Acquiring a Physician Practice?

Lessons learned from one community hospital

BY AMANDA HENSON, MSHA, MBA, FACHE

IN BRIEF

The acquisition of a private physician practice can undoubtedly add value to a hospital-based cancer program. Increased patient volumes and physician resources coupled with additional revenue are some of the obvious benefits. Other benefits can include diversifying staff, improving operational efficiencies, standardizing cancer care, and streamlining patient care processes. There are also challenges related to a change in culture, coding and billing processes, regulatory and accreditation issues, and more. Understanding and planning for both benefits and challenges can help make the transition smoother—for the hospital *and* the physician practice.

Consolidation within the oncology marketplace is likely to continue to increase over the next few years due to ongoing reimbursement reductions and increased expenses. As a result, many physicians are establishing relationships with hospitals in the form of joint ventures, physician services agreements, or hospital employment. The good news: these relationships can be developed successfully, and integrated delivery of care can benefit all parties involved—providers, the hospitals, and their patients. To ensure success, you must first understand the challenges and opportunities associated with a newly-established relationship between a private physician clinic and a hospital.

Where & How Will Physicians Practice?

One survey by the Physician Foundation reports that only one-third of physicians are projected to be "independent" by the end of 2013—compared to nearly 60 percent of physicians that were considered independent in the year 2000.[1] Additionally, more than half the physicians surveyed said that they plan to "change their practice patterns over the next one to three years," including cutting back on hours, cutting back on the number of patients, seeking employment at a hospital, or starting a concierge practice.[1] The Physician Foundation survey was sent to more than 630,000 physicians, and had more than 13,500 responses.

Specific to oncology, in its 2011 Oncology Roundtable Member Survey, the Advisory Board found that 50 percent of cancer programs responding to the survey employ oncologists, with 25 percent more considering employment within the next year (Figure 1, right).[2] Disaggregated by specialty, at least one-third of respondents are employing surgical and/or radiation oncologists and more than 50 percent are employing medical oncologists (Figure 2, right).[2]

Profitable private physician-owned healthcare entities are diminishing and independent practitioners are now more likely to join other large practices or affiliate with hospitals to ease the burdens they are currently experiencing. For example, due to federal mandates and reimbursement restrictions surrounding electronic medical records (EMRs), some physicians are selling their practices to larger groups or hospitals and going to work for someone else rather than spend money to upgrade their practices with the latest technology. In addition, healthcare reform and increased demands by private payers are placing a greater emphasis on a team approach to medical care, making more physicians accountable for medical errors and quality improvement.[1]

One of the main drivers behind physician decisions to reorganize under hospital employment is shrinking profit margins associated with infusion therapy. Since the Medicare Modernization Act of 2003 (MMA), drug margins have declined at a steady pace. As you can see in Figure 3, right, 60 percent of providers experienced a decline in profit margin from 2009 to 2010. And, this decreased profit is not solely from public payers, private payers are also reducing reimbursement for drugs.

Figure 1. Prevalence of Oncologist Employment

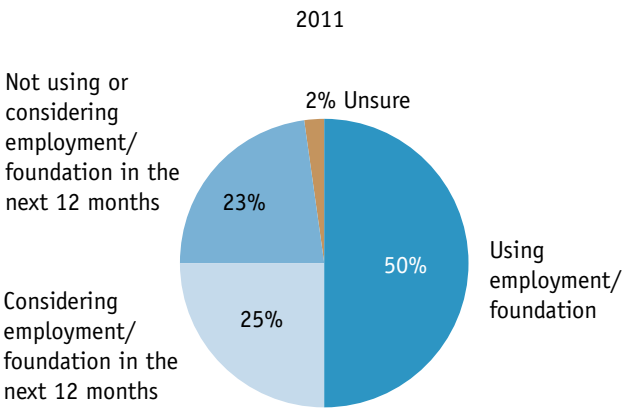


Figure 2. Oncology Employment by Specialty

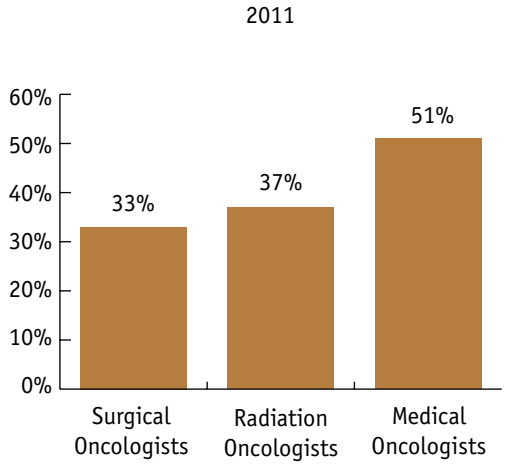


Figure 3. Changes in Profit Margin for Infusion Therapy for Medicare Patients, as Reported by Providers

