

A New Tool for Hospital/Physician Strategic Alignment: *The Subsidiary Physician Corporation*

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Physicians' and hospitals' strategies often diverge—with poor results for both. The causes of this divergence are many. They include different methods of payment, divisive governmental regulations (like Stark) and cultural differences.

In particular, physicians often desire economic independence and practice autonomy. Hospitals desire strategic control. During the 1990s, many hospitals began to buy physicians' practices and employ doctors as a means of assuring strategic alignment. The financial and managerial results were often catastrophic. Large losses occurred as a result of poorly designed compensation plans, loss of practice ancillaries, and the extension by hospitals of hierarchical management practices into previously autonomous medical offices.¹

Practice productivity dropped and physicians became the objects of administrative blame. In purchasing practices and employing doctors, many hospitals found that the theoretical advantages of strategic alignment were overwhelmed by financial and managerial problems.²

Let's examine a model of physician practice that uses the tool of hospital ownership strategically, preserves the financial advantages and accountability of private practice, and affords physicians very significant autonomy in their practice. It's called the subsidiary physician corporation (SPC).

The SPC recognizes that physician practices and hospitals are separate businesses. Physicians often do better running their own show, and while efforts by the hospital to manage the day-to-day operations are often unproductive, expert managerial advice and support from the hospital can be helpful.

An SPC that is owned by the hospital can meet the strategic interests of both the physicians and the hospital. Such a structure can enable the physicians to retain operational control of their practice, and gives the hospital strategic control³ over the practice in return for specific,

IN THIS ARTICLE...

Examine a new financial and management relationship between group practices and hospitals that could help both entities improve patient care.

limited financial benefits to the physicians. Hospitals and physicians do have shared strategic interests such as:

- Developing a stronger specialty capability—new physician skills and services—in a strategic area
- Improving the care they provide for patients
- Enabling a strategic specialty practice to transition to new leadership
- Retaining a strategically important practice on the hospital staff
- Dealing with payers

In our experience, the SPC model is serving to bring together competing specialty practices into a combined entity that works with the hospital to develop new, state-of-art services in that specialty.

A strategically important practice that has closely held leadership was transitioned into an SPC as a new leader for that practice was recruited. Another strategically important practice was transitioned into an SPC to assist with space and other defined support to retain that practice on the hospital staff.

Each situation is different. Payer negotiations can include subsidiary payer contracts along with negotiations for hospital services and for employed physicians.

The hospital can provide specific assistance with the defined support that is most important to the practice. Examples of support have included recruiting, space and transition working capital, and assistance with payer negotiations.

Some support amounts can be forgiven over time if the SPC continues to function through the amortization period. The support amounts are collateralized by the practice assets including the accounts receivable.

If the physicians choose to leave as a group before the full amount is amortized, the balance owed is paid by the corporation from the assets of the corporation before the balance of the assets are paid to the physicians

How does the subsidiary physician corporation work?

1. Key requirements

- Shared strategic interests
- Physicians capable of and interested in running a successful practice
- Asset base, including accounts receivable, as collateral for any liability to hospital if the physicians choose to leave
- Practice retains effective ownership of its assets and bottom line performance
- Hospital provides defined, limited financial support (a “defined contribution”) in return for strategic control

2. The model

The hospital owns the SPC with significant reserve powers as shown in Table 1.

The SPC board is appointed by the hospital CEO and approved by the hospital board. The SPC board has two classes of members (hospital and physician) with the majority composed of physicians.

Majorities of each class are required for major decisions as shown in Table 2. In practice, the physician members are all of the physicians in the group with the exception of recent hires.

The hospital members are chosen to represent the hospital

Table 1

Hospital Health System Reserved Powers

- Approve the annual capital and operating budgets of the corporation
- Approve the incurrence of non-budgeted individual or cumulative indebtedness by the Corporation in excess of agreed amount
- Approve the merger, consolidation, division, sale of assets, creation of a subsidiary or any other fundamental corporate transaction by the corporation, including the acquisition of, or merger with, another entity, or the formation of any partnership, joint venture or other legal relationship in which the corporation shall have any interest, financial or otherwise, or shall have any voting rights
- Elect the directors of the corporation.

