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Physician Practice Models

By Carol S. Miller

In the second of two articles on physician-hospital bonding, the author examines four specific physician practice models, the pros and cons of each model, and their various components, such as hospital-physician contracting.

Over time, the majority of physicians have practiced primarily in a solo environment, utilizing their established referral patterns to continually feed their blossoming businesses. In large, metropolitan areas, many of the practices expanded into partnerships or corporations, involving a variety of subspecialists, who serviced a host of different hospitals, and frequented different office sites. Other than the hospital-based ancillary services of pathology, radiology, and anesthesiology, and the newer specialties of critical care and emergency medicine, most physicians have remained in the private practice arena. Other independent physician relationships with hospitals involve the use of contracts in which physicians are hired to perform a service, such as quality assurance advisor, medical director, section chief, department chairman, etc.

Today, four specific models exist in the practice of medicine across the country:

- Private Practice
- Private Practice with Lease Arrangement at Hospital
- Hospital Employee
- Contracting or "Bonding"

This article will elaborate on each of the models, as well as provide the pros and cons of each model from the perspective of both hospitals and physicians.

Private Practice

Private practice is probably the oldest model in existence today, emanating from the trade and barter days of family practitioners. In this model, physicians are in charge of their own businesses and their own destinies. The private practice physician exclusively depends on established referral patterns, sees patients within the private confines of an office, and admits patients to different hospitals, depending on the institution's service, convenience, familiarity, and quality of care.

Physicians hire and fire their own staff and set the salaries and benefits for employees (nurses, receptionists, billing clerks, lab technicians, office managers, accountants, and others), depending on the size of the operation. In addition, the physician's practice pays for all direct, indirect, and overhead expenses (furniture, drugs, equipment, forms, stationary, marketing, advertising, legal fees, postage, etc.). Private physicians depend on the services of a billing clerk to generate sufficient revenue from third-party payors and patients to offset the expenses of operating the practice, as well as to pay their own salaries and benefits.

Pros for Physicians. As mentioned, private physicians are in total charge of their business practices; they determine their schedules, bill for their services, depend on the income generated from the services they render, and they guide and direct the practice. To succeed in this competitive and costly environment, the private physician must depend on the skills and expertise of the office manager.

Cons for Physicians. Because of the contractual regulations governing reimbursement by the government's Medicare and Medicaid programs, the negotiated rates of HMOs and managed care programs, the discounted rates of PPOs and IPAs, and changes in the Current Physician Terminology (CPT) codes for chemotherapy, private physicians are experiencing decreased levels of reimbursement that are affecting their bottom lines. In addition, office expenses (salaries, benefits, malpractice insurance, office supplies, drugs, legal fees, etc.) continue to escalate each year.

Pros for Hospitals. There is only one positive aspect to the office practice model: status quo for the medical staff. In other words, the medical staff, at large, remains content that a special arrangement between the hospital and a physician which could adversely affect their practices or their relationship with the hospital, will not occur.

Cons for Hospitals. This model provides no direct linkages or ties between the physician, the hospital, or any hospital program. The only commitment between the two parties is membership on the medical staff and its affiliated admitting privileges. In addition, because of the independence of both the hospital and the physician, there is a lack of coordinated planning for the overall program; each party acts and plans on its own. Finally, the hospital continues to lose revenues for outpatient chemotherapy, ancillary services, and drugs—services that continue to be provided exclusively in physicians' offices.

Private Practice With Lease Arrangement at Hospital

This arrangement is similar to the private practice model, except that the hospital builds offices for physicians on the premises, or it converts hospital space into physician offices. In this arrangement, the hospital is the landlord, renting available office space, and the physician is the tenant, paying monthly lease payments to the hospital—a true business relationship.

As in the private practice model, physicians remain independent, running their own businesses, seeing their own patients, utilizing various hospitals, hiring staff, and billing for all of their services. However, the hospital lease model does provide patients with easy access to the hospital and its services (pharmacy, lab, radiology, etc.).

Pros for Physicians. Once again, the physician is in total control of the business entity, including billing for services, payment of expenses, and collection of revenues. In addition, offices located on hospital property provide the physician with easy access to hospitalized patients; it facilitates the admission of patients to the hospital; and the physician can easily move back and forth between the office and the hospital. Basically, this arrangement saves the physician time and travel.

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Cons for Physicians. As in the private practice model, the physician continues to experience decreased payments from major third-party payors and, secondarily, office expenses continue to rise, sometimes more than revenues. In this arrangement, there is the potential that the lease cost per month, which is based on the current market rate, may be higher than an office complex that is separate from the hospital's premises. Finally, there is a perception, on the part of other physicians, hospital staff, and patients, that the physicians are more loyal to that particular institution, because their offices are located on the hospital campus.