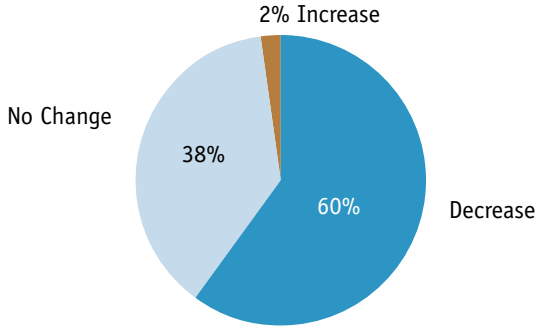


Figure 4. Changes in Profit Margin for Infusion Therapy for Patients with Commercial Insurance, as Reported by Providers

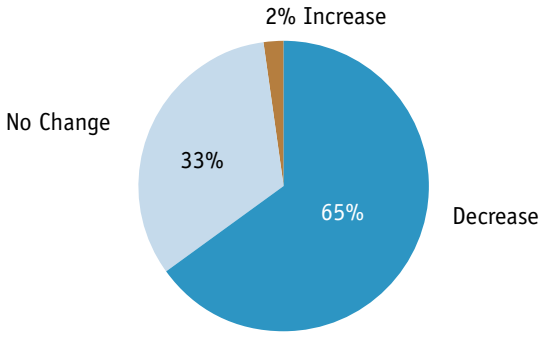
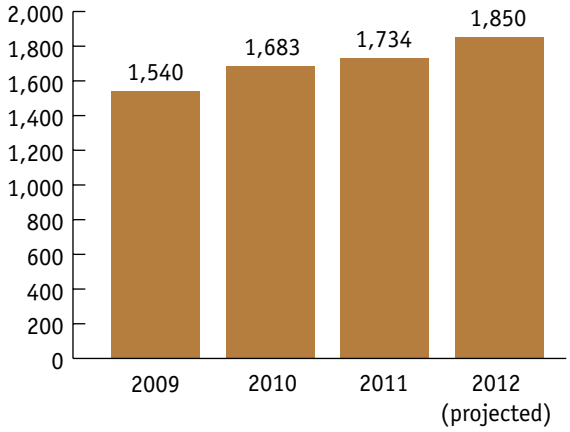


Figure 5. Total Patient Case Counts as Reported by the CBH Tumor Registry



Looking at Figure 4, above, nearly 65 percent of providers experienced this trend from their commercial payers. As a result, with reimbursement decreasing and costs increasing, physicians are finding it difficult to financially manage and sustain a private oncology practice.

Alignment Models

The evolution of physician and hospital relationships has been discussed for many years. Way back in 2007, five alignment models were identified—all with varying relationships, depending on the needs of the community, hospital, and physicians, and the strength of the relationship between both entities.[3] In brief, here's a look at those five models from the least to the most aligned.[3]

- ***Cancer center development accord*** where the hospital and the physicians develop a contract defining each party's role in the growth of the oncology service line.
- ***Co-management contract*** where the hospital and select physicians sign a contract for the physicians to provide management over the oncology service line.
- ***Customized leasing arrangement*** where, under contract, physicians rent services from the cancer center based on their needs, and the hospital pays fair market value for physician services rendered.
- ***Equity joint venture*** is a legal entity including physicians and the hospital in a jointly-owned clinical infrastructure. All risk and profits distributed are based on equity in proportion of governance.
- ***Employment*** where physicians are employed by the hospital and paid a salary and incentive based on RVUs or other productivity measures and administrative responsibilities.

Recent trends suggest that the employment model is becoming the most common method of alignment for 2013 moving forward.

From the physician perspective, there are quite a few benefits associated with hospital employment, particularly from a financial standpoint. Aligning with a hospital can bring financial security to physicians experiencing declining profit margins in their private practice through set salaries based on fair market value and incentives based on productivity. Additionally, hospitals can provide physicians easier access to patient support services, clinical trial participation, and a larger peer network for referring.

