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THE IMPACT OF PHYSICIAN PRACTICE ACQUISITION ON PRACTICE MANAGERS

ACMPE Paper, July 2013

This exploratory professional paper manuscript is submitted in partial fulfillment of the requirements for election to fellow status in the American College of Medical Practice Executives. The research methodology used for the paper included literature search, interviews and surveys of medical practice executives.

This manuscript was prepared as part of meeting various recognition criteria as set forth and may be changed from time to time by the American College of Medical Practice Executives (ACMPE). The experiences, though, ideas and opinions set forth are solely those of the author.

They do not reflect any position on part of the ACMPE with respect to their completeness, correctness or accuracy of the paper’s contents.
I. Introduction

The healthcare environment is undergoing significant change. One of the major changes is the number of physicians selling their practices to hospitals and becoming employed. The percentage of physicians who remain independent diminished on a monthly basis in 2012. (1) As a result, practice managers are often in the middle of the negotiations and are required to adapt to the new organizational model of the employing hospital. The role of the practice manager is changing, primarily due to additional financial and organizational pressures due to becoming part of a larger healthcare organization.

The purpose of this paper is to educate practice managers and administrators to identify the changes in managing a hospital-owned practice and to respond appropriately to the new culture. Administrators must acquire different and possibly new skills in order to meet new agendas set by hospitals and to allow a more efficient transition to hospital ownership. This paper will explore the various financial and organizational governance issues as described in the MGMA’s Body of Knowledge for Medical Practice Management and how administrators must adapt in order to survive. Much of the supporting documentation is based on interviews and results of the survey from practice managers.

II. Background of Physician Practice Integration

As physicians struggle with declining reimbursement, increasing labor costs, and slimmer margins, they are increasingly looking toward hospital employment as a strategy to remain financially viable in this current healthcare environment. The American Hospital Association’s data reflects the trend of physician employment increased 34% from 2000 to 2010. (2) The number of independent physicians represented 57% of all practicing physicians in 2000, but only 39% in 2012 according to Accenture. (3)

According to The Physicians Foundation, the top concerns facing physicians in seeking employment with hospitals include: (4)
• Business costs 87%
• Managed care pressures 61%
• Maintaining staffing 53%
• Electronic medical records and government regulations 53%

There are five key trends that point to the continuation of the trend: (5)

• Cuts in reimbursement
• Rise in uninsured population
• Reform challenges
• Practice expenses
• Work-life balance

These pressures in the healthcare environment are not only increasing, but increasing at a pace that makes it difficult for independent physicians to maintain financial stability. In addition, hospitals seek to employ physicians as a strategy to secure market share and service lines. Hospitals believe employed physicians will most likely refer patients to other affiliated physicians and the hospital for various services instead of allowing patients to select specialists and competitor services.

Hospitals benefit from physician employment to further their goals of:

• Enhancing their competitive position in local and regional markets;
• Generating revenues and patient volumes essential to maintaining the financial strength of the organization;
• Advancing improvements in clinical quality and patient safety efforts;
• Achieving synergies among academic, total health, and clinical program development activities that are fundamental to favorable outcomes in patient care, market position, and finances;
• Managing and controlling hospital and system resources; and
• Leveraging new models for healthcare delivery and health services management.

Rapid consolidation is partly the result of incentives for organizations to better coordinate care. This is a way to maintain control over processes that are known to keep patients out of high-cost areas of care and to better manage the health of the populations. (6)

Overall, physician integration with hospitals appears to be a win-win proposal from the onset. However, integrating physicians under one management umbrella can be a huge challenge. According to Steve Corso, Managing Director of Physician Engagement at Medsynergies, “It’s not the acquiring that is hard, it is the integrating.” (7) Physicians’ goals often conflict with those of the hospital, and practice managers are put in the position of reporting to new managers at the hospital as well as to the physicians that they have been loyal to in the past.

**Overall Impact of Integration on Physician Practices**

a. New Culture and Expectations

The culture in a physician practice is much different than that of a hospital. The differences focus primarily on the organizational structure of each. A physician practice decision making process is fundamentally different from that of a hospital or health system. Table 1 illustrates the differences in organizational structure between independent physician practices and hospital-owned practices.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Comparison of Organizational Structure: Private Physician Practice vs. Hospital-Owned Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure</td>
<td>Private Physician Practice</td>
</tr>
<tr>
<td>Decision Making Process</td>
<td>Made by individual or group of physicians; typically decisions made quickly</td>
</tr>
<tr>
<td>Management</td>
<td>Typically an office manager or practice administrator over a few staff</td>
</tr>
<tr>
<td>Culture</td>
<td>Individual, informal organization</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Staffing</td>
<td>Generally consists of a clinical person assigned to a physician and some administrative/clinical staff</td>
</tr>
</tbody>
</table>

Although the multilayered governance structure of a hospital allows for better monitoring of resources, it also consumes more time. Capital investments are generally part of a hospital’s annual expenditure budget. The need to run such decisions through a chain of hospital administrators and committees can tax the patience of physicians in a practice group that has just been acquired. In physician practices, a small group of key physicians often is responsible for making decisions regarding long and short-term strategy, capital investments, and compensation. This compact structure means decisions are made relatively quickly and are not subject to the compliance oversight and regulatory approval under which hospitals operate. (8)

Medical practice experts and consultants such as Steve Corso, Managing Director of Physician Engagement at MedSynergies believe that “chaos can result from a basic disconnect between the expectations of the hospital system and that of the physicians they are acquiring.” (9) This presents a problem when dealing with building a strong unified organization. Practice managers are at times torn between what the hospital wants from the physician and what the physician wants from the hospital. The practice manager acts as a middleman, trying to understand what the hospital wants and making it happen. (10)

Formerly independent physician practices likely have not had the infrastructure to apply the same rigor that is common with large health systems in controlling labor and non-labor spend, standardizing operating processes, streamlining work processes through technology, and managing by the numbers via decision support and business intelligence. Table 2 illustrates the differences in culture between physician practices and hospitals. (11)
<table>
<thead>
<tr>
<th>Attribute</th>
<th>Hospital Executives</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to organization</td>
<td>Employed</td>
<td>Voluntary medical staff member</td>
</tr>
<tr>
<td>Primary basis of knowledge</td>
<td>Behavioral, managerial, and social sciences</td>
<td>Biological and life sciences</td>
</tr>
<tr>
<td>Focus</td>
<td>All patients, the community</td>
<td>My patient, my practice</td>
</tr>
<tr>
<td>Time frame of action</td>
<td>Weeks or months, strategic plans, budget cycles</td>
<td>Short-run or immediate; the patient in front of me</td>
</tr>
<tr>
<td>View of resources</td>
<td>Always limited</td>
<td>Should be unlimited for my patient</td>
</tr>
<tr>
<td>Overall gestalt</td>
<td>Physicians exist to help meet the overall goals of the hospital</td>
<td>Hospital exists to help me care for my patients</td>
</tr>
</tbody>
</table>

Source: Cultural Differences Between Hospital Executives and Physicians, by Sharon Riley, FACHE, 2011

As a result of these differences, the culture of a physician practice is more likely to be less formal than a hospital. The culture in a hospital is oriented toward processes, whereas in a physician practice, the ultimate benefit is to the physicians or practice’s bottom line.

