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Hospital Owned Medical Practices: Tips for Success

MEDICAL PRACTICE BUSINESS GAME. HOW CAN YOU COME OUT AHEAD THIS TIME?

Our presidential election is only days away. Forty eight million people in America are uninsured and healthcare costs are rising 2 to 3 times faster than our nation's GDP. Where will America's healthcare system be in 5 years? Welcome to ReachMD's monthly series focused on public health policy. This month we explore the many questions facing healthcare today.

Today, many hospitals are once again getting back into the medical practice business game. How can you come out ahead this time? They need to win the medical practice game on the revenue side. Accordingly to Halley Consulting Group, there are 8 network wide initiatives that are crucial to win. Welcome to the business of medicine. I am your host, Dr. Larry Kaskel. Joining me today is Mr. Mark Halley, founder of the Halley Consulting Group. Mr. Mark Halley has served as its president and chief executive officer since 1995. The company was the culmination of many years of providing practice management and consulting services to various specialties including hospital-owned primary care networks.

DR. KASKEL:

Mark, welcome to the show.

MR. HALLEY:

Thank you Larry, pleasure to be here.

DR. KASKEL:

So looks like they are added again. I have read that the definition of insanity is repeating the same thing over and over hoping for a better outcome.

MR. HALLEY:

Ha, ha, ha, ha.

DR. KASKEL:

And it sounds like the hospitals are once again insane.

MR. HALLEY:

Well, they learnt those who at least tried to disaster their practices or starve their owned networks between about 1998 and the early 2000 that says they did so, they lost market share.

DR. KASKEL:

Yeah, I was a victim in 2001, my hospital disastered, fired all the doctors and now again 8 years later, they are scrambling.

MR. HALLEY:

Everybody is getting back into the business this time, not just on the primary care side, but more and more specialty practices are either being acquired or specialists being employed by hospitals.

DR. KASKEL:

And what kind of money are you seeing being paid by, I know it is different for every specialty, but what are hospitals paying. I imagine they are not paying the big bucks they paid 10 years ago, but are they paying 1 times revenue, 2 times revenue or how is it calculated?

MR. HALLEY:

Well, generally, Larry, what we are seeing in most markets, hospitals are tending to buy tangible assets only. Sometimes they will buy discounted receivables, but frequently, it is tangible assets only. On occasion, they will pay $3-7 per chart, but there is very little good will as you mention the blue sky, the goodwill portions that were being paid in the early-to-mid 90s are just not present yet. We anticipate that as markets become more competitive, the goodwill component will come back into play.

DR. KASKEL:

So why would a physician sell his practice on the cheap?

MR. HALLEY:

Well, right now many physicians are looking to get out of the administrative side of the business. They are concerned about what they see on the payer's side. They are concerned about the increasing cost of staffing and the complexity of the business and some are just tired of it and want out. They want to be able to practice the clinical side of medicine and stay out of the business side if they can.

DR. KASKEL:

And Mark, what has changed on the hospital side? How have they learnt to manage these practices? What have they learned in the last 10 years?

MR. HALLEY:

Well, those practices that stayed in the business since the mid 90s, many of them have learnt to control the losses, work with their physicians to improve performance, although many practices I might say safely most practices that are hospital-owned still lose some money, but many are still making the same mistakes that they made back in their late 80s or early 90s.

DR. KASKEL:

And what are those mistakes? I mean, I remember just having enormous bureaucracy, enormous levels of management.

MR. HALLEY:

Yes, and there are a number of mistakes that were made by hospitals from paying too much, which we have already eluded to early on to overbuilding. We just throw more and more physicians into a market place without paying attention to demand. We see a lot of hospitals increasing the cost of doing business, putting physicians on high-based salary instead of an eat-what-you-treat compensation model and adding benefit costs to support staff, adding occupancy cost by increasing rents, and a whole myriad of challenges like that.

DR. KASKEL:

Mark, running a medical practice, it is a terrible business model. I mean, our overhead is consumed by labor and so I do not know why they would want to get into the business, but let us say they are getting into the business. You came out with a special supplement for the HFMA talking about how to win the medical practice game this time and you have 8 factors. So, why do not we start with the first one?

MR. HALLEY:

That sounds good and we do have 8 revenue factors. Let me just mention that hospitals and I have been a hospital executive in the past and a health system executive. When we used to get into trouble financially, we would always focus on the expense side of the income statement. Hospitals have a tendency to do that same thing when they get into the ambulatory business, into the medical practice business, and of course that rule does not work in medical practice business. Instead we win on the medical practice side by looking at the revenue side of the income statement and there are 8 factors that we look at as you mentioned. The first one is what we call volume capacity mix, meaning, do we have the right number of physicians or the potential patient population or have we over-doctored an area? So making sure that we match up what is going on in the market place with the number of physicians we put in that market area. Secondly it is payer mix. Every private practice physician has to watch his or her payer mix, in hospitals their own practices need to do the same.

DR. KASKEL:

Mark, you talked about payer mix and does not that have a lot to do with location, location, location?

MR. HALLEY:

It does, managing the location of our medical practices particularly primary care, which tend to capture the market share that builds this specialty practices and the hospital inpatient and outpatient services are very critical. If we are serving an area that has; for example a high Medicaid population, we need to get a practice to meet the needs of that special population. Other practices may need to manage the percentage allocated to various payers across their profile that create a portfolio that allows the practice to survive. That is what has to happen in private practice settings.

