Continued reimbursement and cost pressures in radiology and the prospect of system-wide healthcare reform are fueling a new wave of integration between physician practices and hospitals. Increasingly, providers are aligning to reduce expenses, improve negotiating clout, and strengthen the continuity and quality of care.

A variety of business models exist to accommodate operational and strategic integration. These traditional approaches, including joint ventures, physician-hospital organizations, and physician-employment agreements remain viable. However, a lesser-known alternative is gaining ground and represents – for many radiology practices – perhaps the most effective means of achieving hospital integration.

Known as the subsidiary physician company (SPC), the business model maximizes the benefits of integration for both parties while eliminating what often is the single greatest roadblock to closer hospital ties for some physician groups: Loss of operational control.

**The Best of Both Worlds**

A radiology practice properly organized as an SPC continues to be able to establish compensation levels, create benefit packages, and set physician work schedules. At the same time, the structure can help reduce costs, improve care quality, and boost market share.

Radiology groups considering closer ties with their affiliated hospitals should work with qualified business and legal consultants to explore the opportunities presented by the subsidiary physician company approach. While more complex and time-consuming to establish than the alternatives, the “best-of-both-worlds” benefits offered by a well-designed SPC have the potential to make expending the effort worthwhile.

**A Checkered Past**

In the past, attempts to effectively integrate physician practices and hospitals often proved problematic for both parties. Physicians who entered into hospital employment contracts frequently felt constrained by hospital oversight and demands. Expectations for meeting “production quotas” also alienated doctors, as did the requisite but seemingly excessive meetings and paperwork. Hospitals, meanwhile, found it difficult to spur productivity gains or greater organizational involvement from physicians who were employed on a guaranteed salary basis.

**Market Pressures and Healthcare Reform**

Today, an array of market forces are compelling hospitals and physicians to reconsider the mutual benefits of integration. Significant, ongoing reimbursement cuts have made it more difficult for radiologists to sustain income levels. Competition is intensifying, and operating costs continue to rise. Hospitals, meanwhile, face growing pressure to reduce costs and provide greater continuity of care. In addition, some are facing a growing shortage of physicians and thus are looking for ways to guarantee coverage and specialist availability.

Another key factor fueling renewed interest in integration is the near-certainty healthcare reform will require greater cooperation between providers. Medicare already has launched pilot projects in which hospitals are financially at risk for readmissions or continuing care. The Centers for Medicare & Medicaid Services also is experimenting with bundled reimbursements that consolidate all provider payments associated with a single incident of care.

When combined with the growing shift toward pay-for-performance reimbursement, recent trends are forcing hospitals to find new ways to align with physicians to ensure the highest-quality, lowest-cost care. According to the Medical Group Management Association’s annual Physician Compensation Report, the number of hospital-employed physicians of all types rose by 8 percent between 2005 and 2007, while the number of independent physicians fell by the same amount.¹
Hospital Ownership – Physician Control

Subsidiary physician companies present an attractive way to meet the needs of both the hospital and the physician group. The entities generally are created as limited liability companies or C or S corporations. Typically, 100 percent of the equity ownership is controlled by the hospital or the hospital’s for-profit subsidiary.

In the expected SPC structure, the hospital establishes the strategic direction for the group and is represented on the board. However, the hospital does not directly control distribution of revenue and does not receive revenue beyond incidental and ancillary payments agreed upon in the company's bylaws. Nor does the hospital have direct control over operational issues or income distribution. Those prerogatives remain in the hands of the physicians.

An Array of Benefits

With this kind of structure, radiologists essentially are free to operate as they have traditionally. Productivity-based compensation plans may be used, and benefits structured, according to physician needs and desires. Likewise, scheduling and call duties can be developed without interference from the hospital.

The physician group retains responsibility for the cost side of the ledger, including insurance, supplies, and other expenses. However, aligning with the hospital should create savings opportunities in the supply arena due to the hospital's purchasing power and economies of scale. In addition, employee benefits, such as retirement-plan management and health or life insurance, may be less costly when acquired through the hospital.

Groups likewise stand to benefit in the area of support-staff recruitment and retention. By aligning with the hospital, the practice can gain access to a larger personnel pool, including office staff, RNs, and technicians. And information-technology support is likely to be greater and data sharing more seamless if the physician practice is owned by the hospital. Finally, the SPC should have greater access to capital for expansion and equipment needs, assuming the hospital’s credit is good.

Hospitals Gain

The advantages of the SPC structure for hospitals are perhaps less direct but no less important. By owning the physician practice, hospitals can ameliorate physician shortages and better manage coverage and availability. They also can work with physicians to present a united front during contract negotiations to obtain the most advantageous managed-care rates.

Perhaps most important, the contentiousness that often accompanies hospital-physician group relations can be reduced or eliminated. As a result, both parties are in a position to work cooperatively to expand services, boost market share, and meet payor integration and quality demands. The latter points will become increasingly important as payors shift to bundled, consolidated payment and pay-for-performance for a growing number of incidents of care. Integration has the potential to reduce costs and make hospitals more competitive. Indirectly it can have a positive impact on the quality of care.

Indeed, the growing emphasis on quality reporting and the physician's central role in the care process make it imperative hospitals establish closer ties with physicians. Fully 87 percent of healthcare spending decisions are controlled by physicians, while 46 percent of key quality reporting indicators are exclusively the responsibility of physicians.

Creating a Subsidiary Company

Groups considering the development of an SPC need to take into consideration a number of factors, including:

• Strategic and financial imperatives of both the hospital and practice
• Governance imperatives of both organizations
• Cultural differences between the organizations
• The natural tendency to "morph" an SPC into a traditional employment model

Practices should conduct a rigorous due-diligence process that compares and contrasts the SPC with other business models such as direct employment, joint venture, physician hospital organization, and management services organization. And the radiology group should be capable of – and prepared to – manage their practice successfully.

Because many in healthcare are not familiar with the SPC business model, considerable time needs to be taken to familiarize all parties with the structure and alleviate any concerns or anxieties. Groups should anticipate the entire process of establishing an SPC will take anywhere from six to 24 months. Ultimately, the success or failure of the entity will largely depend on the kinds of provisions written into the organizing documents and company bylaws. As a result, it is essential groups and hospitals work closely with qualified and experienced third-party consultants and legal counsel in establishing the SPC.

A Foundation for the Future

Properly structured, an SPC may be an effective way for radiology practices to prepare for the future. By integrating with a hospital through a subsidiary physician company, groups retain the ability to manage their practice in a manner acceptable to physicians. They also gain access to the resources of the hospital, including IT assistance, capital, staff, and expert assistance in strategic planning. Most important, they’re strategically aligned with the hospital to jointly meet the many emerging challenges of today’s fast-changing healthcare environment.

KEITH E. CHEW, MHA, CMPE, is the MGMA Liaison to the RBMA Board of Directors, a membership-committee member, and a senior consultant with McKesson Practice Consulting Solutions. Keith can be reached at McKesson Practice Consulting Solutions, 18 Hawks Nest, Chatham, IL 62629; phone 217.483.6467; fax 217.483.6468; Keith.Chew@McKesson.com.

FOOTNOTES
1. 2008 MGMA Physician Compensation Survey (based upon 2007 data)