Many hospitals and medical practices forming integrated health care delivery systems (IDSs) are falling into the same traps that ensnared many of these efforts in the 1990s. That’s unfortunate, because the rewards of creating a successful IDS are greater than ever.

IDS startups of the 1990s promised “win-win” results to all concerned — hospitals could grow to negotiate managed care contracts more forcefully and edge out competitors, while physicians could escape business hassles and improve compensation.

Unfortunately, ugly financial realities soon appeared. Medical Group Management Association data show that employed physicians receiving guaranteed compensation are not as productive as those who own their practices. Yet hospitals tended to overpay for primary care practices while burdening their physicians with additional overhead and decreasing revenue opportunities. After several years of financial losses, many hospitals sold their acquired medical practices back to physicians. Some hospital-owned practices re-engineered themselves to improve financial results under the IDS banner.

Gaining market clout remains a prime motivator for hospital integration efforts, but this time around more physician practices are initiating acquisition discussions with hospitals. They want to stay competitive with medical groups pursuing joint ventures.

Specialists seeking to integrate

Today’s integration trend broadens the focus from high-volume, low-margin referral sources like family physicians. Many high-producing medical specialists, such as cardiologists, orthopedists, oncologists, and neurosurgeons, are linking up with hospitals through sale or joint ventures.

Many IDS acquisitions seem to be avoiding the worst of the errors made in the 1990s, when hospitals set unrealistically high practice values and made unconditional salary guarantees to physicians. Yet others are at risk. Hospitals and physician practices may form legal connections but remain operationally and strategically disconnected.

Fictional example

Galaxy Medical Group, a multispecialty medical practice, is a hospital-owned organization with 55 full-time-equivalent (FTE) employed physicians. Galaxy Health System (GHS) owns an acute-care hospital, laboratory, diagnostic and therapy clinics and other facilities. It had accumulated a few primary care medical practices during the IDS craze of the 1990s and tolerated moderate financial losses on each group (approximately $73,000 per FTE physician annually). Recently, GHS added several more primary care and specialty practices to compete with its expansion-minded crosstown rival St. Cosmos Hospital.

see Size Matters, page 36
The president of the GHS board realized that the medical practice units of his IDS weren’t performing well. The employed physicians had:

- No commitment to the larger organization;
- Few opportunities to influence the health system or practice operations; and
- Sparse data for making comparisons to similar groups.

GHS needed accurate data to compare to established benchmarks. Because it had integrated ancillary services across its system, GHS effectively removed any fair measure of Galaxy Medical Group’s ancillary services. That alone chopped away nearly $150,000 of revenue per physician.

Making matters worse, the system’s financial statements included a portion of the hospital’s administrative overhead expense and other costs not typically assumed by

### Hospitals and physician practices may form legal connections but remain operationally and strategically disconnected.

private medical groups. Again, the groups were made to appear as underperformers.

GHS leaders decided to restructure governance mechanisms to give physicians a bigger voice in managing the medical group.

### Pieces now form a whole

The GHS leaders:

- Formed an elected physician committee to lead Galaxy Medical Group. The hospital system retained final approval of

### A self-assessment for hospital-owned physician practices

Investigate any areas where the answer is “no” or “don’t know.” They may indicate strategic or operational weaknesses.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
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<tbody>
<tr>
<td>1.</td>
<td>Are physicians represented in the management of the medical practices?</td>
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<tr>
<td>2.</td>
<td>Are physicians represented on the boards and committees of the broader hospital system?</td>
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<td>3.</td>
<td>Are physicians allowed to share in the success of their practices and the broader system?</td>
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<td>4.</td>
<td>Are physicians involved in developing strategic initiatives?</td>
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<td>5.</td>
<td>Does the strategic plan list specific and measurable goals?</td>
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<td>6.</td>
<td>Do medical group administrators and managers have experience with medical group administration?</td>
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<td>7.</td>
<td>Do financial statements recognize the ancillary service revenue generated by the medical groups?</td>
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<td>8.</td>
<td>Is hospital- or system-related overhead separated from medical practice overhead on financial statements?</td>
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<td>9.</td>
<td>Is physician productivity benchmarked and compared with similar systems and medical groups?</td>
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<td>10.</td>
<td>Does the compensation system provide incentives for contributing to organizational success?</td>
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<td>11.</td>
<td>Are physicians involved in addressing practice guidelines?</td>
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<tr>
<td>12.</td>
<td>Are medical practice staffing ratios analyzed and compared in terms of what ambulatory sites need?</td>
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</tbody>
</table>
major decisions. With the committee’s input, the group’s hospital-appointed administrator was replaced by one experienced in leading medical groups;

- Developed an internal reporting system to reflect ancillary service revenue;
- Eliminated inappropriate general administrative costs from Galaxy Medical Group’s financial statements; and
- Included the group’s physicians in broader IDS planning and governance.

The result: More proactive physicians who take a proprietary interest in financial and operational results. The physician organization now receives an equivalency credit of slightly less than $50,000 per physician for ancillaries and the system continues to realize savings from consolidated services. The physicians take responsibility for excess costs attributable to them, no matter how unfavorable the reimbursement.

Path to success

GHS’ experience reflects issues in many hospital-owned IDS organizations. Hospitals that buy medical practices will increase odds for success if they:

- Embrace integration as an opportunity to expand access and improve community health care;
- Focus on creating long-term relationships between the IDS and physicians; and
- Understand that a dysfunctional IDS serves neither the hospital, the physicians nor patients and the community.

Physicians in acquired practices and their hospital employers must share a common vision and common goals to succeed financially and strategically.