Organizational processes in hospitals focus on working together in groups and committees, but physicians usually work alone to deliver care to their patients in practices. As in the words of Marshall Baker, President/CEO of Physician Advisory Services, Inc., “while the changes are minimal to the physicians, they are HUGE for the rest of the staff and management. The loss of organizational autonomy is too often underestimated and the impact the loss will have on the group.......plus hospital politics.” (12)

b. New Roles and Responsibilities for Managers and Physicians

The agenda of physicians was to control the scope of independent, private practice with minimal barriers between themselves and their patients. The agenda of the increasingly rationalized “corporate” hospital, on the other hand, is to increase the efficiency of medical production in order to realize ever greater gains to the financial bottom line – the charity mission of voluntary nonprofit hospitals and the real desire to improve health outcomes notwithstanding.
When physician practices are acquired by hospitals, the one area that may be overlooked in the transition is that of the culture change.

According to the Summary of Integration Survey results conducted in April 2013, it is the consensus of the respondents that hospitals don’t really help practice managers to adapt to the new hospital system. Practice managers are typically left to their own skills to learn and to find the right people to contact to get the job done. In addition, hospital administrators tend not to appreciate what practice managers can bring to the practice or hospital to enhance the integration process. Practice managers are sometimes looked down on since they may not have the technical expertise or educational background of other healthcare workers or administrators. As a result, hospital administrators sometimes miss opportunities to learn about the physician and the practice.

There are differences in leadership, decision making and work styles between hospitals and physician practices. According to Suzette Jaskie, President of MedAxiom, “Traditional hospitals, for example, tend to be more hierarchical and ordered, whereas traditional physician practices tend to be more entrepreneurial with a less formal work style.” These differences cause a great deal of frustration for both organizations during the integration process and after. "This is a big hump to get over," said Ms. Jaskie. But organizations need to find a way to reconcile these differences to be able to move forward. Some of the attributes of the cultural change can be explained by comparisons:

- A physician might be willing to spend whatever it takes to help their patient. A hospital manager has to put the expenditure into a larger financial context of competing requests.

- A physician sees patients one at a time. A hospital manager is required to address the needs of multiple patients and meet community health needs. For physicians, reimbursement is a personal issue. For hospital managers, it is an organizational issue.
Physicians tend to detest meetings and organizational politics; they interfere with their practice. Hospital managers may schedule numerous meetings and “manage” the politics. It’s their model. Hospital managers know that if there isn’t a margin, there can’t be a mission. Many physicians operate in small groups with local ownership and control. They tend towards the anarchistic. Hospital managers operate in large organizations with diffuse control. They tend towards the bureaucratic. Physicians value autonomy and consensus – a guild model. Hospital managers emphasize tight business practices and administrative lines of communication – a corporate model. (17)

Practice managers need to understand that once a practice is purchased, the entity becomes part of the hospital’s organizational structure. The role of the manager will change based on the job description of the position and based on the expectations of hospital managers in similar roles. Employment by acquisition is a different channel, and there seems to be a real void on the hospital side when bringing in a practice that is used its own way of doing things. (18) Dea Robinson of Inpatient Medicine Service, PC stated that “the expectations from the hospital are never clear and can be a contributing factor to a manager’s success or failure.”

What qualities and competencies must the successful manager possess? These will vary based on the new role of the manager. According to Ms. Robinson, “the biggest weakness is understanding what they will NOT have to be doing, and where they can focus more resources to become more proficient.” (19) The competencies listed in the Body of Knowledge by the American College of Medical Practice Executives serve as a guideline. (20) The skill sets examined in this paper as they relate to practice managers under hospital employment include:

- **Human Resources:** Ensure compliance with hospital policies and procedures, and federal/state laws and regulations.
- **Organizational Governance:** Manage the intricate interrelationships of the organization, staff and stakeholders.
• **Financial Management**: Conduct financial benchmarking, including revenue, expenses, collection rates, productivity, A/R and profitability.

• **Patient Care Systems**: Enhance referrals in and out of the practice.

• **Quality Management**: Develop and oversee patient satisfaction and customer service programs.

III. **Operational Changes Due to Integration**

a. **Human Resources**: Ensure Compliance with Hospital Policies and Procedures, Federal/State Laws and Regulations

The Human Resources department of hospitals typically has standard policies and procedures that apply to all employees, regardless of the location or type of the department. Once a practice becomes part of the hospital, physician practice employees are under the hospital’s policies and benefits. The hospital may offer “grandfathering” of staff into the hospital’s benefit plan in order to provide an equal amount of vacation/sick time for employees based on their tenure. The prior practice’s policies may or may not be similar to the hospital’s policies and benefits. For example, the physicians in the free-standing practice may give two days’ paid time off (PTO) for Christmas, but the hospital’s policy states only one PTO day is allowed for the holiday. In addition, hospital PTO may be a combination of vacation, sick and holiday time, whereas the PTO time in the free-standing practice may be divided into vacation, sick and holidays, which all could be taken separately without affecting the total time off.

