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Physician Integration - California Style

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According to an Association of American Medical Colleges and AMA survey of physicians under the age of 50, time for family/personal life is very important. (Edward Salsberg, Association of American Medical Colleges, *National Physician Workforce Trends*, April 22, 2009)

The aging physician population and family friendly work attitudes of younger physicians are the major limiting factors on physician supply. In some cases, it may take two younger physicians to replace one older physician who has been working 75+ hours a week.

In addition, as a response to unreasonably low reimbursement from governmental payors and the increased administrative headaches associated with third party insurance companies, some physicians have begun practicing concierge medicine. These physicians limit their practice to a small number of patients who pay an annual "access fee" which affords them quicker office visits that are not hurried.

Other physicians have become more hospital-based. These include hospitalists, intensivists, neurointensivists, orthointensivists, pediatric intensivists, laborists, and nocturnists. Combining this trend with the increased demand for healthcare services due to population growth, aging of the population and advances in medical technology will only result in additional physician shortages.

Physician integration strategies are increasing as hospitals attempt to secure a stable base of physicians to work with. These strategies include:

- Medical Directorships
- Emergency Room On-call
- Co-management Arrangements
- Joint Ventures
- Employment

Medical Directorships

Medical directorships are used by some hospitals to secure the administrative services of physicians with specific clinical experience. The duties of these medical leadership positions are typically documented in written agreements, which also state the average number of hours required per month and the fair market value of hourly compensation.

Emergency Room On-call

Hospitals are deciding whether to pay fair market stipends for ER on-call or to have their ER go on divert status. In certain specialties, like neurosurgery or orthopedic surgery, it is not unheard of for hospitals to pay a stipend of $1,000 a day.

Co-management Arrangements

Under a Co-management service agreement, a hospital works with a management company formed and jointly operated with individual solo practicing physicians and physicians from medical groups to co-manage a clinical department or specific service line. The management agreement is typically from one to three years and provides fixed and incentive compensation.

The incentive portion of the compensation is based on achieving specific targets focused on opera-

tional improvements, patient satisfaction and/or improved outcomes. The fixed portion of the management service agreement is paid monthly and used primarily to pay operating expenses and physicians for their time served on management boards and committees. A fair market analysis may be used to support hourly rates paid. In addition, the rate paid to other healthcare management providers may be reviewed to justify any percentage of revenue co-management fees paid. Depending on the specific duties and performance incentives, co-management fees of 2 to 6% of net revenues are not unusual.

Joint Ventures

Hospital and physicians may decide to work together on a health care joint venture that generates technical revenues. Joint ventures are much more complicated and take significant time and resources to develop. Investors frequently earn a return based upon their ownership percentage.

Should a joint-venture involve an established business such as an ambulatory surgery center, it should be purchased at fair market value to avoid ruling afoul of Stark regulations and anti-kickback statutes.

Employment

California has a corporate practice of medicine doctrine which prohibits business corporations from employing physicians. Accordingly, hospitals have contracted with physicians to provide their professional expertise. In most cases, the hospital produces a technical bill with the physician producing a separate professional bill.

Some hospitals have developed medical foundations, which hire physicians in medical groups through a professional service agreement. The medical foundation may be a subsidiary of the hospital but has its own medical foundation board.

The medical foundation oversees the day to day operations, assets and research/community education, while the medical group is responsible for distribution of compensation, quality of care/patient satisfaction and other physician employment duties. The medical foundation needs at least 40 physicians in 10 different specialties.

Conclusion

Some hospitals may attempt alternatives such as employing physicians to staff hospital clinics/outpatient departments. Others may attempt to use a "Friendly Professional Corporation" where a professional service agreement is secured with a physician corporation.

As hospitals and medical groups struggle to cope with decreased reimbursement and the limited supply of physicians, other physician integration strategies may evolve, with the market determining who the winners will be.

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