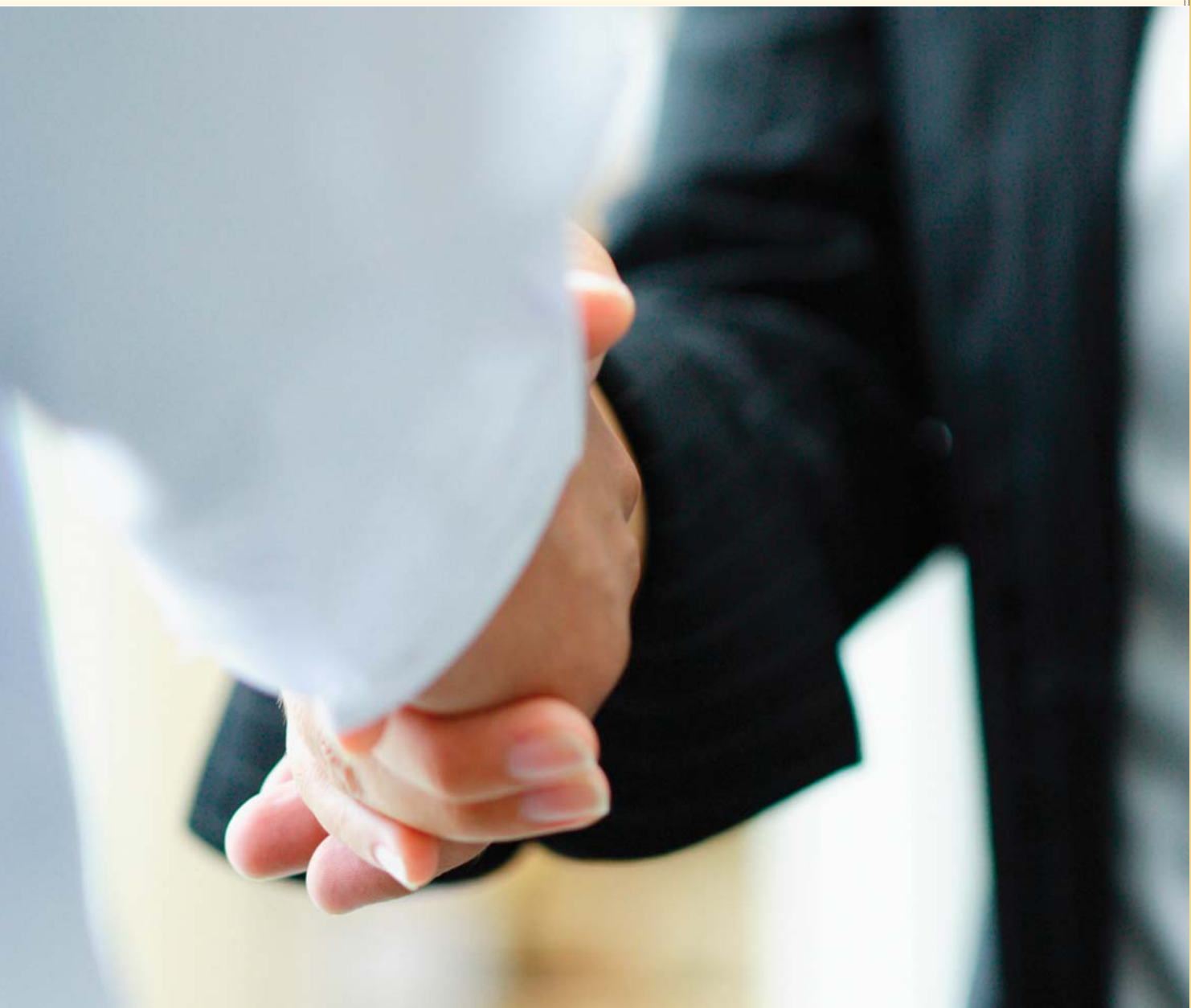


Your Strategy for Nonhospital Competitors



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Outpatients are an increasingly desirous patient population as healthcare providers keep an eye toward revenue growth. For example, while hospital inpatient survey volume has remained static between 2001 and 2005, total outpatient survey volume (in hospital and nonhospital settings combined) has grown 25 percent.^a

Of course, many others are after this business, as well. Consumers are finding more venues than ever for meeting their healthcare needs. In many markets, physician groups have established their own outpatient surgery centers or specialty care facilities, sometimes partnering with for-profit companies to do so.

