

The Changing Economics Of Physician-Hospital Relationships

BY SR. GERALDINE M. HOYLER, CSC

During the past year hospitals have had a number of reasons to reexamine the economics of their relationships with physicians, especially significant medical staff leaders. Important changes include:

- The introduction of the resource-based relative value scale (RBRVS) payment methodology for Medicare physician services
- The publication of the final rules for Medicare safe harbors on joint ventures
- The release of the General Council Memorandum (GCM) 39862 revoking previously released private letter rulings concerning the tax consequences of certain joint ventures
- The anticipated final regulations on the grouping and resultant payment for Medicare outpatient services (ambulatory patient groups)
- The anticipated final regulations requiring



Sr. Hoyler is regional coordinator, Mercy Housing, Inc., Denver.

the bundling of certain Medicare outpatient hospital services

Although the effective dates of these changes vary, all will affect the way physicians will derive income in the future. (For more information, see the following *Health Progress* articles: Paul L. Grimaldi, "Medicare Physician Fees Overhauled," January-February 1992, pp. 32-36; T. J. Sullivan, "New Arrangements, New Scrutiny: The IRS Reconsiders Hospital-Physician Relationships at Tax-Exempt Facilities," January-February 1992, pp. 52-57; and Gregg J. Lepper and John Swoboda, "Narrow Harbors: Few Joint Ventures Will Find Haven in the Investment-Interest Safe Harbor," December 1991, pp. 44-47.)

DECLINING PHYSICIAN REVENUES

Hospitals have become accustomed to a continually changing payment environment, but the same cannot be said of physicians. Most physicians have relied on fee-for-service or modified fee-for-service payment methodologies. This method of payment, where the units of service times the charge (discounted or undiscounted) constituted revenue, gave physicians significant control over their income. The RBRVS methodology, coupled with significant disincentives for not accepting Medicare assignment, may cause the revenue of some specialists to decline.

In view of the combined impact of these changes, economic consequences to physicians can be expected in two areas:

1. A lower income resulting from reductions, ceilings, and elimination of certain fees (e.g., EKG readings, anesthesia)
2. Lower returns resulting from the restructuring or dissolution of joint ventures to meet the demands of the safe harbor and tax requirements

It is an oversimplification to say that all physicians will be equally affected by these economic changes. The impact will vary by location and specialty, and members of a staff-model HMO will not be affected as seriously as other physicians. However, it is fair to anticipate that the

ECONOMIC CHANGES

RBRVS The resource-based relative value scale—the method by which Medicare is now paying physicians for Part B services. It is based on the expected resources to be used and the expected "value" for the services rendered. This payment methodology is generally assumed to reduce payments to most physicians, especially specialists.

General Counsel Memorandum An internal letter issued by the Internal Revenue Service's legal office that gives direction regarding interpretation of the law by the agency. GCM 39862 revokes three previously issued private letter rulings and thus changes the way the IRS will interpret the acceptability of certain joint venture arrangements between hospitals and physicians.

Outpatient Bundling A change in the way hospitals will bill Part B Medicare outpatient services. It will require certain services to be billed as one, even if they are rendered in different settings. Regulations interpreting the law have not yet been released.

Safe Harbor Regulations Regulations issued by the U.S. Department of Health and Human Services. They describe certain limited activities (including some joint ventures and relationships with physicians) that will be considered "safe" within the constraints of the Fraud and Abuse provisions of the Medicare law.