DR. KASKEL:

Mark, as you mention that, I think of mission statements that most hospitals have, I think many of them have something that is actually to serve their local population yet they forget that when they start looking at the payer mix.

MR. HALLEY:

Right, sometimes that is a difficult challenge. The correct principle we try and teach is never turn a patient away. In other words, we try and create alternatives that can better meet the needs of patients who are unable to pay and that is actually good business because if patients are not able to get access to primary care; for example, they will end up much sicker in the emergency department at a much higher cost. So it is good business to pay attention to how we move patients and provide access to primary care. While at the same time in a majority of our practices still managing that payer mix, we may designate certain practices in the right part of town along bus routes to make them accessible to patients who do not have the ability to pay.

DR. KASKEL:

Do any hospitals use the concept of lost leader any more or do they not allow any losses and they just cut them off immediately.

MR. HALLEY:

Well, I am not _____ to hospital or health system thought process as I used to be, but at least among those clients that we work with, there is still a strong sense of mission and again that mission ends up having a strong financial indicator as well simply because we do not want sicker and sicker patients trying to treat our emergency rooms as primary care sites.

DR. KASKEL:

Let us move on to the third crucial element.

MR. HALLEY:

Yes, many organizations do not pay attention to fees anymore and obviously having the correct fees is critical for a hospital-owned practice. We do not want to leave any money on the table and so we want to make sure that we take a look at what our payers are reimbursing and make sure that we capture those dollars that are legitimately available. We also want to make sure that we do not price ourselves out of the market if you will so that our write-offs become so high that it becomes disheartening to try and manage the practice. So making sure if these are accurate given the locale is critical.

DR. KASKEL:

The fourth element is provider productivity and you had mentioned earlier the eat-what-you-treat out in the trenches we call it eat-what-you-kill, which does not sound as nice, but are the hospitals incentivising their physicians because I do not think they did that the first time around.

MR. HALLEY:

Well….

DR. KASKEL:

They guaranteed them a salary.

MR. HALLEY:

That is right.

DR. KASKEL:

And they lost their shirts.

MR. HALLEY:

And productivity dropped 25%. We see less of that this time around. There is a lot more discussion around productivity models. Unfortunately sometimes hospitals think that if they have a 10% kicker at the end of the year, they have adequate incentive for a physician and in our experience in developing compensation model and implementing them, physicians have to feel the sense of reward

coming from their behavior literally on a monthly basis so the incentives, they are almost like private practice. I worked hard this month. I see it my pay check next month becomes the key, but many times when we are talking with physicians who are employed by hospitals they will say to me, Halley all you want us to do is work harder and I say, “well, yes.” I do not know any private practicing physicians today that are not working much harder for the same amount of money they were making 2 years ago. The nature of the business has forced out upon us at this point at least.

DR. KASKEL:

Mark, what is #5?

MR. HALLEY:

Five is relationship management. Again, real, real critical to make sure that we are sensitive to, if I am a primary care provider, my customer being the patient and manage that relationship with the patient and that my policies and procedures are focused on that patient-physician relationship, patient practice relationship. If I am a specialist, I have at least 2 different types of customers I have to be concerned about, one of course being Mrs. Smith or her children who is the patient. The second very importantly, being my primary care physician. How do I meet the needs, wants, and priorities of my referring physician and not leaving that to chance, but rather focused on it, thinking about it frequently in a practice setting.

DR. KASKEL:

We are running dangerously low on time, so let us speed up and do #6, 7, and 8. I know, 6, you have as coding and documentation and I think electronic medical records should help in that arena by helping the physician pick the proper code and actually create a charge instead of it getting lost.

MR. HALLEY:

That is correct and we tend to under-code and under document for billing purposes and that is probably enough said, they are paying attention to our coding especially if we are on a compensation model that looks that , works I have used; for example, which are tied to the CPT codes makes a lot of sense. Certainly receivables management, a lot of hospitals do not do a great job of managing receivables on the ambulatory side. Again, it is a different business.

DR. KASKEL:

Are they outsourcing or using new types of programs?

MR. HALLEY:

Well, some are outsourcing using web-based software. The most important thing is to get it out of the CBO, the hospital’s central billing office, have it managed with the network itself.

DR. KASKEL:

Right, needs to be worked daily.

MR. HALLEY:

That is right, daily.

DR. KASKEL:

And the final item is service mix. Service mix means to hospitals letting the practices still run with the ancillary services that would normally be found in private practice rather than stripping those ancillaries out, which was a major mistake in the past decade. A 25 to sometimes 30% of net patient revenue were collectible dollars related to ancillary.

DR. KASKEL:

So, this time around, they are letting their private practices hold on it.

MR. HALLEY:

Some of them are, but again, the majority I would dare say, are still making the same mistake of trying to keep those ancillaries out and push it into the hospital.

DR. KASKEL:

What is your idea of what is going to happen this time around?

MR. HALLEY:

If they take our 8 criteria and implement effectively and get out of the way of their employed physicians, I think they will find that their employed physicians can operate just as effectively as those who are in private practices and in fact if they are not one has to ask the question why not?

DR. KASKEL:

Well, Mark Halley, of Halley Consulting, thank you very much for talking with me today.

MR. HALLEY

My pleasure.

I am Dr. Larry Kaskel and you have been listening to the business of medicine on ReachMD XM157. To comment or listen to our full library of on-demand podcast, please visit us at ReachMD.com. You can also reach us by phone with your comments and suggestions at 888MD XM157 and thank you for listening.

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