Pros for Hospitals. The biggest advantage to the hospital is that the physician is accessible to the hospital's staff and its patients. A secondary advantage is the rental income from the office lease arrangement. Similarly, because the physician and the hospital are in the same location, the patient perceives an integrated service.

Cons for Hospitals. The same negatives apply to the office lease arrangement as the private practice model: tenuous linkages with physicians, a lack of coordinated planning between hospitals and physicians, and the loss of drug and ancillary revenue for outpatient chemotherapy services.

Hospital Employee

In this arrangement, a very succinct relationship exists between hospitals and physicians. The physician moves from total autonomy to being an employee of a large business operation. The physician is a hospital employee, similar to any other employee who receives a set salary, yearly increments based on performance, vacation and sick leave, a pension, disability and malpractice insurance, annuity plans, and other benefits. The physician is still independent, but only within the confines of the job description. The potential for change or creativity is nil, unless the hospital agrees to budget for a physician's idea and the physician adheres to that budget. With this change in role, the physician is perceived by peers, patients, staff, and other hospitals as a dedicated staff member who is part and parcel of the hospital organizational chart.

Pros for Physicians. The headaches accompanying private practice (billing, collection, overhead, and expenses) disappear in this model. A sense of security prevails. Physicians and their patients have easy access to the hospital and affiliated hospital services. This arrangement, by far, is the cleanest, most ethically sound contractual relationship that exists between a hospital and a physician.

Before the physician and the hospital can negotiate a contract for services, both parties must overcome previous prejudices, and both must be willing to develop a closer working relationship

Cons for Physicians. As mentioned, a physician's autonomy and independence are sidestepped in the hospital employee arrangement. The physician must adhere to job descriptions, budgets, and budget adjustments, and deal with the bureaucracy of the hospital structure. Physicians receive a set salary and yearly bonus, but they do not receive the income from patients or exert any control over its use. The physician is perceived by everyone as part of the permanent hospital structure.

Pros for Hospitals. The primary advantages for the hospital are revenues from outpatient chemotherapy services and a closer employer/employee relationship with the physician. The latter enables the hospital and the physician to cooperatively plan mutual program goals, to integrate the oncology service among the different disciplines, to collectively work with nursing to determine mutual policies and procedures, and to determine the future growth of the oncology program. The patients perceive the cancer program as an integrated service involving all disciplines, and the hospital has a coordinated and managed quality program to provide to patients. Physicians are accessible to administration, patients, radiation oncologists, referring physicians, and other outreach oncology services. Finally, like the physician, the hospital has a clean, ethically sound business arrangement.

Cons for Hospitals. The hospital must now pay all of the overhead, direct and indirect expenses of the physician's salary, benefits, office space, furniture, secretarial support, office supplies, drug costs, and staffing of the outpatient chemotherapy center (i.e., nurses, lab techs, a receptionist). In addition, with such a special arrangement, the overall medical staff may perceive that administration is catering to a specialized group of physicians, or a specific physician. This, in itself, may create animosity among some medical staff members.

Contracting or 'Bonding'

This is a new concept for oncology physicians. In this relationship, both the physician and the hospital must give and take in order for the arrangement to succeed; everyone cannot have everything. Physicians in this arrangement are not hospital employees; they contract with the hospital for their services. Physicians are not totally under the management of the hospital and they do not receive benefits, but they are part of the decisionmaking body for the oncology program.

Before the physician and the hospital can negotiate a contract for services, both parties must overcome previous prejudices, and both must be willing to develop a closer working relationship. Prior to actually developing a contract and contract rate, the hospital and the physician must have access to information about

Look Good... Feel Better Announces Toll-Free Number

Look Good...Feel Better, a nationwide public service program dedicated to teaching women cancer patients beauty techniques to help restore their appearance and enhance their self-image when undergoing chemotherapy or radiation treatment, has established a toll-free number (1-800-395-LOOK).

The new 800 number will operate during daytime, office hours and has been established solely to answer questions regarding the Look Good...Feel Better program. Look Good...Feel Good is a free program for cancer patients that is sponsored by the Cosmetic, Toiletry, and Fragrance Association Foundation, the American Cancer Society, and the National Cosmetology Association.