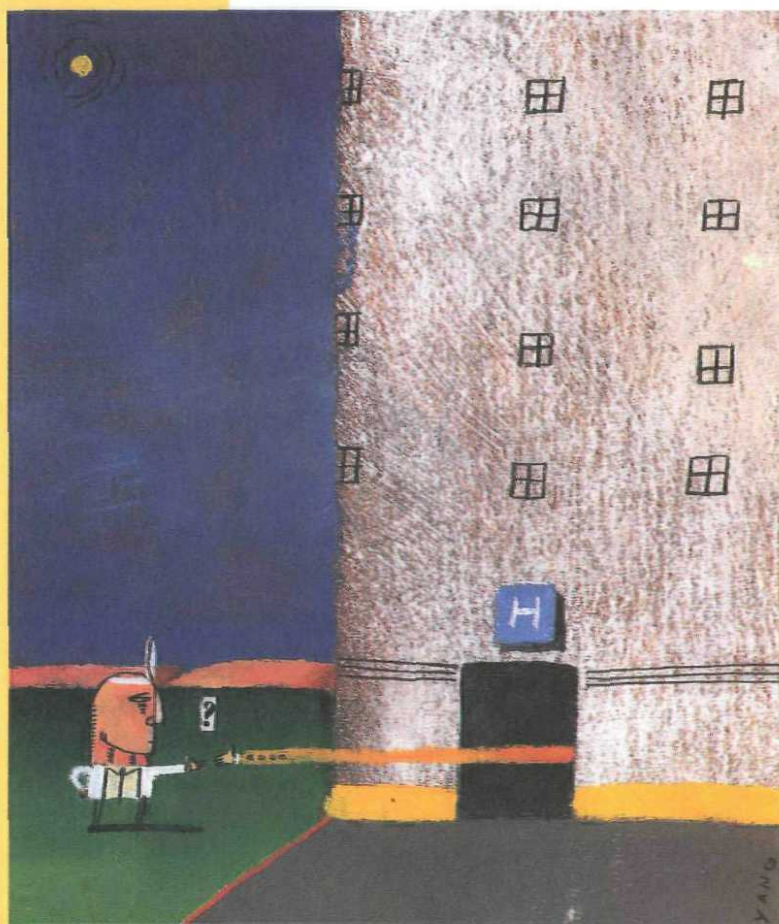
physicians most affected by decreases in fee income resulting from the RBRVS payment system will be the same physicians who have participated most heavily in joint ventures that may require restructuring.

EFFECTS ON HOSPITALS

These changes in fee-for-service payments and joint ventures will also affect hospitals because physicians may expect them to make up for income lost. As in past instances of payment changes, the economic incentives of the hospital and its medical staff are not in harmony. Many physicians will be looking for ways to make up the income lost through reduced RBRVS reimbursement. Hospitals, of necessity, will become more wary of joint ventures because so few desirable ones reside within the safe harbors. Hospitals cannot afford to lose their tax-exempt status by continuing high-risk joint ventures. Catholic hospitals must guard their tax-exempt status more closely in order to wisely and prudently use all the resources available to serve the entire population. Yet the temptation will grow to help physicians maintain income levels.

The GCM has undergone and will continue to undergo analysis, but clearly it questions the allowability of physicians, or any other individual, to participate in the income of services that historically have been the province of the exempt institutional provider. Joint ventures that involve only new technology may not be affected because anticipated revenue associated with such technology does not currently constitute revenue to the institutional provider. Clearly, however, the constraints of the safe harbors must be considered. These joint ventures require significant capital participation and restrict the referral relationship. Physicians seeking additional sources of income will not be drawn to safe joint ventures because these investments will not meet the expected return.

In addition, the anticipated bundling requirements will cause hospitals to enter into limited numbers of contractual relationships for outpatient services related to initial outpatient services given at the hospital or one of its sites. Since the hospital must bill for these services provided by others and will receive only limited payments, the independent physician's referrals to specific services (e.g., imaging centers and outpatient surgery centers) will violate the hospital's respon-



James Yang

Hospitals must review and revise policies and procedures for both physician contracts and joint ventures.

sibility under these rules. Again, as physicians seek ways of maintaining their present income, conflict may arise between the hospital and its most significant medical staff members.

POLICY REVIEW AND REVISION

What can a hospital do to ensure its continuing ability to provide services both to the community and to the physicians who are essential to the provision of these services? Clearly, administrators must review and revise policies and procedures for both physician contracts and joint ventures. Then they must evaluate all extant contracts and joint ventures in light of these revised policies. Changes will probably be needed.