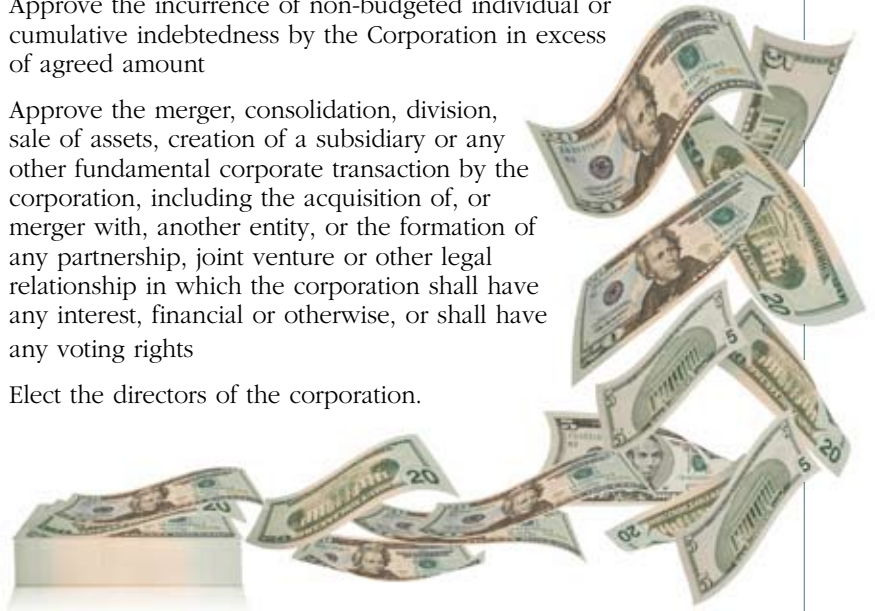


Table 2

Subsidiary Board of Directors Actions Requiring Majority of Each Class

- Approve any strategic business plans of the corporation
- Approve physician employment agreements entered into by the corporation and any amendments
- Approve any physician compensation plan for the corporation
- Undertake any material change or expansion of the business of corporation that is not otherwise approved as part of the corporation’s operating or capital budget.



leadership's interest in the practice as well as leaders with previous experience and appreciation for physician group practice. Hospital members to date include the hospital chief medical officer or the department chair, the physician leader of the employed physician group, and the hospital chief financial officer. This board meets quarterly and is provided with monthly revenue and expense reports.

The physician compensation pool is collected revenue minus the expenses of the practice. The physician compensation system functions like that of a well-run private practice.

A monthly "draw" is established for each physician at 70 percent of what they can expect to make if the practice performance, and their individual performance, proves to be what was budgeted.

At the end of each quarter, actual performance shows the amount that each individual "earned" in the period year to date. Ninety percent

of that earned amount, minus the sum of all draws and incentives paid year to date, is paid to the individual as their quarterly incentive.

At year end, 100 percent of the amount earned in the year, minus all payments to date, is paid to the individual as their year end incentive payment. As in well-run private practices, the objective is to not overspend the collections generated by the practice.

Physicians run the practice within the limits of the hospital reserve powers and the supermajority requirements for board decisions. The hospital board approves the operating budget, capital budget and the strategic plan for the SPC, but within the context of those approvals, the physicians and their practice manager run the practice as they choose.

The SPC establishes its fee structure, does its own billing and collections, and decides its staff salaries and physician and staff benefits. The SPC is not required to use any

hospital services, but if it were to choose to buy information systems, as an example, it would be charged a mutually agreed rate for any services it chooses to buy.

Other than the rate for any services the SPC chooses to buy, there is no hospital charge to the SPC. If the hospital has a requirement that the practice would not have in private practice, the cost of that requirement is the hospital's responsibility.

As an example, the hospital is required to audit the SPC in addition to the audit done by the SPC's outside accountants. The cost of the added hospital audit is a cost of the hospital.

3. Comparison with other strategic and financial model relationships

A summary comparison of the strategic and bottom line financial relationships with other financial model relationships is shown in Table 3.

Table 3

Comparison with Other Strategic and Financial Model Relationships

	Hospital Employed Group	Subsidiary Physician Corporation	Joint Venture	Private Practice
Strategic Relationship	Direction Hospital decides	Discussion Subsidiary decides	Discussion Joint Venture decides	Deduction Strategy from Actions
Bottom Line Financial Responsibility	Hospital	Subsidiary	Joint Venture	Practice

Insights on Subsidiary Physician Corporations by Two Hospital CEOs⁴

Negotiating rates with payers, dealing with competition among physician groups, potential competition between hospitals and physicians, and enabling better management of care were legitimate concerns in the 1990s and drove hospitals to acquire physician groups.



Richard A. Reif

The acquisitions frequently fell short of mutual expectations for several reasons, not least of which were the lack of strategic alignment and a poor business model. For both hospitals and physicians, the issues continue to be significant concerns today. New models seek to address the issues while avoiding the pitfalls.

Physicians with long-established practices are finding that the squeeze of little or no increases in reimbursement, coupled with increasing costs, are limiting their ability to replace themselves and to add physicians with new skills to their practice.



Thomas P. Ferry

A large private payer in our area is refusing to negotiate with groups of less than 15 physicians. Hospital CEOs are finding more and more physicians coming to them and asking: "What can you do to help me?"

From the CEO perspective, it is important to find ways to maintain and grow a strong medical staff. Pay for performance is adding emphasis to improving how care is provided. It is no surprise that hospitals and physicians are looking at ways to integrate again today.