As Executive Director of Oncology Services at Central Baptist Hospital (CBH) in Lexington, Kentucky, I received firsthand experience about physician employment after the hospital acquired a medical oncology practice to further develop its growing service line. The following are lessons learned from that experience.

The Players

Located in a highly competitive healthcare market, Central Baptist, a full service community hospital, serves patients from Central and Eastern Kentucky. The robust oncology program diagnoses and/or treats around 1,700 new cancer cases per year. Oncology services include outpatient radiation oncology (with the first CyberKnife in the state), outpatient infusion therapy, surgical oncology specialties, and an inpatient oncology unit. Under a patient-centered care model Central Baptist Hospital offers a large number of support services for patients, including:

- Social work
- Financial counselors
- Nurse navigators
- Dietitians
- Genetic counselors
- Rehab services
- Clinical trials
- Multidisciplinary clinic
- Palliative care.

Additionally, the hospital is accredited through the American College of Surgeons Commission on Cancer and the National Accreditation Program for Breast Centers. It is also the only hospital in Lexington with Nurse Magnet designation.

Baptist Physicians of Lexington, Inc. (BPL) is a multispecialty physician group affiliated with Baptist Health and Central Baptist Hospital. Since October 2006, BPL has grown to include: internal medicine and family medicine practices, oncology, cardiology, pulmonary, and CT surgery. Currently BPL has more than 80 employed physicians spanning a number of specialties. Physician offices are located throughout the Lexington area, as well as on site at Central Baptist Hospital campus. These clinics provide a strong referral base for our hospital and a primary intake of many patients within the Lexington and surrounding communities.

The Kentucky Oncology Clinic (a pseudonym for the private physician clinic now employed with the hospital) was once a private medical oncology physician practice located on the Central Baptist Hospital campus. This private clinic provided outpatient clinic services, as well as infusion services to their private patient base up until acquisition by Baptist Physicians of Lexington in 2010. Prior to acquisition, the group had a trusted and collaborative relationship with the hospital and its providers were considered valuable members of the medical community. Prior to the employment, there were three full-time medical oncology physicians and two ARNPs (advanced registered nurse practitioners). Currently, there are six medical oncologists and two ARNPs.

A Tale of Two Practices

In June 2010 Baptist Physicians of Lexington began an onboarding process of the Kentucky Oncology Clinic. This process included pre-acquisition strategic and operating plan development by BPL along with an analysis of common goals between Kentucky Oncology Clinic and BPL. The alignment of both entities resulted in a proposal to the Kentucky Oncology Clinic physicians and ARNPs to become part of the BPL network. Once negotiations concluded and contracts were signed, the clinic physicians started under their newly-employed role in the summer of 2010.

The initial acquisition also included the hire of all original clinic staff, both clinical and non-clinical. All staff obtained a benefit and salary structure similar to what was already set up within the BPL organization. In addition, BPL took over all expenses and overhead, as well as all billing responsibilities for the oncology practice. The infusion center owned and operated by the physicians was combined with the existing Central Baptist Hospital infusion center. The physician infusion staff became hospital employees; the combined infusion center hospital-based.

The hospital experienced positive downstream revenue when BPL acquired the Kentucky Oncology Clinic. Prior to the acquisition, patients treated in the physician's private infusion center and who may never have entered the hospital for the treatment or diagnosis of cancer, were not counted in hospital registry data. After the acquisition, the hospital's total case counts reported by tumor registry increased significantly from 2009 to 2011 (see Figure 5, left).

The hospital also experienced a significant increase in infusion visits after the consolidation of the physician office and hospital infusion center. From 2009 to 2010, the hospital's infusion visits increased by 104 percent (Figure 6, below). Specifically, when the physicians signed on with BPL in June 2010, the hospital saw a 134 percent increase in infusion visits in the second half of 2010 (June through December) compared to the second half of 2009. Infusion visits have continued to increase by 25 percent in 2011 and 16 percent in the annualized 2012.