In addition, nonurgent services are increasingly available in retail settings. About 7 percent of Americans have tried a retail clinic at least once, according to the Convenient Care Association. That number is expected to increase dramatically, as major pharmacy operators such as Wal-Mart Stores Inc., CVS Corp., Target Corp., and Walgreen Co. continue to partner with retail clinic providers such as RediClinic and MinuteClinic to expand operations.

Such dynamics increase pressures on hospitals to protect their market share and grow their revenue streams. But exactly how will today's hospital financial executives do so?

HFMA's 2008 CFO Summit, an invitation-only event sponsored by Cerner Corporation, explored this question as speakers and participants in roundtables gathered in Phoenix this past spring to share their practical strategies for competing and collaborating with nonhospital entities. The following is a highlight of some of these discussions, addressing:

- Physician employment
- Economic collaboration with physicians through various types of joint ventures
- Participation in retail health endeavors

Physician Employment: If You Can't Beat Them, Hire Them

Things at Baptist Health South Florida have been good—for now, according to speaker Ralph E. Lawson, CPA, the system's executive vice president and CFO. With six hospitals and nine (soon to be 15) outpatient service centers, Baptist has a strong presence in the southern part of Miami Dade County,

which is why it has been able to maintain market share despite intense competition from surrounding physician-owned ambulatory facilities.

But Lawson doesn't expect to maintain the same comfort level regarding outpatient business 10 years from now. "There are too many people competing for it, and the managed care companies are always trying to negotiate better deals with the physician owners," he says.

In the 1990s, Baptist saw other hospitals as its principal competitors and was busy entering collaborative arrangements—health insurance, malpractice trusts, air ambulance services—that have since fallen away for a host of reasons: religious and cultural differences, legal barriers, management self-interest, inefficiency, and, to a large degree, says Lawson, "the desire for control on our part. It was often easier and more effective for us to acquire rather than collaborate."

The hospital market has generally stabilized now, he says. As a result, Baptist is losing some degree of profitable outpatient business to its physicians. "We've tried to collaborate with them, but we've found it difficult for two reasons: One is the physicians' own desire for control—why share 50 percent with Baptist when they can have 100 percent to themselves? The other is that they've had easy access to capital." However, Lawson anticipates physician and hospital attitudes toward collaboration, at least in this market, may soon change. "What's happening now is that physicians are starting to compete with each other, and credit markets are tightening."

Lawson reports that within the past two years and accelerating over the past six months, physicians and specialists have been coming to Baptist asking to be employed: older physicians who are looking to get out of private practice before Medicare, inevitably, cuts their payment; and younger physicians who are looking for a less stressful lifestyle and more security than overseeing the business side. There are a lot of reasons, Lawson says, for the system to oblige, among them to:

- Build critical mass for key specialties
- Keep reputable physicians in the community
- Build strategic market position
- Attract key specialties to meet community needs
- Create a seamless system of care

Another benefit for Baptist is getting out from under such burdens as paying particular types of specialists to take call.

“We’re paying thousands of dollars a day, 365 days a year, for key specialists to take call. That’s millions of dollars a year. Sometimes it makes sense to employ the specialist rather than pay call rates.”

And, as Lawson points out, if the industry ever moves to a single payment for an entire episode of care—as many believe it might—then an employment model would best position Baptist for such a transition.

Of course, a physician employment model can have its drawbacks, as several attendees pointed out. One of these is the increased level of responsibility the hospital may carry in relation to malpractice insurance, especially for high-risk specialties. “The hospital has deeper pockets when it comes to malpractice coverage,” said one CFO. “You could end up bearing a larger financial risk than if the physicians were in a separate entity, which can be particularly scary for those that are self-insured.”