The purpose of explaining the differences in benefits and policies is to draw attention to the role of the practice manager, who is expected to enforce the hospital policies with the practice staff, physicians and ancillary personnel. The manager must now enforce the new policies and benefits as part of the new role and responsibility. This change might anger some staff, because historically the manager might have bent the rules for certain staff. The new rules cannot be bent or else the manager will be responsible for any negative outcomes as a result. The manager is on
the line with his/her supervisor or the Human Resources department when it comes down to enforcing the hospital policies and procedures.

b. Potential Transition to New Billing System

Another area that will affect the practice manager during the transition is the potential change to a different billing or EMR system that the hospital may already have in place for existing practices. The current practice manager may have played an important role in selecting the current billing or EMR system and may not approve of the hospital’s system. Regardless of the manager’s attitudes towards the hospital’s system, it will be the manager’s responsibility to assist in the transition from the current system to the hospital’s system. The manager is in a position where it is imperative to be able to work with his/her supervisor, the IT department and computer billing vendor to convert to the new billing system. Conversions are time and labor intensive projects which require project management skills that the manager may or may not have. In addition, the manager must be able to seamlessly move the practice staff onto the new system within a time and cost budget set by the hospital.

According results of the Summary of Integration Survey results, some managers have not been involved in computer conversions, and this project may tax the manager’s ability to manage the practice’s operations while converting the computer billing system. The manager may not have been involved in the selection process but is nonetheless in a position to support a major change to the practice and must move the practice to the desired goal. (21)

c. Ancillary Services Transitioned to Hospital

Many practices are surviving reimbursement cuts by performing various ancillary services in the office. A sample of such services may include radiology, MRI, physical therapy, durable medical equipment, ultrasound, and lab tests. The physicians may have received a large amount of their compensation from these in-house tests. However, once employed by a hospital, the physician’s compensation is primarily based on professional services performed in the office or hospital, and most likely will not include the technical portion of the procedure. Therefore, it
is in the best financial interest of the hospital to move the ancillary tests from the practice’s office to the hospital, where the reimbursement for the technical portion will most likely be higher than that of an office-performed procedure. (22)

The manager’s new role in a hospital-owned practice is to enable the physicians to perform as many of the ancillary procedures at the hospital instead of the office. A thorough financial analysis should be performed to determine if the ancillary service should be performed in the hospital or in the practice to accommodate patients and increase their satisfaction level. However, if the decision is made to move some of the procedures to the hospital, the manager is in a position to convey the reasons to the staff as well as to patients who will be affected by the changes. Again, the manager may not have had a chance to provide input into the decision, but it is up to the manager to implement such changes. The manager must put procedures in place to accommodate transferring the ancillary services to the hospital, although it may not be a positive change for the practice.

d. Expense Control

Labor expense comprises a large percentage of practice’s overall expenses - - approximately 25-30% of total expenses. (23) Other expenses, such as supplies, outside services such as copier or equipment maintenance, and malpractice insurance premiums may also represent a large portion of the total expenses, depending on the practice. The transition from free-standing to hospital-owned practice will entail reducing some of those costs to improve the practice’s profitability. Many times, the practice must cut its long-term ties with suppliers and outside services in order to adopt the hospital’s suppliers and service agreements. (24) Once again, switching suppliers may not necessarily be in the best interest of the practice manager or staff, but adopting the suppliers from the hospital may be necessary in order to obtain better pricing. The level of service of the vendor may be less than satisfactory, but the impetus is on moving all departments to use specific suppliers and vendors. The practice manager is in a
position of directing staff to use different suppliers and services and ensuring that all supply changes occur.

In addition to converting to potentially different suppliers and service contracts, the practice manager has the responsibility of overseeing the expense budget for the practice and ensuring the practice adheres to the budget. This responsibility may not have been the manager’s in the past, but hospital administration will expect the manager to manage the expenses, just as do managers in other hospital departments. If the manager’s financial skills are not good, the manager will need to improve these skills in order to meet expectations.

IV. Changes to the Manager’s Roles and Responsibilities

The aforementioned areas are just some of the changes that managers must learn to adopt in order to be successful. The key determining factor is whether the manager has the interpersonal, financial and operational skills to meet the criteria and expectations of the new role. Based on responses from a survey sent to MGMA members who experienced the transition of a private practice to a hospital-owned practice, the following areas have the greatest impact on a manager’s role in a practice after purchase.

a. Changes in Billing Services

The core area of any practice is in the billing services, whether performed in-house or outsourced. Many times, when a practice is purchased, the billing system must change to that of the hospital’s current billing system for hospital-owned practices. A conversion from the practice’s current system to the hospital’s billing system will be required in order to maintain a uniform system for all hospital-owned practices. The practice will likely maintain its existing system in order to run out the accounts receivable of the physician’s practice prior to purchase.

Several survey responses indicated that the responsibility for the billing and managed care contracting was transferred from the practice to the corporate office. (25) A manager’s ability to control certain billing functions is reduced if the core responsibility falls under the
A practice manager’s role may change to include the conversion project from the current system to the desired system. The practice manager’s roles are changing to include roles that were not previously present, while excluding roles that the manager may have had. A computer conversion may be a project that the practice manager may not have had experience with, and it is very time consuming, especially when added to daily operational tasks. In addition, the new billing system may not necessarily be one that the practice manager may know or like. But it is the responsibility of the manager to convert to the new system within a specific time frame. (26)

b. Changes in Span of Control over Staff, Physicians and Other Providers

In many practices, the practice manager has line responsibility over all staff and ancillary providers such as mid-levels, therapists, and audiologists. The physicians have the ultimate authority over all staff, but the manager has the operational responsibility over staffing issues. Human resources administration lies in the hands of the practice manager, and the manager enforces the policies of the practice that were developed by the physician(s). The physician owner(s) create the policies, the benefits, hours of work and all aspects of staffing.

In a hospital-owned practice, a manager has responsibility to enforce the hospital’s policies and benefits. The ultimate authority of the staffing is with the Human Resources Department of the hospital or corporation. No longer can the manager accept the physician’s direction in terms of disciplining staff or favoring one person over another. All human resources policies must be enforced uniformly by the manager regardless of the manager’s opinion toward them. The manager may find the policies to be too autocratic or too stringent. If the policies of the new corporation are not enforced, staff will have a different avenue to pursue to ensure their rights are maintained. The Human Resources department of the new corporation, and not the physicians, will become the interpreter of policies and the judge of staff issues. If a staff person sees favoritism in the workplace, the person may notify the Human Resources department, who will investigate and make a decision on the actions of the physicians and manager. Under
hospital ownership, the Human Resources department will ensure compliance with employment laws and ensure an equitable workplace.

