a result of salary guarantees is often identified as the main culprit for why acquired practices are losing money. However, there is not universal agreement about this. Sue Cejka, President of Cejka and Associates, a healthcare consulting firm, believes that in most situations physicians maintain the same level of patients seen before and after their practices are purchased. One of the reasons physician productivity on a fee-for-service basis may appear to decrease is that ancillary revenues for office lab, radiology, and so forth, are often no longer credited to physician productivity. In some practices this can account for 15% to 25% of a primary care physician's revenue. These revenues are often assigned to the hospital's ancillary departments. Careful measurement of physician productivity in terms of the number of doctor-patient encounters before and after acquisition can help resolve this issue.

Table 1. Issues Hospitals Face with Acquired Practices

Issue
Immediate financial losses
Increase in overhead costs and capital improvements
Decreased physician productivity
Reduced collections
Need for practice system upgrades
Increased capacity with recruiting of new physicians
Problems with patient access
No increase in hospital inpatient or ancillary revenue
Inability to secure global risk contracts
Presence of side deals and verbal promises to physicians
Functioning as a group of independent practices as opposed to a group practice
Ineffective governance structure
New liability issues

Reduced collections

Reduced collections are a common experience after practices are acquired. When the physicians were in control of billing and collections, they worked hard to ensure collection rates of more than 90%. As hospital departments take on this responsibility, collection rates often fall into the 70% to 80% range. One result of this can be internal bickering among the physicians who may have a productivity bonus and the collections department who feel physicians are not providing all the information needed to increase billings and collections.

Need for practice system upgrades

Lack of timely information about practice performance is a common problem because each practice may be using a different information system. The cost to upgrade and standardize each practice's systems is significant, yet is an additional investment that the hospital needs to make to run the practices more effectively. Most hospital administrators expect to make this investment, but as the practices lose more money than planned on an operating basis, investments in information systems become more difficult to achieve.

Increased capacity with recruiting of new physicians

As part of the acquisition strategy, hospitals are often simultaneously recruiting new PCPs to join existing purchased practices and to start new practices. One result is increased capacity, which negatively impacts the hospital-purchased medical group's bottom line. Practices which, when left to themselves, may not have added another physician, are much more willing to finance this expansion with the hospital's money.

Patient access problems

In addition to financial losses, practices may begin to experience patient access issues. Salaried physicians with income guarantees may not be as aggressive in fitting additional patients into their schedules, especially late in the day. Paid vacation, limited hours of operation, and less frequent on-call responsibilities may also contribute to this problem. Excess capacity, noted above, may solve this in some practices, but not in all.

No increase in hospital inpatient or ancillary revenue

Hospital inpatient and ancillary revenues often remain unchanged. Most hospitals have purchased practices of physicians who are already loyal and already use their services. Therefore, in many cases there is no increase in other revenues to offset the costs of acquiring the practices and the ensuing operating losses.

Inability to secure global risk contracts

One of the key reasons for purchasing practices is to improve managed care contracting with the goal of receiving a more global capitation rate. However, this may take several years to develop, so in many cases the practices continue under a fee-for-service or PCP capitation-only reimbursement. This is another reason that hospitals often do not realize overall increased revenue. The growth of managed care and the trend of reduced fee schedules compound this financial impact.

Presence of side deals and verbal promises to physicians

While acquiring the practices, there are often a number of verbal statements and promises made to physicians that come back to haunt those who are expected to manage the new medical group. Some examples of statements made to physicians during contract negotiations include: "You still run the practice"; "Nothing will really change for you"; "Of course, your office manager will keep her job"; "We'll give you equity in the MSO"; "We'll put in an electronic medical record"; and other special deals.

Functioning as a group of independent practices

To attract physicians to become part of a purchased group, promises are often made about maintaining physician autonomy. This issue is rarely explored in the depth necessary to resolve key issues. The result is that the hospital is frequently faced with a collection of individual practices rather than a cohesive group practice. Bringing individual and small group practices together to form a well-functioning large group practice is an important but difficult task.

Ineffective governance structure

Despite all the attention spent on governance issues when practice acquisitions are begun, the result is usually an ineffective governance structure. What is often set up is a representative form of governance with dispersion of authority. Consequently, the newly formed medical group cannot make the difficult decisions necessary for the group's success. Often, individual factions have the ability to block initiatives that would benefit the whole.

New liability issues

The liability issues of owning physician practices pose unique challenges. The practices may have little experience handling human resources issues such as wrongful discharge, discriminatory hiring practices, and so forth, yet there is now a significantly increased exposure because of the affiliation with a large institution. Malpractice issues take on a new dimension when a large number of physicians are employed. Compliance with Occupational Safety and Health Administration and other regulations at a large number of small sites requires a different administrative approach than managing a few large facilities.