Another major concern is the complexities that come with involvement in practice management, including negotiating physician contracts—something most hospitals don’t have the infrastructure or expertise to handle. Baptist has outsourced physician billing and collections, even the employment of office staff, but as Lawson says, “outsourcing the office staff hasn’t worked out very well. There’s hardly anybody that does it, or does it well, at least in Florida. We finally hired someone to oversee the physician practices, so now at least we know when we’re losing money.”

In fact, each Baptist hospital has a separate line in its financial statements for gain/loss on physician practice “to ensure that management and the board of each affiliate is fully aware of the economics of the physician practices.” While employment is a good way to avoid many regulatory risks, it doesn’t eliminate financial risk. Lawson, for one, worries that people tend to underestimate this. “We’re making five-year commitments, 10-year commitments; if the transactions fail, what happens to the business? What happens to the community service?”

For this reason, among others, Baptist imposes two imperatives on the physicians it employs. One is that they must sign a legitimate noncompete covenant. The other, ironically, is that they are often encouraged to practice at other facilities as well as Baptist. “We’ve found this is one of the best ways

for physicians to build a regional reputation and sustainable referral patterns,” says Lawson. “Also, other hospitals may feel less need to recruit some of these specialists if they at least have access to these employed doctors.”

What about joint ventures? Lawson describes this as a work in progress. Having seen any number of joint ventures “blow up” in the past, Baptist is cautiously exploring some options. “The physicians involved in the discussions know we’re going to want control but they want us to have it too, because we bring management expertise and improve managed care contracting.”

Kathleen Cain, CFO of St. Agnes Medical Center, in Fresno, Calif., says that her organization, too, is leery of joint ventures. “We’ve gotten out of a lot of them, either by choice or by circumstance, because the doctors have already peeled off every profitable thing around us—urology surgery centers, eye surgery centers, ambulatory surgery centers, and imaging centers. So we’re migrating more toward comanagement models, instead—hiring doctor groups to help us manage the business we do have.”

St. Agnes has put together a management council from its hospital physicians and pays for the council’s management advice. “It’s strictly a management consulting fee for them; they’re not exposed to the profit and loss of the activity,” Cain explains. “This helps align the physicians and the hospital since the physicians are giving advice on helping the hospital succeed.” She continues, “I can’t put in a noncompete clause, but if they’re not delivering results for example, supply savings or scheduling efficiencies, or if they do go out and compete against us, at least I can fire them by terminating the comanagement agreement—unlike in a joint venture, where capital and other political factors can make it hard to get out.”

Other hospitals and systems are working hard to get in—not out—of joint ventures.

Economic Collaboration: Open for Business

Reid Hospital & Health Care Services, a regional referral center in Richmond, Ind., that is constructing a new \$300 million campus, is one of those places. With past experience limited to 49 percent ownership in a standalone ambulatory care

center—the first structure on the new campus—the single hospital system decided to pursue a strategic course of action “modeled on the option of economic collaboration with any and all appropriate members of the medical staff,” in the words of an August 2003 executive committee and board resolution.

The statement, says Craig Kinyon, vice president and CFO, was really an open-for-business sign. “We wanted to say to our medical staff: ‘Come on out and lay your cards on the table, and let’s talk. The last thing we want is to build this new campus and have you guys go out and build something across the street.’”

The idea, Kinyon says, was not just to re-cut the pie but to grow the pie. “We will not be able to sustain our profitability if we just divide up the current market share,” he says. “And so the incentives had to be very carefully constructed in every venture.”

So far, there are five ventures:

Expanded outpatient surgery/endoscopy center. The transaction is for fair market value (FMV) under arrangement. It started in July 2007. As of February 2008, staff members have transferred from the hospital, management positions are filled, and benefit packages are in design. The facility flipped from a freestanding surgery center to an under arrangements deal, in which Reid is a 55 percent owner with 26 physician partners. By arrangement, Reid does the billing, owns the medical records, and contracts for surgical services on a per-case basis with the joint venture company, which hires all the staff, pays for the supplies, and provides the lease for the building. The operating agreement, Kinyon says, “includes the necessary language about furthering the hospital’s mission, accepting charity care, etc. So the dividends that we get are nontaxable; those of the physicians, however, are taxable.”