One of the major findings in the survey results relates to the transition of the human resources management aspect from the practice manager to the corporate entity. Managers have expressed that their responsibility for daily human resources management has not changed at the primary location, but functions such as payroll, benefits, policies and procedures have shifted to the corporate entity. The implementation or enforcement of the corporate policies and procedures remains with the practice manager at the physician practice site.

In the Body of Knowledge of Medical Practice Management, one of the tenets is effective human resource management. All practices should have systems and processes in place for the awareness, education and compliance with employment laws and regulatory standards. Ensuring compliance with employment laws such as the Fair Labor Standards Act (FSLA), Americans with Disabilities Act (ADA), Family and Medical Leave Act, and Equal Employment Opportunity Commission (EEOC) are required and necessary to create a workplace that is free of discrimination and also provides equitable treatment of staff. Hospitals pay particular attention to these laws since one complaint may bring a federal investigation for an entire organization that may employ thousands of people. Significant fines and penalties may be imposed due to a lack of adherence to federal and state laws. As a result, hospital-owned practices fall under scrutiny that may trigger audits or inspections.

c. Change in Responsibility over Accounts Payable

The practice manager in a typical physician practice may be responsible for the accounts payable function, or it may fall to the outside accounting firm who prepares tax returns and files quarterly tax reports for the physician owners. Typically, if the practice manager is responsible for the payables, invoices are paid on a regular basis. Contracts may or may not exist to support invoices, and the process of obtaining quotes for specific work may or may not be performed. According to the Body of Knowledge of Medical Practice Management, under
Financial Management, there should be internal controls for cash management, check signing and payables. (29)

Under a hospital-owned entity, the payables process is more complicated and requires adherence to a different set of policies and procedures. In a hospital-owned entity, managers are expected to comply with providing all required documentation to support all expenses, and the payable is subject to scrutiny by accounting staff at the corporate or home office. One of the accounts payable areas that affect practice managers is the ability to purchase supplies and services from any willing vendor - - even from relatives of the physicians or manager. In the corporate hospital arena, there are policies that require an “arms-length” relationship with the vendors. One hospital system, Tenet Healthcare, requires its practices to purchase supplies and services only from a list of approved vendors. When purchasing capital equipment, it is necessary to obtain three quotes and complete numerous forms that require signatures from administrative managers including purchasing, directors, vice presidents and president of the local hospital. In addition, when contracting with vendors and renewing contracts, it is necessary to have the vendor complete a W-9 and a Stark form stating that the vendor will “comply with federal law concerning financial arrangements between physicians and entities that provide certain health care services.” This process ensures Tenet that the vendor will disclose any relationships with physicians prior to contracting with the hospital. (30)

Managers are under the microscope when it comes to approving staff time, paid time off, and overtime. The hospital entity requires managers to maintain a very low amount of overtime regardless of the hardships it may create for the practice, especially when overtime in some staff may occur as a result of a physician’s clinic running longer than expected, or as a result of other staff taking time off due to paid time off. The amount of paid time off and the process of obtaining it require managers to more effectively manage their staffing since there is very little flexibility in the rules.
d. Additional Responsibilities for Safety and Accreditation Standards

Many physician practices are not required to comply with certain safety or accreditation standards unless the practice voluntarily joins the JCAHO or AAAHC. However, if a practice is on the campus of a hospital, there may be additional requirements that the practice must adhere to as a result of its affiliation with the hospital entity. In some circumstances, hospital owned practices may have to comply with JCAHO standards, which may place more burdens on the manager to train the practice’s clinical and clerical staff to meet these standards. Some examples of these standards include disposing of expired medications, ensuring medical assistants are not performing tasks that are out of their scope of practice, training staff on specific emergency preparedness policies and procedures, and ensuring that no patient identifiable material is present in hallways or desks where patients may have access. The JCAHO surveys hospitals and their practices every three years, so the practice manager and staff will need to prepare the practice for such visits.

e. Staff Performance Reviews

“Effective governance is essential to a successful medical practice.” (31) This is quoted under the “Organizational Governance” section of the Body of Knowledge for Medical Practice Management and is the new tenet for managers who experienced the transition from private practice to hospital ownership. It is the responsibility of the manager to “lead the integration of the corporate mission statement into all aspects of the organization’s culture.” This is even more evident in a hospital-owned practice, where the corporate entity requires the front line directors to provide leadership and uphold and advocate ethical standards, behavior and decision-making. This directive is even more important when performing staff reviews and approving salary increases.

Managers in many physician practices may be responsible for reviewing staff in terms of their performance and salary increases. Many times physicians are involved in the process, and at times, physicians actually drive the review process. This process may change when a practice
becomes hospital owned. This process becomes more formal and rigid since there are formal position descriptions and salary adjustment levels. Increases in staff salaries may be based on a point system incorporating organizational cultural attributes. An example of such a performance review is included. (Exhibit 2, Source: Tenet Healthcare)

f. Responsibility of Staffing Levels and Costs

Practice managers are responsible for managing costs - especially staffing salaries and benefits. However, under hospital ownership, this responsibility is more important since staffing is a very closely monitored cost and driver of overall costs of an entity. Hospital-owned practices typically have a staffing model for each practice type: Family Practice, OB/GYN, Cardiology, etc. Any additional staffing or changes in staffing must go through a level of approvals, from Director to Vice President and possibly President of the hospital. If a physician wants to add staffing, many hospitals require supporting documentation to show reason for the additional staffing, the costs, and the additional revenue associated with the additional staffing. (Exhibit 3, Source: Tenet Healthcare) A practice manager would need to obtain all the information necessary to complete the request and provide enough supporting documentation to pass approval. This type of approval process may not exist in a private practice, especially if a physician wants another staff person hired for his/her services. Many times physicians will forego some compensation if a specific service or procedure is desired. In a hospital-owned entity, the corporate office makes the final decision.

g. Additional Hospital Meetings

One of the characteristics of managing a hospital is the number of committees and meetings that managers must attend. These meetings range from clinical (nursing, physician medical staff, cardiology services) to administrative (materials management, emergency preparedness, disaster committee). Practice managers may be requested to sit on a committee or even several committees, depending on the practice specialty or whether the hospital administration requires representation from the hospital-owned practices. According to Marshall
Baker, President/CEO of Physician Advisory Services, Inc., “the issue typically falls with the great change the group administrator experiences with his/her inclusion now in numerous hospital meetings and other service line responsibilities (task forces, rounding, operating council meetings, etc.); leaving his/her day full, only to return to the office about 5pm and discover all the issues that need attention in the group, plus a full in-basket!” (32)

The committee membership need not be related to hospital specific areas. At Tenet, practice managers attend onboarding conference calls with administrative staff from the home office, the credentialing company and the outsourced billing company. Altogether, practice managers may spend at least an additional five to eight hours a week attending conference calls that they otherwise would not need to attend in a private practice. (33)

Overall, practice managers become part of the hospital system. As a result, they are expected to attend hospital meetings and become part of committees to improve the communication between hospital and practice staff.