Subsidiary physician corporations (SPC) provide an innovative way for a hospital to have a strategic relationship with a physician group without buying the practice or employing the physicians.

A well-led and managed hospital-employed physician group would be an alternative, but many hospital CEOs know from painful experience how difficult it is to develop such a group. Many physicians, who have observed this experience, do not want to be part of a hospital-employed physician group.

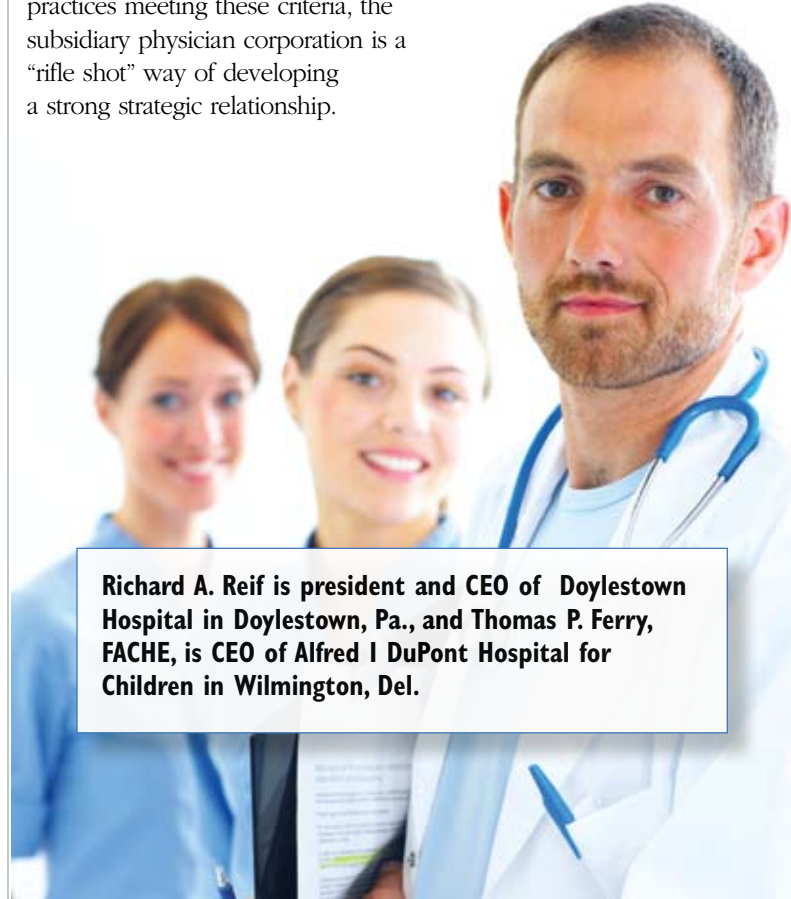
A key feature of the SPC is that it focuses both the hospital and physician group on meeting the strategic needs of each other. The financial relationship is a business relationship designed to meet the strategic needs of both the hospital and the physician group.

The SPC's explicit business model with the aligned strategies and incentives while maintaining the clinical and operational independence for the physicians enhances mutual success. Further, the opportunity for the SPC to benefit from the hospital's greater negotiating power with payers should enhance the financial success.

Investments are collateralized by the group's receivables and possibly amortized over time. Either party can choose to dissolve the relationship if it is no longer meeting their strategic needs, but if the relationship is dissolved, the physician group loses the associated financial benefits. The hospital may lose an important group to a competitor.

Subsidiary physician corporations are not for every hospital-physician relationship. They look to be particularly useful in the context of a high-profile practice that is well-managed, with specific limited financial needs, that has no interest in being employed by the hospital.

While not for every relationship, for practices meeting these criteria, the subsidiary physician corporation is a "rifle shot" way of developing a strong strategic relationship.



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Table 4

Comparison of Employed Model and Subsidiary Physician Corporation Responsibilities**

Dimension	Employed model	Subsidiary phys. corp.
Bottom line responsibility	Hospital	Physicians
Ancillary revenue	Hospital	Subsidiary provides or chooses provider
Employee benefits	Benefits provided and managed by hospital	Decided and managed by the practice
Compensation	Various methods	Revenue minus expenses
Decision making	Limited by hospital / medical group culture	Limited by hospital reserve powers

** Assumes employed model as part of hospital

Hospital Employed Group. In groups that are employed as part of the hospital, the strategic direction is decided by the hospital. Physicians in the group may have views that are taken into account, but the final decision is made by hospital leadership. The hospital is responsible for covering the bottom line loss.

Subsidiary Physician Corporation. In subsidiaries, the strategic direction is developed in joint discussion between the physicians and the hospital, and it is limited by the hospital reserve powers, but it is also limited by the physicians' ability to dissolve the relationship and return to private practice. The result is a decision that explicitly recognizes the interests of both the hospital and the practice. The subsidiary is responsible for the bottom line of the practice, which, through the physician compensation model, is the responsibility of the physicians.