Outpatient cardiology center. Currently the physicians are employed; eventually this will be a FMV provider-based joint venture. As of Feb. 2008, operations had moved to the new outpatient building, new cath lab equipment had been purchased, and clinical operations and patient flow were under review. Reid expects to start joint venture operations later this year. Ultimately, Reid will be a 51 percent owner of the center; right now, it still owns 100 percent.

Participating bond transaction. In accordance with Stark regulations, the bonds for this type of transaction constitute debt (not ownership); they pay a FMV interest rate. In 2005, \$5.66 million in subordinated bonds (566 units at \$10,000) were issued to fund construction of an imaging center, with 55 physician investors accruing 11 percent tax-free interest. Unlike traditional bonds, the tax-exempt participating bond transaction is two-year callable, meaning Reid can end it any time after two years. The contract includes a noncompete clause that forbids physician investors from being involved in another outpatient imaging center for two years after selling back a bond.

Medical office building/outpatient care center. This transaction is a real estate venture that involves FMV 10-year leases, with an FMV interest rate on a \$30 million construction loan from the hospital. Under the arrangement, the owners must be tenants. As of this past February, there are 13 individual partners; the medical office building is 75 percent leased, the outpatient care center is 97 percent leased. The first tenants moved in this past year.

Under the arrangement, Reid provides security, environmental services, and engineering services for both buildings. The hospital currently owns just less than 46 percent of the shares, but it aims to go as low as 10 percent over time.

Management services organization. This transaction involves FMV incentives for physician investors, earned on improvement measures plus a base management fee. To belong to the medical service organization, a physician must engage in at least one participating bond transaction. Designated seats on the board include one for the hospital, one for specialty physicians, two for radiologists, and three for primary care physicians. The management services organization was intended to relate strictly to the imaging center, says Kinyon, but in the establishing documents it just says “diagnostic services,” which means it has worked on other issues as well. As of February, 40 physicians had invested and members were working on an MRI backlog concern, as well as other designated projects.

Based on Reid’s experiences, Kinyon had several key points of advice to share with the CFOs in attendance. His first point is to enlist legal help in identifying potential concerns regarding Stark regulations.

Kinyon's advice: "If you're beginning to wade into this minefield, make sure you have an attorney with you at the get-go. You don't want to get halfway into something and say, 'How do I get out of this?'"

Also, he stresses the importance of being practical regarding the timing of agreements with physicians. It's optimistic to think you can get an IRS determination letter about a specific venture in less than a year, he cautions. "The problem is, when you tell physicians, 'We're thinking about this but it's going to take us 18 months to find out if it's OK,' they lose interest quickly," he says. "They have limited time in which to develop their practices, and so they naturally want to progress as fast as they can during this span."

This need to meet physician desire to move forward quickly is why Reid hired the cardiologist group that eventually will own 49 percent of the outpatient cardiology center. Employing the cardiologists was an interim step to get them to leave a good relationship and move to Reid while the building was going up, explains Kinyon.

Other than a few surgeons and psychiatrists, the cardiologists are the only specialists the hospital currently employs. "For the rest, it's your vintage 1950s medical staff model," Kinyon says, although he adds it won't be this way for long. "Everyone wants to be employed—urologists, orthopods, infectious disease specialists," he says. "And then, quite frankly, to handle the normal attrition in family practice and internal medicine, we're probably going to have to have employment contracts for the new recruits, or else we're not going to get anybody to come to Richmond."

Kinyon believes his market and many others are well on their way to seeing the death of the three- or four-person primary care practice. "The overhead is just consuming them," he says.

In contrast, Reid's radiologists are not employed, don't have an exclusive contract, and don't want one. What was important to the radiologists was stopping an outside promoter from building a freestanding imaging center in the area as well as the support offered by the managed service organization, Kinyon says.

For the hospital, too, the managed service organization has proved highly beneficial in terms of strengthening its position. Notes Kinyon: "The MSO board gets together two

or three times a month and talks about business issues and the need for clinical and financial improvement, while the physician subcommittees meet separately throughout the month. It's really great when you have physicians around the table who are part and parcel of the issues you're talking about. You don't have to work as hard to enlist their help."