To successfully complete these revisions, hospitals should provide educational opportunities to board, management, and medical staff. Each

Continued on page 24

VOLUNTEERS

Continued from page 23

be a problem, especially for the poor. Parish nurse programs in these communities could facilitate access to needed healthcare services.

PROGRAM BENEFITS

Although it is too soon to evaluate program outcomes, anecdotal data indicate increased awareness of and interest in healthcare at the congregational level. Evaluation of the hospital's total outreach program is planned for 1992.

Throughout the history of Christianity, nurses have served the Church in various capacities—deaconesses, nursing sisters, and church nurses. Nurses who served in and through the Church have always brought a special sense of caring to the faith community. Today's parish nurse is no different in this respect. Because of their stability, congregations are becoming like extended families to which individuals and families turn in time of crisis and need. In this setting, the parish nurse helps families deal with their hurts and stress through presence, prayer, and counsel. The parish nurse brings understanding, caring, and support to individuals and families through personal sensitivity and skill in dealing with life problems.

As Catholic hospitals scrutinize their future roles in the Church's healing ministry, new models and partnerships are emerging. SEHMC believes that the parish nurse's role and health ministry in a congregational setting offer great potential for renewal of the holistic concepts of health, wellness, healing, and salvation. □

NOTES

1. *Catholic Health Ministry: A New Vision for a New Century*, Commission on Catholic Health Care Ministry, Farmington Hills, MI, 1988, pp. 7, 11.
2. P. A. Solari-Twadell, A. M. Djupe, and M. A. McDermott, eds., *Parish Nursing: The Developing Practice*, National Parish Nurse Resource Center, Park Ridge, IL, 1990.
3. Solari-Twadell et al.

ANALYSIS

Continued from page 19

and TQM—the marriage of the big-bang breakthrough and CQI. TQM provides the best return on investment in terms of process improvement over time.

To achieve TQM, hospitals must learn to identify both the breakthrough opportunities and the incremental opportunities, said Currie. Hospitals need to create management systems that allow for major innovations while facilitating continuous fine-tuning, she added.

Long-Term Commitment to TQM What happens if a CEO committed to TQM unexpectedly leaves the organization after it has spent a lot of money and time establishing this innovative management system? To prevent a new CEO or the board of directors from discontinuing TQM, Ummel suggested the following precautions:

- Get total employee commitment.
- Get the chief of the medical staff to buy in to TQM and exploit that as a power center.
- Make the board believe TQM was their idea.
- Make TQM part of the mission statement.
- Add to the CEO's contract that he or she must continue an effective TQM program.
- Ask the board of directors to approve a covenant statement, adopting TQM as a board policy (e.g., "All senior executives must have TQM experience as a prerequisite to hiring").

A WAY TO SURVIVE

Hospitals that have adopted TQM systems have evaluated and improved their processes to maximize quality and cost efficiency. They offer something payers seek—"predictable outcomes at predictable prices," said Mohlenbrock. He concluded, "Those hospitals and physicians willing to work together to implement TQM will survive." —Michelle Hey

FINANCIAL MANAGEMENT

Continued from page 15

The payment changes present significant challenges.

of these constituencies must come to understand that normal economic relationships have been altered by these payment and tax changes. New relationships must be developed. Hospitals must help physicians understand that attempts to remove hospital services and the resultant revenues by transferring them to their own income stream may be positive in the short run, but in the long term will weaken the hospitals' financial and service position and eventually harm the physicians' ability to serve patients in most settings.

The outpatient bundling regulations may prove to be a point of intersection where all parties can evaluate ways a patient receives services. If discussions and educational opportunities are held without preconceived notions of what is the "right" approach, all may be able to see these services through the eyes of the patient who receives them. Then the contracts developed may represent the best possible way to meet patients' needs, rather than simply addressing disjointed economic objectives.

SIGNIFICANT CHALLENGES

The payment changes for both physicians and hospital-based outpatient services present significant challenges. The Catholic provider community should strive to use them as a vehicle for improving the way it meets people's needs, rather than a time to introduce further fragmentation of services in an already fragile delivery system. □