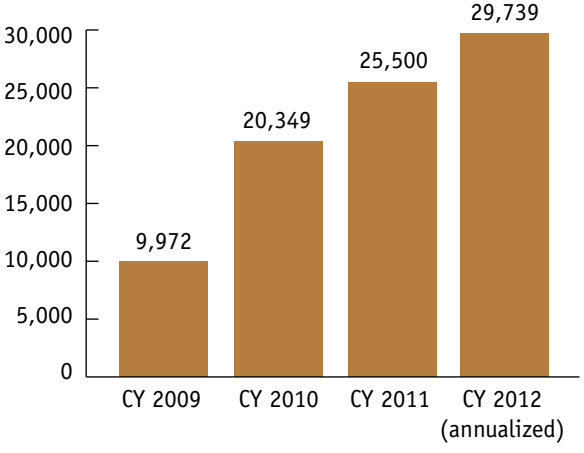
The Central Baptist Hospital Experience

As Central Baptist Hospital's cancer program continued to expand, ensuring operational efficiencies and administrative oversight consistencies within the entire cancer program became critical.

Two management structures were essentially in place, with the hospital managing radiation oncology, outpatient infusion, inpatient oncology, and all oncology support services and BPL managing the outpatient medical oncology clinic staff. There were noticeable inconsistencies between the two management structures. Thus, bringing medical oncology, one of the most critical components of the program, underneath the hospital management structure seemed necessary to ensure continuity of care and growth of a unified program.

Further, there was a programmatic initiative for the cancer service line to come together within a new space (currently under construction) as part of a patient tower expansion on the hospital campus. The goal is to provide a comprehensive cancer program in one location, including all outpatient services

Figure 6. CBH Infusion Room Visits



for medical and radiation oncology. (The current services are separated in various buildings on campus.) In addition to improving patient convenience and cancer program efficiency, bringing together services in one location would enable cross training of staff so they have flexibility to work between different departments. Utilizing staff this way would be difficult to manage if some staff worked for Baptist Physicians of Lexington and others were hospital-employed. To ensure a more operationally efficient, comprehensive cancer program, leadership determined that moving the entire cancer program under the hospital "umbrella" would offer the most long-term benefit.

In November 2011, the medical oncology clinic transitioned from office-based under BPL to a hospital-based clinic under Central Baptist Hospital. This shift in site of service ultimately changed the billing and staffing structure. From a billing standpoint, BPL billed only the professional fees for the physicians, while the hospital billed a facility fee. All clinic staff became Central Baptist Hospital employees, with the exception of the physicians who remained with BPL. While this conversion had the potential to increase revenue for the hospital because of the facility fee, the added expenses for clinic operations and overhead made any revenue minimal. For BPL, the decrease in expenses (operating and overhead) far outweighed any revenue lost (provider fees were reduced) upon transitioning from an office-based clinic to a hospital-based clinic.

Programmatic & Staffing Benefits

From a staffing perspective, the clinic acquisition helped bring a shared vision of the cancer program to the employees, removing silos and ensuring employees were held accountable to the same standards. The entire patient throughput process became easier to manage. Additionally, standardization of policies and procedures allowed the hospital to streamline the workflow and communication between staff. The hospital already had a system in place for overseeing revenues and expenses, including a process to monitor billing and medical record and documentation compliance and established hospital purchasing contracts.

For physicians, the benefits of hospital employment are realized mainly through financial incentives, including fewer financial stresses, increased work and life balance, contracted salary, and productivity incentives.

For physicians, the benefits of hospital employment are realized mainly through financial incentives, including fewer financial stresses, increased work and life balance, contracted salary, and productivity incentives. Other benefits include removal of stressors, such as managing practice staff, billing and collection responsibilities, and medical malpractice and legal responsibilities, as well as ongoing changes to reimbursement, which continue to constrain an already tightened profit margin.

For the physicians in the Kentucky Oncology Clinic, the main benefit to hospital employment was financial. The practice faced financial pressure from increased overhead and decreased revenues. Its ability to make a profit was becoming more difficult and patient volumes continued to increase with little incentive. The practice needed to recruit additional physicians to keep up with growing patient demand, especially since two of the senior medical oncologists looked to decrease their work loads. Through employment with BPL, the physicians could also shift the burden of managing their practice (including the human resource, billing, and collections aspects) to the hospital and secure a set salary based on fair market value while recruiting for additional physician partners. Ultimately, these changes enabled the physicians to create a better work and life balance.

Further, as expectations of accrediting organizations continue to increase, it is becoming mandatory for hospitals to provide a full range of support services. The additional expenses that smaller private practices in particular would have to pay to remain competitive with growing comprehensive cancer programs would be too costly.