In the beginning, he says, the hospital was doing most of the talking. But once Reid encouraged the physicians to form subcommittees, they started talking to each other and, as important, to other physicians on the medical staff. Kinyon cites the example of a fixed site PET/CT (positron emission tomography and computed tomography) scanning unit the hospital is going to put in to replace a mobile one. Referring physicians really didn't understand the advantages of the superior technology until a radiologist put together a point-by-point presentation. "That's the kind of straight talk they need to hear from an MD, not an administrator," Kinyon says.

Enticing the Consumer: Retail Health

Another dynamic changing the healthcare competitive landscape has been the emergence of retail health clinics in many communities. These ventures are being established through a variety of investors, including hospitals, for-profit companies, physician groups, large employers in the community, and sometimes the retailers themselves.

One healthcare system that has entered the mix is Sutter Health Partners, a not-for-profit network of 28 hospitals with affiliated clinics and physician organizations. Sutter has launched Express Care, which is made up of six California-based clinics housed in Rite Aid drug stores.

Express Care's pitch to consumers is easy access, affordability, and the service quality associated with a known and trusted local brand. For a typical cash payment of \$59, Express Care offers services by a nurse practitioner from 9 a.m. to 8 p.m. weekdays, 10 a.m. to 4 p.m. weekends. The target is women, families, and young working adults, and the track record so far suggests that Sutter is, indeed, breaking new ground: About 50 percent of Express Care patients are new to the network and 12 percent make repeat visits. Continuity of care is supported via connection to Sutter's

electronic medical record and referrals for follow-up visits; 6 percent of patients make subsequent appointments with Sutter physicians.

Many hospitals are shaking their heads at what that's going to require in cost reduction, given the tsunami of baby boomers moving into that category of reimbursement, according to Margaret Sabin, CEO.

"In the past, it has been very profitable for us to engage consumers on the acute care end of the spectrum, but now we have to look elsewhere on that spectrum to create relationships that will ensure our revenue flow in the future," she says.

Reaching out to consumers is a big part of Sutter's overall strategy. As it is for a growing number of organizations.

Many are after the retail dollar. Four of the largest retail clinic companies estimate that by 2009, they may each have up to 1,000 clinics open nationally.^b Large employers, too, are queuing up for much of the same business with in-house clinics and primary care kiosks. One conference attendee said his system has already co-branded with a number of employers to provide clinics within their facilities, figuring part of a revenue stream is better than none.

Before entering into such ventures, however, hospital executives need to be aware of potential downsides as well as principles that support optimal safety and continuity of care (see sidebar, "Doing Retail Right").



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From a business perspective, several factors also should be considered: physician dynamics, payer mix, and location.

Physician dynamics. When hospitals consider participating in a retail venture, Sabin notes it is important to weigh effects on physician relations. Sutter has a physician foundation model, meaning Sutter physicians provide the oversight for the nurse practitioners. It helps, too, that the physician leader of the clinics is part of the integrated medical group in that area. An independent medical staff and autonomous physician models might not accommodate Sutter's set-up, she says.

In addition to growth and lengthening the provider's relationship with consumers, Express Care offers a way for Sutter to offer quick, low-cost nonemergency care while avoiding the fixed overhead that would be associated with delivering such services in an emergency department setting. And it's that overhead, she says, along with legal issues regarding pricing, that make it impossible for many hospitals to offer inexpensive fast-track care—such as a \$59 treatment for bladder infection—as part of their emergency department operations.

Payer mix. Also, a profitable patient base is no guarantee. As an attendee pointed out, motivating insured patients to use a retail clinic when they don't have to pay the extra cost associated with using the hospital's emergency department can be difficult. Sutter's current payer mix for clinic visits is 48 percent cash payment, 32 percent PPO, 15 percent HMO, and 5 percent Medicare.

"We are negotiating with insurance companies to allow the clinic visits to count toward a member's deductible to encourage utilization in these settings," Sabin says. Potential to minimize insured individuals seeking nonemergency care in the intensive setting of the emergency department provides a strong financial incentive for this sort of relationship among payer, employer, and hospital.