According to the managers’ responses to the survey, they had to think more broadly, less about one location and more about multiple locations and new providers. As in the words of one respondent, “No longer did the manager have the authority to make on-the-spot decisions, as corporate policies required intervention of a corporate department before action could be taken.” (34) Additionally, the same respondent indicated that “attending corporate meetings, getting corporate directives and implementing them were different than being involved with the providers in making decisions for the practice.” Hospital administrators and managers have a different perspective than physicians, and they differ in how they make decisions. Hospital managers make decisions as a group, or in a committee. Physicians typically do not. Practice managers have to change their way of getting things done when part of a hospital entity.
V. Strategies and Tactics to Preserve Financial Viability of the Practice under New Ownership

The financial management in a medical group requires skills in several areas, including accounting, budgeting, revenue cycle management and financial analysis. (35) Financial management is even more important for a practice under hospital ownership since many practices lose money in the first several years of ownership. Statistics from the MGMA Cost and Production Survey illustrate losses average over $100,000/year for some medical specialty practices. (36) Therefore, the practice manager of a hospital-owned practice becomes a key variable in the financial success of the practice. Hospital administration relies on the practice manager to develop an accurate budget, to effectively manage the revenue cycle process and maintain low accounts receivable, and to analyze the revenues and expenses on the income statement to identify areas that need improvement.

a. Changes to Financial and Billing Policies

The Body of Knowledge for Medical Practice Management published by the MGMA includes many financial systems that a manager should develop and maintain to ensure a profitable practice. These areas include budgeting, internal controls for cash management, processes for external financial audits, revenue cycle management, analyzing financial performance and reporting financial results to stakeholders, and developing relationships with individual insurance carriers to optimize contract negotiations. (37) Although a practice manager is responsible for most of these areas in a private practice, these areas may be put under a microscope by a hospital system in order to maximize revenues and the return on their investment.

According to Jeff Rydburg of HCA, the more successful practice managers are those that have received more formal training in financial areas. (38) Many managers are not academically
trained, through a college or university. These managers struggle more because they do not have a basis upon which to build additional financial information.

Hospitals that purchase practices must provide due diligence to government agencies, comply with many federal regulations, state and county agencies, and if the hospital is for-profit, report financial gains/losses to the stockholders of the company. Practice losses may illustrate that hospitals purchase practices just for the referrals, and the practice may not be able to sustain itself under a private practice setting. “In the case of overpayments, it becomes a compliance issue because CMS and the OIG may get the impression that the hospital is essentially buying referrals.” (39) Therefore, more emphasis is placed on the profitability of a practice under hospital ownership than under a private practice environment.

As a result of these external pressures, practice managers must adopt and comply with the hospital’s financial and billing policies. These policies may differ from those in the private practice, but the manager must communicate and support these policies to the staff and physicians. This may mean not allowing physicians to provide free care to their friends or business acquaintances by reminding the provider of the new policy. This may also mean that staff may not be able to see their physician and waive a copay or deductible. In addition, hospital policy may dictate sending patients to a collection agency within a specific period of time, but in a private practice setting, a physician may have accepted monthly payments of $5.00 or write off the account. The manager must comply with new rules for billing and ensure all parties, staff and providers, are adhering to the policy.

b. Charity Care Policy Changes

Most hospitals have charity care policies that allow for writing off balances for patients with a low income, typically one that does not exceed 200% or 250% of IRS poverty guidelines. (40) Although many practices may have similar policies, the charity care policy for the hospital owned practices may be different from that of the hospital due to the typical balance of a patient for provider’s services. Hospital bills may be as much as $100,000, but most providers’ bills are
substantially less, typically from $200 to $1,500. Therefore, applying a hospital policy to practice
balances may not be practical. In addition, how the hospital-owned practice is established (for-
profit versus non-profit) will determine the charity care policy. Some hospitals may not have a
policy for charity care in a practice since the total balance is less than that of a hospital. Other
hospitals may have a charity care policy only if the total balance exceeds a certain monetary limit.
In any case, the practice manager must again adopt and enforce the charity care policy to all
patients without showing favoritism and provide the necessary documentation required to enable
a patient to apply for and obtain charity care.

c. Operating Budgets and Monitoring Expenses

Operating budgets in private practices are a necessary financial tool to enable the
physician owners to predict future cash flows. Operating budgets in hospital-owned practices are
also a necessary financial tool to enable the hospital to predict future revenues and expenses.
However, there is a stark difference between budgeting in private practices and hospitals or
hospital-owned practices. The difference is between accrual and cash accounting. The majority
of private practices use cash-based accounting, where only revenues and expenses actually
incurred or paid is recorded on a financial statement. Expenses such as malpractice or
insurance premiums are recorded in the month the practice actually pays the premium. Capital
expenses may or may not be depreciated over time, so the financial statements may or may not
include depreciation expense to account for capital equipment expenses to the practice.

In hospitals, and also in hospital-owned practices, the accrual method of accounting is
used. This method records revenues and expenses as they are incurred, and not when they are
paid. So in terms of revenues, gross revenues are the charges billed every month. Net revenues
do not represent cash actually received from third-party payors or patients, but rather, are
estimated based on contractual allowances expected from third-party payors. Reserves, based on
specific hospital policy, are made on the amount of the contractual allowances and patient bad
debt to record each month. (42) As a result, the net revenues are not necessarily equivalent to actual cash received.

The same method of accounting is applied to expenses. Accrual accounting records expenses as they are incurred and in the month when the invoice is received, not necessarily when the invoice is paid. A financial statement, therefore, will include “non-cash” items such as accounts payable (invoices received but not paid) and depreciation (expensing capital equipment expenditures). Expenses such as insurance premiums are expensed each month since the expense is related to the revenue generated each month.