Patient Benefits

From the patient perspective, numerous benefits were associated with the hospital's acquisition. Central Baptist Hospital Cancer Center's cornerstone philosophy is a comprehensive "patient-centered care model" that surrounds patients with a clinical care team of experts, ranging from oncology certified nurses in the infusion center to dietitians and genetic counselors. Under this model, patients are assessed at each visit for any distress or need and referred to the wide range of services the hospital offers in its cancer center. The transition from a practice-based clinic to a hospital cancer program made it easier for our patients to access these support services, which falls in line with the evolution of care and the holistic nature of treating complex cancer cases. Coordination and communication by our caregivers ensure that patients receive support throughout their treatment and beyond. A true partnership model exists between the patients, their practitioners, and the hospital's support services (see Figure 7, right). This partnership between physicians and hospitals on behalf of the patient can truly elevate the care and opportunities provided to patients.

Figure 7. Central Baptist Hospital's Patient-Centered Model of Care

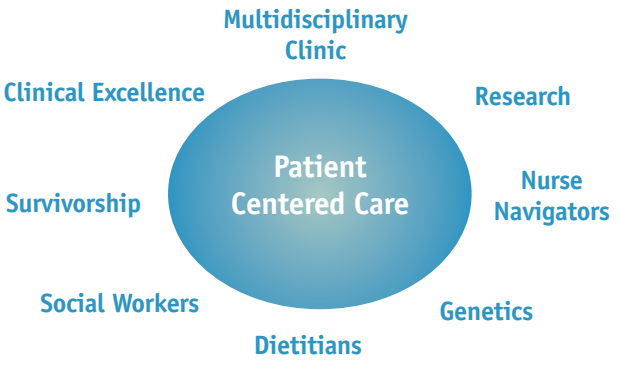
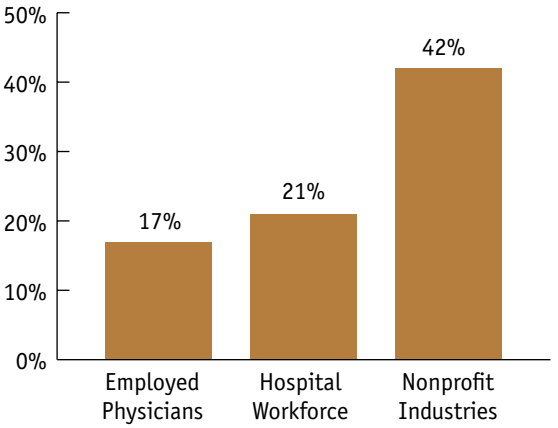


Figure 8. Percentage of Highly Engaged Staff by Industry[1]



Staffing Challenges & Lessons Learned

Despite the multiple benefits, the transition also had its challenges—not only for the physicians, but also for the staff, the hospital, and the patients. During both transition phases, staff who were used to a different salary, benefit, and management structure were required to change. Staff that may have had more freedom in the practice setting were now held accountable to well-defined HR policies and procedures. These changes met with some initial resistance. One of the steps the hospital took to minimize staff anxiety was to sit down with each employee privately—with a member of the hospital HR team—and review specific policies and procedures related to: payroll and paid time off accrual, benefits, time and attendance policy, and dress code. The meetings were conducted in the weeks leading up to the hospital's acquisition of the practice.

Additionally, the hospital hired a new practice manager with hospital experience. This individual was a positive influence, and was able to advocate for the hospital during the transition to a new management structure. The office manager also played a key role in providing development opportunities for the staff. Connecting staff with resources within the hospital, she worked on improving communication and phone skills, leadership and team development, and appropriate peer relationships.

Combining the two separate infusion centers also added to complexities in staffing, so we worked hard to coordinate and standardize staffing at both locations. Although the locations were physically situated next door to each other and connected by a hallway, the communication between the nurse manager and staff RNs played a more integral role. As a magnet nursing hospital, we encourage all RNs to obtain their bachelor degree or beyond, and we require 100 percent oncology nurse certification. Fortunately, infusion staff from the physician office was willing to meet these expectations, and the practice infusion team and the hospital infusion team were integrated almost seamlessly.

