Complete transcript of Practice vs Employment

[00:00:03] The healthcare dynamic is rapidly changing. Understanding the basic fundamentals related to the Business of Medicine empowers practitioners to advance their skills in, and knowledge of, the business aspects of Medicine. SMA's Business of Medicine Simplified program explores the essentials of everything from reimbursement and compensation models, insurance and risk management, to practice employment and business finance.

[00:00:29] Welcome to the Southern Medical Association's Business of Medicine Simplified podcast. I'm Jennifer Price and today we are discussing contracting and reimbursement with Jeff Gorke. Jeff is a managing director in the management consulting group leading Stout's healthcare advisory and consulting area. He is also a contributing editor to Forbes.com. He joins us to offer some key tips designed to empower providers with the information they need to succeed in today's business of medicine environment. Thank you for joining us, Jeff.

[00:00:58] Thank you for having me; I appreciate it.

[00:01:01] Based on a study published by the AMA, only 47.1% of physicians in 2016 had ownership stakes in a medical practice. Jeff, is this what you see happening in the market?

[00:01:14] Yeah, and I had also seen that study and the interesting, one of the interesting findings to that study is that that is the lowest rating of physician ownership that the AMA has noticed since they've been querying physicians about their employment relationships. So they have never seen a time when there been this few physician owners in the private practice setting. I think that, broadly speaking, the, there's still going to be a great deal of acquisition of smaller practices as we move forward and during the course of 2018 that did not slow down. But I think I would be surprised if you didn't see some physicians trying to leave hospital employment to form their own clinically integrated networks. I think that the lure of hospital employment as was the case in the 90s may have not proven, may have proven not to be all that it was cracked up to be. In other words, physicians went around in the 2000s and became employed and the grass isn't always greener. I think there are some physicians who at this point are looking at the market thinking that they can do it better on their own and by that I'm alluding to even smaller groups three-, four-, or five-doc groups getting together and clinically integrating with larger groups to form clinically integrated networks that can go out and contract and manage their care as good or better than the hospital system. So, so I think there'll still be acquisition. I also think that in the market now the private equity players are out there trying to aggregate practices similar to what the hospital systems have done. So they're focusing on certain specialties; many of those specialties are elective or specialties that have elective procedures. So there's a lot of cash involved and not a great deal of working with insurance companies. For instance, ophthalmology with elective ophthalmic procedures, refractive surgery, and dermatology with services offered outside of your normal dermatological exam

[00:03:37] You touched on clinically integrated networks. Would you mind sharing a little bit more about those, please?

[00:03:43] Clinically integrated network really is, is a way for physicians to work together while maintaining their own practices so you can integrate either financially or clinically and be able to leverage your physician count to go out and contract. Certainly, in this day and age of value-based care delivery, it's going to be essential in a clinically integrated network to manage the episodes of care, especially chronic conditions throughout the, throughout the integrated network. For instance, you may put together a network that consist of say 5 or 10 internal medicine physicians; maybe 3, 4, 5 cardiologists; maybe an ophthalmologist; a derm doc, and these docs will all work together to manage a care continuum. So if you had a patient present an internal medicine practice the, even though it's a separate practice from the cardiology practice, it would be incumbent upon them to manage that patient's care. Let's say that the patient presented with a cardiovascular issue, the internal med doc would then refer to the cardiologist and they would manage that patient's care. So, the idea is, and the way many reimbursement models are going now or, or they are on their way to this end, is that the federal government, via Medicare, is now trying to keep patients more managed in an outpatient setting. So, for instance, let's say it's a cardiovascular issue same as congestive heart failure. The goal there is they present to their internal med doc; he refers to a cardiologist. The goal is to manage that patient in an outpatient setting. So, to get back around to your question, this is an integrated group that works together to manage patient care. And it's different in that it's different than in the old days where an internal medicine doc might just refer over to a cardiologist who might manage the care and follow-up with the internal medicine doc. But some of those follow-up conversations, calls, the exchange of notes could be sporadic and this is a more tightly woven methodology for physicians to work together at managing a patient's care among the different practices that are integrated.

[00:06:05] What are the top three mistakes you see when providers contract with a hospital?

[00:06:10] So, I think the top things that stick out to me, just top of brain type of things, would be cultural fit, understanding how life will change under a hospital employment model, and a really good sound understanding of what the contracts entail. There are some physicians who in the 90s went through the acquisition process, were acquired by hospital systems, and then divested for one reason or another. Some of them have gone back around and done employment models in the 2000s, but for those folks who have not engaged in employment model with the health system, I think one of the things that gets left on the cutting room floor if you will is the cultural fit. If you're going from a 2- to 5- to 10-doctor practice that's privately held, privately managed by the physicians and run, into hospital employment, the challenge is making sure that the culture that you have grown in the practice will transfer over to the health system.

[00:07:15] Many times those cultural attributes fall by the wayside after integration and it's a challenge. If you look at it from the hospital's perspective, let's say Hospital X has acquired 35 different practices, each one of those practices comes with the good and the bad, but it also comes with its own culture that has grown as the practice has grown. And so ensuring that there's a cultural fit, I think, would go a long way to at least mitigating some potential downside risk of a bad marriage in the future.