Overall, a practice manager must understand these differences in order to understand the financial statements and prepare accurate budgets. Practice managers may not have the background or education to understand the differences and therefore may not be able to develop budgets in a timely manner as required by the hospital. It is the responsibility of the manager to monitor actual expenses to budget, but if the manager does not understand the accounting nuances, the manager may not be able to perform this essential responsibility. In addition, it would be difficult for a manager to ensure budget goals are met if the manager’s accounting and financial skills are not adequate.

The opposite perspective is also true. Hospital administration does not understand how physician practices work or the differences between the cultures in a practice compared to that in a hospital. One survey respondent wrote, “The corporate system did not understand private practice,” which led to more difficulties for the practice manager in communicating why certain policies could not be implemented in a practice. (43) Physician practices typically act quickly since the decision-making process is limited to the physician owners, whereas hospitals tend to move slower and with more involvement from administrators, managers and others to make decisions. As a result, the long process and the time it takes for managers to comply with certain financial policies can be arduous.
d. Optimizing Revenues/Revenue Cycle Management

The key to driving practice revenue is physician productivity. Most organizations enter into the acquisition to boost revenue – not only the hospital revenue that is generated through referrals, but also the revenue that physician practices generate. (44) Sometimes there is an urge to change all physician billing processes immediately after an acquisition, but such an approach is bound to disrupt the core production of physicians. So hospitals should look to protect that existing book of business and maintain that revenue stream. (45)

The revenue cycle process in hospitals differs substantially from the process in a physician practice. Hospitals deal with larger balances for each patient and also have different payment methods - such as DRGs, APCs, and carve-outs - from insurance payors. Physician practices typically have lower balances per patient or per encounter but many more charges, and they only deal with one type of reimbursement - primarily fee-for-service. As a result, the revenue cycle processes to optimize revenue are different as well.

Although the billing and collections process will remain the same after an acquisition, the responsibility of the billing may change. For example, collecting copays at check-in is highly recommended. However, the hospital may require a percentage that the manager must achieve, such as 90% of all commercial patients. In addition, maintaining proper medical record documentation is a key and vital area of physician offices. Electronic Medical Records (EMR) have been repudiated as the reason for higher than normal reimbursement from Medicare and commercial payors, as well as being responsible for cloning notes to enhance office visit coding. (46) As part of a hospital entity, the practice may pose a greater risk of liability for the hospital if an audit were performed and CMS (Centers for Medicare and Medicaid Services) found documented cause for a refund based on inaccurate or incomplete documentation in the EMR. The manager needs to stay abreast of CMS and OIG (Office of Inspector General) rulings and ensure the physicians in the practice are completing medical record documentation appropriately. Physicians may be targets of RAC (Recovery Audit Contractors) and OIG audits
regardless of the type of practice setting - - private practice versus hospital-owned - - but the implications and results of audits have significant impact on the entity, such as a hospital that owns the practice versus a physician-owned practice. A manager has to be more cautious and alert in a hospital-owned entity than in a physician-owned practice.

Practice managers must also be aware of billing services with the correct place of service. Identifying the correct place of service for hospital related services is paramount since reimbursement by Medicare and commercial plans is dictated by the place of service. A physician billing from a hospital location may not have overhead expenses associated with this location, resulting in lower reimbursement from Medicare. However, if the physician were to bill the service as though the service were provided in an office, the reimbursement would be higher, but subject to refund and potentially to fines and penalties if substantial evidence were available to demonstrate that fraud occurred. Managers of hospital-owned practices are exposed to more risk if they do not know the billing requirements and closely monitor the billing process.

e. External Audits/Compliance

Practice managers typically are not exposed to external audits required by outside entities when managing a private physician-owned practice. There may be IRS audits, but managers do not face the audits that hospitals must comply with on a routine basis. Many hospitals must comply with SOX (Sarbanes-Oxley Act) mandates that specify there are policies and procedures in place for the proper approval of employee’s time, all asset sales are approved by administration in advance, final time sheets are approved by the respective department director, and that charges submitted are reconciled to charges processed every day. In addition, vendor-paid services and supplies offered to employees endanger the tax status of non-profit hospitals. All gifts to physicians must be pre-approved by administration, who in turn tracks non-monetary compensation. (47) Audits are performed on an annual basis to test the accuracy of transactions and ensure that arms-length controls are in place. Managers must learn these new procedures and
the regulations behind the procedures and ensure that practice staff and physicians are complying with such regulations. (Exhibit 4, Source: Tenet Healthcare)

In addition to the financial and external audits, there are audits performed to ensure compliance with HIPAA Privacy and Security regulations in the practice. Practice managers in a hospital-owned entity now have the responsibility of ensuring the practice complies with rules and procedures associated with compliance that goes beyond that of a private physician practice. Managers must attest and certify that specific controls are in place. (48) This places more responsibility and pressure on managers to do the right thing or suffer severe financial and regulatory consequences.

f. Fee Schedules

The backbone of the physician practice revenue cycle is the fee schedule. Practices set fees based on market rates, which are obtained by way of informal means or through formal methods such as fee analyzers sold by various practice management firms. The fee schedules can be based on a multiple of the Medicare fee schedule or based on a multiple of the fees from the most prevalent payor in the geographic area. However, the majority of the time, fees are set for years before any major changes are made.

In a hospital-ownership environment, fee schedules for physician practices must be used for all types of practices owned by the hospital. The fee schedule may be set on a multiple of the Medicare fee schedule and updated annually. However, the fees are set for all practices, regardless of the type of specialty. Office visit fees for primary care practices tend to be lower than those for surgical or sub-specialty practices. However, when a new practice is acquired, the new practice must conform to the established fee schedule regardless of how much the pre-established fee schedule may differ from the fees of the newly acquired practice.

The role of the practice manager is to educate the physicians and staff on the new fee schedule and enforce the collection of such fees from self-pay patients, no matter how high the
fees may appear to the manager. In addition, the fee structure may affect the physician’s compensation, depending on the structure of the compensation formula.

g. Maintaining Productivity Levels

Practice managers in a hospital-owned practice must adopt new roles, and one such role is to assist hospital administration in achieving and maintaining the productivity of its physicians and other providers. Under Organizational Governance in The Body of Knowledge for Medical Practice Management, the fifth major objective is to “Establish and monitor production and compensation standards for physician and mid-levels.” (49) In addition, the Body of Knowledge element further states a practice manager should understand the components of an effective compensation system, including practice and physician goals. Typically, practice managers may monitor the physician production and compensation, but peers can put pressure on physicians in a group to increase or maintain a certain level for the profitability of the practice. Practice managers typically do not prompt physicians in a private practice to increase or maintain production. Practice managers primarily report production and compensation levels to the physician owners.