In addition to the HR issues, there was added stress from adjusting to an overall new work environment. Federal, state, and local hospital policies, as well as regulatory organizations like The Joint Commission (TJC), brought immediate changes to some of the private clinic's long-standing practices. From a regulatory standpoint, the practice staff and physicians were required to make multiple changes in their physical environment. Storage of supplies, inventory of supplies, infection prevention precautions, and other environment of care regulations created numerous challenges for the clinic. Being sympathetic to the magnitude of changes being made and explaining the reasons for the change was critical for staff and physician buy-in. It is important for hospital staff to understand change from the perspective of physicians and staff that have spent years practicing in a private clinic setting. Additionally, physicians unaware of program accreditation requirements for entities such as TJC and ACoS are challenged to participate in quality studies, cancer committee, chart reviews, and many other initiatives that begin to shape a more structured clinic practice.

EMR adoption brought its own challenges. When developing the initial contract for hospital employment, it is important to prepare physicians for the transition to an EMR. Physician participation and buy-in with the EMR product is instrumental to successful implementation of the technology. Luckily, hospitals can provide more support to physicians and allocate more resources for a successful EMR implementation than most private practices. During the last few months of EMR implementation within Central Baptist Hospital's outpatient

cancer clinics and treatment centers, successful implementation depended, in large part, on physician engagement.

Billing Challenges & Lessons Learned

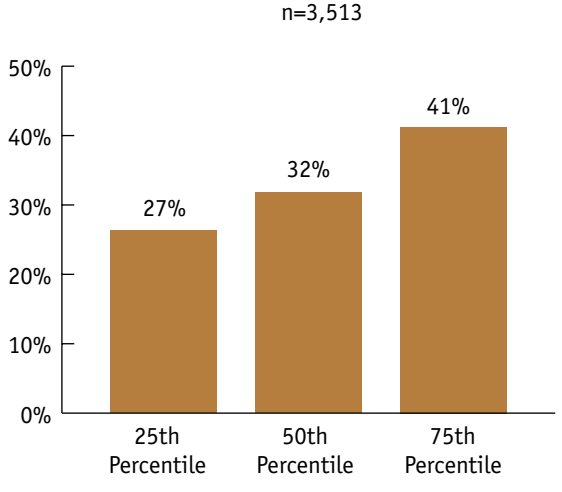
Another challenge was the implementation of a hospital billing and coding process to increase physician attentiveness to ordering infusion therapy. The hospital has very structured processes in place for pre-authorization, coding, and billing oncology services. Due to an organized pre-certification process, these changes have helped minimize, if not eliminate, denials of chemotherapy drugs. Hospital staff had to walk physicians through the billing and revenue cycle so they were aware of these processes. With this knowledge, physicians understood why patients could not start on a chemotherapy regimen the same day they saw the physician. (Of course, there are always exceptions to this rule.)

Staff solely dedicated to obtaining pre-authorization sit next door to the physician clinic so communication is as fluid as possible.

The hospital has provided support to physicians on its coding and documentation requirements. Each patient visit is audited for charge code capture, and if needed, education is provided on site with the physician if there is a question about coding. Likewise we have educated the physicians on their responsibilities for properly completing orders so that coders can efficiently file claims on chemotherapy infusions. This process of support and accountability has been challenging to implement with a physician practice not used to strict processes.

Having a new boss (the hospital), who brings a new set of policies and procedures, billing and documentation processes, and regulatory requirements is challenging, no matter how easy going and flexible the physicians you hire. Thus, educating the physicians on changes and why they are vital to the success of the transition and the future of the cancer program is essential. Initially, during the first several months after the transition from clinic-based to hospital-based, frequent meetings with staff and physicians kept lines of communication as clear as possible.

Figure 9. Percentage of Physicians Engaged by Hospital[4]



Source. Advisory Board Physician Engagement Survey Cohort; 2012.

The Patient Perspective

Hospitals must communicate changes to patients before, during, and after the acquisition of a private practice. Central Baptist Hospital mailed letters to all patients in its database, outlining the conversion of the clinic from an office-based practice to a hospital-based practice. The hospital also posted signs in the clinic, as well as educated front desk staff on what to say to patients who checked-in following the conversion.

In hindsight, converting the clinic to a hospital-based clinic had a much greater financial impact than the hospital had originally anticipated. For example, patients with high deductibles started receiving large facility fee bills to coincide with the physician charge (professional fee). Several upset patients did not understand the reasons for the increased charge. Having financial specialists close by made conversations with patients easier, and took some of the pressure off staff who were not as educated about the differences between hospital- and office-based billing.