Location. Location also can be a concern when establishing a retail health venture. From a referral standpoint, the hospital doesn't want to put an Express Care clinic so far from other elements of the system—outpatient diagnostic centers and the like—that it discourages potential patients. On the other

Doing Retail Right

Despite benefits, retail clinics are not without controversy. Potential downsides vary depending on how a particular venture is structured. Particularly when there is lack of physician oversight, concerns may include undue delay in the diagnosis and appropriate intervention of a medically complex condition. Also a common fear is that a retail clinic model will foster episodic care where all of the patient's providers are not appropriately informed of the patient's needs. When a retail clinic venture involves the financial participation of a retail pharmaceutical company, another concern is potential for conflict of interest in prescription writing and filling.

The American Medical Association (AMA) adopted policy in 2006 at its annual meeting that acknowledges retail health clinics are controversial, but ultimately that the clinics fit long-standing AMA policy that encourages "multiple entry points" into the healthcare system. In 2007, the AMA board resolved to ask state and federal regulators to investigate possible conflicts between clinics and the hospital chains that are affiliated with them.

To support patient safety and continuity of care, the AMA and the American Academy of Family Physicians (AAFP) have developed several principles for in-store clinic operations.

Scope of service. Retail clinics must have a well-defined and limited scope of clinical services.

Evidence-based medicine. Clinical services and treatment must be evidence-based and quality improvement-oriented.

Team-based approach. The clinic should have a formal connection with physician practices in the local community, preferably with family physicians, to provide continuity of care. Other health professionals, such as nurse practitioners, should only operate in accordance with state and local regulations, as part of a team-based approach to health care and under responsible supervision of a practicing, licensed physician.

Referrals. The clinic must have a referral system to physician practices or to other entities appropriate to the patient's symptoms beyond the clinic's scope of work. The clinic should encourage all patients to have a "medical home."

Electronic health records. The clinic should include an electronic health record system sufficient to gather and communicate the patient's information with the family physician's office, preferably one that is compatible with the Continuity of Care Record supported by the AAFP and others.^c

hand, says Sabin, too close to a hospital, say 15 or 20 minutes away, isn't good either. An ideal site would be "in an area where we'd love to have a hospital but where there's not enough volume yet to build another facility, so the clinic becomes a small anchor for us."

Asked by an attendee if the Express Care clinics are taking business away from any community clinics, Sabin acknowledged that a bit of that is probably going on. "We've tried not to place them too close to one another."

The business proposition can be tricky, notes Sabin. It has been a challenge getting the clinics to attract a suitable

level of visits and revenues. However, she noted there are many factors going in their favor:

- Appropriate service offerings
- A strong host location
- Effective and ongoing marketing
- Strong integration with the market's physicians
- Successful nurse practitioner recruitment
- A competitive cost structure
- Efficient operational processes
- A standardized product/brand promise

Not to mention the clinics' overall business structure has significant speed to market: "We're leading, not following," she says.

Clearly, there is an advantage simply to putting a competitive stake in the ground. "At the end of the day," Sabin says, "what you don't want is to have someone else open a retail clinic and leave you—the hospital system and your primary care doctors—out of it. If we don't provide an open avenue, Wal-Mart will."

A Strategy for Competitive Advantage

An old proverb states, "Competition is the whetstone of talent." And today's diverse healthcare environment provides ample opportunity for financial executives to hone their skills, strategic vision, and leadership abilities as they continue the increasingly challenging quest of attracting outpatients. Discussions with the select group attending HFMA's CFO Summit show they are not about to sit quietly by as their destiny is decided by other players in the healthcare marketplace.

Endnotes

- ^a Avalere Health analysis of Verispan's Diagnostic Imaging Center Profiling Solution, 2004, and American Hospital Association Annual Survey data for community hospitals, 1981-2004.
- ^b "Attention Shoppers: Low Prices on Shots in Clinics," *New York Times*, May 14, 2006.
- ^c www.aafp.org/online/en/home/policy/policies/r/retailhealthclinics.html



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