In a hospital-owned entity, practice managers play a crucial part not only in communicating the monthly production and compensation levels to physicians, but also in urging physicians to either increase production or maintain a high level. Practice managers serve as an arm of the hospital administration to assist in enhancing the profitability of the practice. According to an article by Zirmed, hospital revenue is largely dependent upon physician referrals, making physician alignment or ownership vital to profitability. (50) Hospital administrators set compensation arrangements with employed physicians based on certain production levels. If those production levels are not met, the practice may lose money. Administrators put pressure on practice managers to find ways to maintain specific levels of production to avoid losses.

This role is probably the most uncomfortable position of all - to monitor physician production and to identify ways to either increase it or maintain it. This may mean approaching
physicians with whom the manager has worked for years and requesting changes to their practice. One practice manager, Kathy Fitzpatrick of Cape Care for Women, stated that “it is difficult to approach physicians who were once your bosses.” (51) These types of confrontations are difficult for a manager, especially one that has taken orders and direction from the physicians.

h. Monitoring Physician Referrals

One of the goals of hospital-owned physician practices is to enhance the referrals from primary care practices to specialty practices in order to sustain procedures performed at the hospital. Regardless of the type of hospital - -for-profit or non-profit - - monitoring referral patterns is a key duty of a practice manager.

According to the Body of Knowledge for Medical Practice Management, a critical component is the effective process surrounding the patient encounter. (52) One of the methods to develop and maintain efficient operations is the ability to implement a referral management process. It is necessary for medical and surgical specialty practices to monitor the source of new patients referred to a practice. Referrals are the lifeblood of specialty practices, and the manager should know where the referrals originate in order to maintain a busy and effective practice.

The difference between a practice manager in private practice and a manager for a hospital-owned practice is that referrals between physicians should enhance the physicians employed or affiliated with the hospital that owns practices. In an organization such as Saint Francis Medical Partners, there are many primary care and specialty physicians employed by the organization. Primary care physicians are encouraged to refer patients for specialty care to the physicians in the same organization. According to the Integration Survey Results, referring physician reports are typically reviewed monthly and the results are reported to administration and to the physicians. Any patients referred outside of the employed physician network are scrutinized by administration and an explanation is required. (53) Explanations such as “patient preference” or “physician specialist was not available” are valid reasons.
Physician practices under the umbrella of a hospital entity are highly encouraged to keep referrals within the system. Practice managers are a key component in urging physicians to refer patients to physicians in the network. Managers have an additional responsibility of monitoring referral patterns and taking action when patients are referred outside the network.

i. Performing Procedures at the Hospital’s Organization

The logic regarding monitoring and tracking referrals can be applied to enabling procedures to be performed at the hospital that employs physicians. Surgical and medical specialty physicians are encouraged to perform procedures at the hospital that employs the physicians. Although hospitals are legally prevented from forcing physicians to perform procedures at their institutions, hospital administrators can encourage the use of their facilities for performing procedures. Practice managers play a key role in this management function also. Managers monitor the location where physicians perform their procedures as well as prepare management reports illustrating the locations where physicians perform their procedures. Hospital administrators review the reports to determine if the employed physicians are utilizing their facility on a regular basis.

Practice managers in a private independent practice are not put under this pressure to monitor and report the locations where physicians perform their procedures. Physicians are typically encouraged to perform procedures at hospitals that cater to their surgical schedule, provide slots for surgeons at convenient times, or where physicians have a financial investment in an outpatient facility, such as an ambulatory surgical center. Overall, physicians, and not their office managers, typically determine where they will perform surgical procedures.

Hospital-owned practices are encouraged to use their facilities in order to provide services with a return on investment. Hospital administrators can encourage physicians and the managers to utilize their facilities, but they cannot force physicians to use their facilities. As a result, the manager must monitor the performance of procedures at the hospital and report to administration when physicians do not use their facility. It is a difficult position for managers to
be in when, once again, the managers are urging the physicians to change their behavior in the new paradigm.

VI. CONCLUSION

Physician practice managers are many times not ready for the changes that will impact their roles and responsibilities when a practice is purchased by a hospital. Managers are not aware of the differences in the culture between hospitals and physician practices, or of the differences in financial or compliance areas. Practice managers who are not exposed to hospital operations may not be able to adapt to the changes in their role and responsibilities. This paper has focused on those areas that may pose obstacles to practice managers who may not possess good financial or interpersonal skills.

It is advisable for practice managers to anticipate these changes and to prepare themselves for the changes or face possible termination. The responsibilities are greater and have far-reaching consequences for practice managers since the risks and rewards are greater in a hospital system. Hospital administration’s expectations are higher for a manager over a hospital-owned practice. Practice managers must rise to the occasion and accept the new culture with its new responsibilities. As Marshall Baker said, “it's very different and without the right preparation, runway, expectation setting/understanding we find many cannot adjust and have a short employment history as a hospital employee!” (54)
FOOTNOTES


5. 5 Factors Spurring Physician Employment, Ben Ulrich, AVA, Health Value Insights, 2012, Issue 14, VMG Health

6. Physician Integration Failures are Avoidable, Philip Betbeze for Healthleaders Media, July 12, 2013

7. Physician Integration Failures are Avoidable, Philip Betbeze for Healthleaders Media, July 12, 2013

8. “Physician Acquisition: What to Avoid after the Deal is Complete”, by Mark Driscoll and Anthony Long, HFM Journal, April 2011