Physician Engagement

An important component of a successful physician practice aquisition is identifying physicians who will complement and engage in your hospital's culture. Additionally, understanding the potential challenges associated with employing physicians long-term will help the hospital make the right decisions at the beginning of the physician negotiations. Maintaining physician engagement in your cancer program is critical to a successful partnership with your employed physicians. As federal regulations and payments are tied to quality metrics and as payments begin moving away from a fee-for-service model to an accountable care model, the partnerships established between hospitals and physicians will be critical to putting your organization in a position to succeed in a quality-driven environment.

The physicians with whom the hospital aligns must be advocates for the cancer program. Competition will continue to drive patient referrals, and physicians will be the key to your program's strategic development in order to increase market share. The physicians you employ need to be agreeable to potentially expanding their services to other markets (i.e., satellite clinics) and helping the hospital compete for market share.

Recruiting oncology physicians is difficult because there is a growing shortage of physicians going into this specialty. Hospitals must understand the important role these physicians play in the organization and plan ways to work with aging providers to develop recruitment strategies targeted at oncology graduates.

Interestingly, according to a 2012 survey of employed, or nearly employed physicians, employment alone does not guarantee increased physician engagement. The Advisory Board Engagement Survey found that only 17 percent of employed or closely-affiliated physicians were considered highly engaged (Figure 8, page 25).[4] Even among high-scoring organizations, engagement is lacking. Data shows that even among hospitals at the 75th percentile, only 41 percent of physicians were considered engaged (Figure 9, left).

Improving patient care and the efficiency of care delivery takes collaboration. In hospitals, physicians are responsible for the largest percentage of healthcare spending decisions; just as many quality indicators rely on physicians alone as rely on physician and hospitals combined. That means, in the future of value- and outcomes-driven healthcare, a partnership with engaged physicians will deliver the high-quality product a cancer program and hospital needs to be successful.[4]

Dollars & Sense

One of the most difficult aspects of hospital and physician alignment is identifying the right financial incentives to offer so that physicians continue to sustain long-term productivity that coincides with the ongoing growth in patient volumes. Tying productivity benchmarks to physician compensation is an important component of any initial contract. That said, productivity should not be the only element to the contract. A substantive contract should include ways to measure physician quality, participation in patient satisfaction and accreditation initiatives, and other hospital- and program-specific needs. As our healthcare environment begins to shift to an accountable care model, we all must look for ways to be good stewards in the use of resources and partner together to identify methods to deliver high-quality care in the most cost-effective way. Thus, the alignment between a hospital and physicians must be tied to the shared risks and benefits of such a partnership.

At the employment onset, hospitals must consider how to best incentivize physicians beyond salary, and reward productivity in order to diffuse a salary mindset. Additionally, decision-making requires alignment of expectations, and physicians must be incorporated in the decision-making for the cancer program.

Communication & Culture are Key

Communication should not be underestimated, particularly when employing physicians who have never worked for a hospital or those who have been in the private practice model their entire career. Federal, state, and hospital regulations are different for hospital-based clinics, so physicians must understand the changes that will need to be made or there will be anxiety and confusion. Introducing hospital support services can help ease this transition; collaboration between physicians and these support services can make process changes easier.

Establishing a strong and efficient partnership between a hospital and its employed physicians takes time. A sustainable relationship needs to have open communication and participation from both parties—hospital and physician group—to achieve performance measures that impact both parties. If physicians are motivated to contribute more to a hospital than just clinical service, then the culture of the organization in terms of patient and employee satisfaction increases, as does the cooperation towards meeting quality, financial, and performance measures. A physician who focuses solely on clinical performance will not achieve the level the hospitals need when challenges or new initiatives face the cancer program. A physician who feels connected to the hospital and to the success of the cancer program will come to the table with ideas, input for changes, and a positive attitude. OI

—Amanda Henson, MSHA, MBA, is executive director, Cancer Services, Central Baptist Hospital, Lexington, Ky.

References

1. Jaspen B. Docs Work Less as Flood of New Patients Looms, 10/8/12. Available online at *www.forbes.com*. Last accessed March 4, 2013.
2. The Advisory Board. 2012 Oncology Roundtable Member Survey. Available online to Advisory Board Members at *www.advisory.com*.
3. Farber M, Cheng A, Cuff A. Hospital and private practice partnerships: which model is right for you? *J Oncol Practice*. 2007;3(3)130-132.
4. The Advisory Board. Achieving Sustainable Hospital-Physician Alignment in Oncology. October 2012. Available online to Advisory Board Members at *www.advisory.com*.