If physicians and hospitals are interested in delivering state-of-the-art health care, then they need to develop a mutually acceptable plan and arrangement for working together and for sharing resources

each other's financial position (expenses, revenues, and patient volumes). Only then can they determine what base contract rate should be offered, establish a threshold rate on which to base incentives, determine the parameters of the incentive package with regard to escalated rate and range, and project the future revenue flow to both parties. It is extremely important, in this analysis, to make sure both the physician and the hospital provide accurate, detailed financial data.

After the financial analysis, the hospital will be in a better position to determine the base contract rate it should offer to the physician. In determining the base rate, the hospital should take into account the going market rate for the physician's services, the potential revenue, and the absence of hospital benefits. Similarly, from a cash flow analysis, the hospital will be able to develop an achievable incentive package, which rewards both the hospital and the physician. Needless to say, it is imperative that the contract language and the arrangements of the incentive package are fair to both parties, are understood by both parties, and are reviewed by the hospital's legal counsel to ensure that all legal issues and federal and state regulations are addressed.

As part of this arrangement, the hospital provides the physician with an office, secretarial support, an outpatient chemotherapy center complete with nurses, lab techs, drugs, special equipment, and other amenities the physician requires to treat patients. In turn, the hospital bills and collects payments from third-party payors and patients for the physician's services.

Finally, as part of this model, a special committee is formed, consisting of management and physicians, to oversee, direct, and administer the oncology program. This committee is similar in function to the executive committee, except that its responsibilities are restricted to the oncology program. The physicians and hospital management share in the decision-making process and collectively plan, budget, set policy and procedures, purchase capital equipment, and share revenue and expense information on the performance of the entire oncology program.

Pros for Physicians. The advantages of this model are similar to those in a hospital employee model. Because the physicians are placed under contract for a period of years, they feel secure about their arrangement with the hospital. Their overhead and direct expenses diminish, and they are responsible only for benefits and personal expenses. The patients, physicians, and hospital staff perceive the oncology program to be an integrated, quality cancer center that provides comprehensive care and follow up in one location. Physicians are now part of the governance structure of the hospital, sharing in the risks and rewards of the hospital's operation of the oncology program. This relationship provides a win-win situation for all involved parties.

Cons for Physicians. As in the hospital employee model, physicians' independence is diminished, because their activities are based on contract language. However, the physicians are still viewed, by their peers, as being independent. In addition, physicians initially perceive that their income potential has decreased, because the monies that were flowing to them in the past are now flowing to the hospital. Finally, the physician is now affiliated with a major hospital player, and is not working or acting alone.

Pros for Hospitals. The benefits of the hospital employee and contracted physician models are identical: integrated patient care with more comprehensive and thorough management by the patient care team; mutual goals and objectives for the oncology program; increased revenue to the hospital's bottom line from the drug and ancillary services delivered in the outpatient chemotherapy center; and a closer linkage and working relationship with physicians.

Cons for Hospitals. The overhead and expenses flow to the hospital side of the equation, and, initially, the medical staff may not understand the preferential treatment the hospital is providing to the oncologists it has contracted with. Today, hospitals and physicians are in a rapidly changing health care environment—an environment which suggests that the organizations who survive will have to pool resources, plan together, and combine operational and clinical talent. The long history of antagonism that has existed between physicians and hospital administration needs to be eliminated.

Most of us are aware that the process of working together won't be easy or without problems. However, it needs to be stressed that if physicians and hospitals are interested in delivering state-of-the-art health care, which in itself can be expensive and/or in limited supply, then hospitals and physicians need to develop a mutually acceptable plan and arrangement for working together and for sharing resources. The choice of which model is most suitable for the physician and the hospital is dependent on the political environment and the final outcome of negotiations, as well as other implications, such as the impact of the Internal Revenue Service on physicians' pension plans, and the legal ramifications of contracts. But regardless of the hurdles to be overcome, physicians and hospitals can work together, if they would just try. ■

AICR Annual Research Conference

The American Institute for Cancer Research is sponsoring a professional conference, entitled "Exercise, Calories, Fat & Cancer," to be held September 4-5, 1991, at the Ritz Carlton Hotel in Pentagon City, VA. The conference has been approved for nine CE hours for RDs and DTs and 8.5 hours of AMA CME Category I credits. Sessions will cover such topics as, the optimal diet for breast cancer, dietary fat and human cancer, exercise and pancreatic cancer, caloric restriction and experimental carcinogenesis, and the inhibition of transplantable colon tumors by murine oils.

For registration information, contact: Rita Taliaferro, Director, Conference Management Division, Associate Consultants, Inc. 1726 M St., N.W., Suite 400, Washington, DC 20036. (202)737-8062.