9. Physician Integration Failures are Avoidable, Philip Betbeze for Healthleaders Media, July 12, 2013

10. Interview with Jeff Rydburg, CMPE, Vice President, HCA Physician Services


12. Marshall Baker, President/CEO of Physician Advisory Services, Inc.

13. “Can this marriage be saved?”, Arizona Health Futures, December 2005

14. Summary of Integration Survey results, April 2013

15. Interview with Jeff Rydburg, CMPE, Vice President, HCA Physician Services
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<td>Interview with Rod Miller, Vice President of Ambulatory Services, SSM Healthcare, June 2013</td>
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<td>Bill Garden, Principal Partner, MedicalSuite Consulting and Technologies, LLC</td>
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40. Charity Care Policy, Tenet Healthcare
41. MGMA Cost Survey, 2011
42. Reserve Policy, Tenet Healthcare
43. Summary of Integration Survey results, 2013
46. Summary of Integration Survey Results, 2013
47. Sarbanes-Oxley Report, Tenet Healthcare
48. Sarbanes-Oxley Report, Tenet Healthcare
49. MGMA Body of Knowledge, 2012, Organizational Governance
51. Kathy Fitzpatrick, Office Manager for Cape Care for Women, 2011
52. MGMA Body of Knowledge, 2012, Organizational Governance
53. Summary of Integration Survey results, 2013
54. Marshall Baker, President/CEO of Physician Advisory Services, Inc.
EXHIBIT 1

SUMMARY OF INTEGRATION SURVEY

Questions: Have your responsibilities as manager changed since the transition?
Response: Yes.
Managers have been let go as a result of acquisitions.
My responsibilities have increased, from finance to budgeting.
Assumed more management of all practices owned by health system.

Question: Do you think the transition went well? If not, please describe.
Response: Yes, it went very well due to the time and effort put into the structuring of the documents which reflected in detail how the practice would function post acquisition.
No, the hospital always plays heavy handed and rolls over anyone that gets in the way.
Yes, because the hospital had a great transition team. Without it, I doubt it would have gone very well.

Question: List the areas in your span of authority that have changed as a result of acquisition.
Responses: I served as the director of the site that was sold.
My position was eliminated within 4 months of the sale.
My authority has increased in financing and budgeting, but is less in human resources.
My authority increased in terms of the number of practices. No longer am I responsible for human resources, except at primary site. Billing and contracting moved to corporate responsibility.

Question: What areas are you responsible for now after the acquisition that you were not prior to the acquisition?
Responses: Multiple sites.
Finance and budgeting.

The same areas.

Question: Were there areas in which you feel you need additional training after the acquisition?

Responses: It was learning what corporate handled versus what my duties were, and what the corporate policies and procedures were both for the areas handled by them as well as those for which I was responsible. Mostly needed to learn what corporate policies were.

I understood what my responsibilities were post-acquisition, I did not have a problem.

I had to learn more finance and budgeting since the managers were responsible for explaining all the variances between actual expenses and budget expenses on a monthly basis.

Question: Do you think you were well prepared for the transition?

Responses: Yes, because of past experiences and working through the transition.

Yes, the practice was well prepared due to the transition team and leadership.

Yes, the practice was well prepared, but my position was eliminated four months after the acquisition. So the transition did not go as well as I expected.

Question: Do you have more or less responsibility over the major areas of practice administration?

Responses: I have more responsibility over the financial aspects, including budgeting and explaining variances for administration.

I have more responsibility over every expense, no matter the amount. The hospital expects the actual expenses to be equal to or less than the budget.

Human resources: about 80% of this transitioned to the corporate environment.

Billing: still done at the practice.

Policies and procedures: some changed to the corporate structure.
Finance: the monthly financials are merged into the hospital’s system. It is more arduous now, and more time consuming because the hospital did not understand private practice finances.

Operations: about 60% remained the same.

Compliance: about 90% changed to the hospital’s system since they had the ultimate exposure for the practice.

Question: State the top three issues or concerns you encountered during the transition:

Responses: Trustworthiness in hospital leadership. Hospital will do everything they can to get their way and regardless of what they say, it is subject to change at any time and not necessarily for the best.

Bureaucracy of the hospital system.

Transient nature of hospital administrators.

Human resources: cannot address HR issues readily, had to fill out forms and get others from corporate involved to resolve issues. Staff knew to go over the head of the manager.

Human resources: lack of policies and procedures to address staff issues.

Trust: who do you trust, and would commitments made prior to the sale would be honored.

Communication: getting information on a timely basis from the hospital. There were many more corporate meetings for administrators, managers and staff. The time taken away from the work place disrupted the practice work-flow and included people who should not have been there.

Provider acceptance of corporate policies and procedures: most were not willing to follow them.

Provider motivation: providers thought they could work 9-5 instead of maintaining the schedule they had in private practice.
EXHIBIT 3

Request for Personnel Justification of Position

Region: ________________________________

Date of Request: ___________________________ Date Needed: ___________________________

Practice Name: ___________________________ Position: ___________________________

Location: ________________________________

Replacement/ Addition for (complete as needed): ________________________________

This Request is for: □ A New Position □ A Re-evaluation of Position
□ A Budgeted Position □ The Deletion of a Position
□ A Title Change □ Other:

This Position is: □ Regular □ Full-Time □ Summer
□ Temporary □ Part-Time □ Other:
□ Non-Exempt □ Exempt □ Days □ Evenings □ Nights
□ Rotating □ Shifts

Attach Additional Sheets As Needed (Supporting Statistics, Etc.)

A Questions 1-5 for requests for additional personnel only.

1) Why is this position necessary?

________________________________________________________________________________

2) What statistics support this request? (Include year-to-date and monthly statistics, responsibility reports, or other data if applicable.)

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

3) What staffing alternatives were considered? Were these feasible?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

4) What Financial Impact would this position have?

New Revenue Generated $ ________________

Salary Expense - ____________________

Fringe Benefit Expense - ____________________

Other Expense - ____________________

Net Revenue Generated $ ________________
5) Has the forecast been updated to include this position?  □ Yes  □ No
   If “No”, please explain below:
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

B For all personnel requests.

1) Department Contact: ____________________________  Contact Telephone: ____________

2) Qualifications of this job:
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

3) Duties:
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

4) Refer Applicant for Interviews To:
   __________________________________________________________________________

Signatures Needed

Request Made By: ____________________________  Date: ____________

Snr Manager, Practice Operations: ____________________________  Date: ____________

Regional VP/Director: ____________________________  Date: ____________

VP Practice Operations: ____________________________  Date: ____________

Human Resources: ____________________________  Date: ____________
Human Resources Only

Date Received: ________________  Date Posted: ________________

Date Filled or Action Taken:

Title Change From: __________________________  To: __________________________

Paygrade Classification Change From: __________________________  To: __________________________

Salary Grade/ Hourly Pay: __________________________

Signature of Human Resource Representative Completing Action:

Name: __________________________

Title: __________________________

Date: __________________________

Signature: __________________________
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