Joint Venture. Joint ventures are like subsidiaries, in that they have shared governance, but they are focused on a specific joint interest such as an outpatient surgery center. It is this focus on one part of the practice, as opposed to the whole practice, that is the primary difference. Another key difference is that in the subsidiary physician corporation, the physicians have total responsibility for and benefit from the bottom line. In joint ventures, the hospital and the physician group have a shared interest in the bottom line.

Private Practice. In a private practice relationship, the hospital and the physician group are often left to deducing the other's strategy from their actions. Each is responsible for its bottom line.

What does the hospital get?

- A strong relationship with a strategically important practice

- Knowledge of how the practice is performing financially and ability to recommend corrective action early as potential problems are recognized
- Timely customer feedback on any hospital relationship concerns

What does the practice get?

- Assistance in meeting specific operating and capital investment financial requirements; may include assistance also in negotiating with payors.
- Ability to continue to run the practice as they choose and benefit from that performance just as they did previously
- The assistance of knowledgeable, interested, and influential hospital representatives on SPC board

What are the pitfalls?

Subsidiaries are a new model, and both physicians and hospital staff may see the first few subsidiaries as just another form of employment. The employed and subsidiary models are quite different as seen in Table 4. The differences need to be adhered to and reinforced.

At the time of developing a subsidiary, it is important to have two people representing the hospital in the negotiations. One will be an individual with the interest and responsibility to see that the subsidiary is developed. This individual is often the hospital's chief medical officer or the related department chair.

The second is a partner to the first, but this individual must own the responsibility to see that the focus is first on the shared strategic interests, and then that the financial agreements are consistent with what is required to achieve the shared interests. The key requirement for this individual is someone who understands physician practices, and he or she also needs to understand the strategic interests and reasonable financial agreements.

Without the combined focus of these two individuals, the negotiations can drag out and the opportunity for a reasonable financial agreement will be reduced as the physicians push to see: "What more can we get?"

After the subsidiary is developed, it is important to have the two-person team representing the hospital in the development of the subsidiary be responsible for dealing with any follow-on requests.

The two hospital representatives will need to draw line at the level of the defined, limited support that was agreed in developing the subsidiary. The subsidiary's practice leadership is responsible for managing the expectations of members of the group.

Implementing the new subsidiary requires working closely with the leadership of the practice(s), the subsidiary practice manager, and the subsidiary's outside accountants. The outside accountants are often integral to the past functioning of the practice, and they can be helpful in implementing the new subsidiary, but they need to understand the financial relationship and the reporting requirements of the new subsidiary.

The pre-subsidary practices are responsible for collecting their old accounts receivables and closing out the obligations of their prior practice. Without attention, it is easy for the new subsidiary to look at itself as just an extension of the prior practice, and miss the importance of the starting balance sheet, as an example, for the new subsidiary.

It is helpful to plan for an internal audit, conducted by hospital staff or outside accounting staff retained for this purpose, four to six months after the subsidiary startup. Knowing this audit will be done helps to focus everyone's attention.

Concerns

There are "cookie cutter" aspects to these subsidiaries: the

bylaws and employment agreements are similar from one subsidiary to another. That said, the amount of work in establishing a subsidiary is significant—taking four to eight months of elapsed time and the attention of the two individuals involved in the negotiations.

Ongoing liaison is required and variable based on the issues. The amount of work is justified by the strategic importance of the practice to the hospital—which reinforces the need for that strategic assessment as the first step in considering a subsidiary physician corporation.

Strong legal support is needed to assure that regulatory and legal requirements, and the interests of the parties, are met. In our experience, the hospital paid for legal and consulting assistance to develop and negotiate the agreements; the physicians paid for their legal review of the documents.


Individual practices may choose and appropriately move from subsidiary status to employed status over time. Other practices may appropriately choose to do the reverse. We have had examples of both in our first four subsidiaries.

To manage both models and to offer the choice to individual practices, we have a single medical director/executive director team responsible for both models. In situations where the strategic importance is high, the physicians in those groups appreciate the choice.




References

1. Hudson T. Necessary Losses? *Hospitals and Health Networks*, 71(24):26-7, December 20, 1997.
2. Peck D, Bastian M, Chopra A, Eirich M and Sposito F. Reassessing the Practice Ownership Ambition, Healthcare Advisory Board, National Membership Meetings Presentation - June 1999
3. Strategic control: the subsidiary physician corporation is owned by the hospital as a sole member; hospital has the power to approve the merger, consolidation, sale of assets or any other fundamental corporate transaction by the corporation; if the physicians are dissatisfied, they can choose leave the corporation and lose the associated benefits.



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