[00:07:50] So ensuring that that you asked the right questions, get the right answers, would really help to mitigate future problems and reduce heartburn. I think that understanding what your life will entail in an employment model, vis-a-vis the work hours; work expectations; production

expectations; call expectations -- how those will change your say as a physician or clinician in the, in, in what transpires in the health system. Do you take a backseat? Do you get a seat at the table? How are you going to discuss and manage care throughout the hospital system in the network? So understanding and being willing to negotiate a little bit about what role the physician would like to play within the health system. I've seen many instances where physicians get latched on, get acquired and latched onto a health system and they're so used to running their practice and dealing with the day to day and dealing with the care delivery issues, if you have a sort of a small quality committee in the practice, and then you get to the health system and they kind of sort of don't want to hear what you have to say. And that can be very frustrating, and again, trying to mitigate take the long view and mitigate downward or forward heartburn I think is essential. And then a sound understanding of what the contract entails. The employment contract, your obligation, your noncompete. Obviously the physician compensation component in those physician comp components are getting, maybe not necessarily more complicated, but certainly they have more moving parts than they used to. So in the 90s many contracts were written up with guarantees for physicians. And then in the 2000s these contracts involved a lot of work-hour views and then we'll go into that a little bit later. But, but it's a method of encouraging productivity, and now the next iteration of current models, if you, will is is paying physicians for quality outcomes. And so again this also speaks to physicians getting a seat at the table to talk about the quality expectations so that they can have input on those and help manage expectations of what those look like.

[00:10:15] Are there any features/characteristics that are unique when a physician is looking at a smaller system as opposed to one of the larger conglomerates that you see? I know that sometimes that comes up as a question, "If I choose to contract with an organization, do I want to look at a smaller one"? "Or is bigger the way to go?".

[00:10:37] Yeah. You know as with anything in health care, it's local. Right? So having done work across the country and large and small systems and critical acc, access hospitals the, it really is predicated on the hospital's needs and your lifestyle needs. So, for instance, I did a lot of work with a, what I call kind of smaller, health system out west. They were about 100 practitioners of PAs, NPs and physicians and some of the draw for the physicians was, in some instances, again this is generalization, but quality of life, getting out of the big city, getting a nice compensation package because there was a need for certain specialties in that area. And so I think that, getting back to your first question on, you know, what are the what are three key components, you can really take those and marry them with your expectations of what you need to help make a fit. So it's, "Do you want to end up in Philadelphia in, you know, a 600-bed hospital with 500 employed physicians, and be a cog in the machine?" Or do you want to head out West where there's hiking, quality of life, smaller network, you have a seat at the table, culturally it fits you. Those types of things are really germane in the decision-making process; so, so, so really the predicate before you move forward the question to ask is, "What do I want to get out of this? What what is my end game if you will; and I don't mean that in some sort of mischievous way, but what is best for me as I go searching for this relationship with this health system?".

[00:12:35] Do you feel the trend toward employee providers will continue to increase?

[00:12:41] Yeah, I think it will. I don't think the acquisition speed, the velocity may slow down a little bit but, I, but I think that there will continue to be acquisitions because physicians in private practice, especially those in smaller practices where you're both the physician who sees patients and does charts and all that good stuff for 50-60 hours a week and then has to run a multimillion dollar business, that just becomes very onerous and, and a lot of physicians coming out of training right now just don't want to enter into that, they're not interested in getting into that kind of lifestyle. And so, you know, with, with HIPAA and EMR rules and regs and all the things that have rolled out apropos of MACRA and MIPS, the management piece for physicians in smaller groups has just grown really cumbersome so I could see future aggregation and acquisition. Again, could be with health systems, could be with private equity firms who are looking to acquire what they call, we'll say it's a platform group, they might acquire a group of 25 or 30 physicians in, in a, one medical practice, and then they might acquire other bolt-on groups that are 3,4,5 physicians to, to work in that network. But I think the trend will continue. It may flatten out a little bit, but I also think that entrepreneurial physicians who haven't lost that zest; think some of them may think about what we alluded to a little bit earlier, referred to earlier, as the clinically integrated network or some sort of network affiliation with a group of like-minded physicians. And candidly, I think that health systems are re-evaluating where they are relative to their acquisition process and, and I think that some of them, and again, this is, is, is all predicated on geography and region and things of that nature, but I think that some hospitals are still losing money on their employed physicians and I think some of them are taking a different look at, "How can we work with them? Get the quality of care we need in our community but not have to employ them?". And I think they are different. I hate to say out of the box; it's feels like a trite business aphorism, but, but they're thinking, they're taking the blinders off and thinking with different kind of parameters in mind. "What's our end goal?". "Our end goal is quality care, repeatable quality outcomes, and delivering that at a lower cost." "Do we have to employ physicians to do that? Maybe we don't." I guess I sort of vacillated and went right down the middle without I think it will continue during the course of 2019, but I also think there are different models that are percolating out there.

[00:15:29] Jeff, this has been very informative. Thank you again for joining us.

[00:15:33] It's been my pleasure. Thank you.

[00:15:39] Jeff will dig deeper into these and numerous other business of medicine topics during the one day Business of Medicine Simplified program taking place during SMA's Southern Regional Assembly June 27-29 in Birmingham, Alabama. Visit SMA.org/assembly for more information and to register. I'm Jennifer Price with the Southern Medical Association. Thank you for listening today.