The aforementioned issues contribute to the complexity of successfully acquiring and managing physician practices. Across the country, hospitals and health systems that have purchased practices are facing some or all of these challenges.

What Are the Root Causes of These Challenges?

There are five areas that need to be examined to understand how this array of challenges and problems has plagued the efforts of hospitals to acquire physician practices. First is the lack of a clear strategy and vision, encompassing questions such as what is the hospital really hoping to accomplish and how does acquisition versus other approaches best achieve this; what types of practices and which physicians are best suited to be part of an acquired group; and what assumptions are included in this strategy and how will plans be adjusted if these assumptions turn out to be incorrect?

Second is the absence of an effective governance structure that addresses how the tough decisions will be made; what to do if a physician is not cooperating with the group's initiatives or is not performing well in terms of quality, service, or financial measures; and how the organization can make decisions to consolidate practices to gain administrative efficiencies.

Third is a lack of physician leadership. Issues to be resolved include who are the physician champions and leaders for the newly formed medical group created by these acquired practices; are there physicians who can work effectively in a corporate hospital environment to help address clinical, financial, marketing, human resource, and other issues; and is there a plan to hire or develop physician leaders?

A fourth root cause for the challenges noted above is a lack of practice management expertise. MSO functions that received little attention during the acquisition phase become significant issues in running successful practices. Patient flow, staffing, purchasing, billing and collections, contracting, systems upgrades, and process improvements are all critical functions that hospitals have little experience managing well in an ambulatory physician practice.

A fifth cause is lack of alignment of physician incentives. Often the acquisition contracts deal primarily with financial issues. Physician performance needs to be linked with incentives and aligned with a balance of performance measures, including quality care, quality service, productivity and cost-effective practice patterns, and teamwork. A simple salary guarantee with a bonus for increased productivity does not provide the full range of incentives and alignment necessary for long-term success.

Recommendations for Improving the Performance of Acquired Practices

If acquired practices are not performing well, the best place to start is to revisit your strategy, reformulating your vision with the physicians as active participants [3]. Streamline governance and educate board members about their responsibilities for the entire group's future, not just their constituencies. Develop and recruit physician leaders. Strong physician leaders can be solid business partners and can help encourage the other physicians in the group to understand the strategy and further the goals of the organization [4].

It is also necessary to fix core practice management issues as quickly as possible, even if this means going outside the hospital structure for the expertise. The physicians whose practices were acquired expect the administrative running of the practices to be done well, so assess your current performance and make quick changes to realize improvements. This will go a long way toward improving the financial performance and building physician trust and support for the organization. Review how the financial statements are designed to be sure that the practices are not being unfairly penalized by removing ancillary revenues or adding on excessive hospital overhead. Also, identify and recognize additional revenues to other areas of the hospital due to the acquired practices (*eg*, increased admissions that formerly went to other hospitals).

If the physician contracts are a major barrier to improvement because incentives are not aligned, then prepare to renegotiate them. To do this, evaluate and quantify the impact of each contract if left unchanged, including what happens at the contract's termination. Then decide the appropriate framework for a new contract and quantify the impact of a renegotiation. Decide when to renegotiate and implement the changes that are necessary given the financial impact you have determined.

Conclusions

Hospitals have been acquiring large numbers of physician practices over the past several years and are experiencing significant problems with these practices not meeting financial and other performance expectations. This article has explored the symptoms, underlying causes, and possible solutions to this widespread issue. Focused action by hospital administrators working closely with physician leaders is essential to improve the performance of these newly formed medical groups. The five critical steps to take are 1) revisit the strategy with physician participation; 2) recruit and develop physician leaders; 3) fix core administrative issues such as billing and collections; 4) make sure the financial statements tell the true picture; and 5) align physician incentives, which may include renegotiating physician contracts.

There has been enough experience over the past few years to convince hospital executives to be more prudent in their approach to acquiring physician practices. During the next 5 years, I predict we will see hospital strategies that stress alignment of incentives with physicians without hospitals assuming as much financial risk. As we have seen many staff-model health maintenance organizations across the country "spin off" their physician groups, I also predict some hospitals will pursue this approach. It seems a natural partnership opportunity exists for physician practice management companies and hospitals if they can create mutually beneficial incentive models.

It is important to keep in mind physician practices are acquired to preserve or grow market share. Successful healthcare organizations will recognize that physician alignment is one strategy for reaching the ultimate goal of improving the quality of care and health of the populations served while reducing costs.

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