

PeRspective

MANAGING THE NINTH STANDARD DEVIATION RISK IN COMMUNITY-BASED HEALTH CARE



DANIEL K. ZISMER, PhD

The Author: Dr. Zismer is Director of the ISP, Executive Health Management Program, University of Minnesota and Associate Professor, Health Policy and Management Division, School of Public Health. He also serves as Managing Principal, Essentia Health Consulting. Dr. Zismer may be reached at zisme006@umn.edu or by calling Essentia Health Consulting directly at 218-786-3377.

Capital markets investment managers reference the “ninth standard deviation risk” as one that is remote, but if realized has devastating effects on market values. The ninth standard deviation risk has been realized in the subprime mortgage-based securities markets. The full effects of related risks have yet to be fully realized.

Is there a parallel in community-based health care; its own “ninth standard deviation risk”? That risk could be the risk of an unstable, non-renewable, “traditional” medical staff structure; including future effects on the tax-exempt organization credit ratings. An unstable and non-renewable medical staff model structure is one that cannot be relied upon to deliver physicians in the right specialties and right locations in clinical and business models that best serve the community-based health system over time.

A Look at the Future of Tax-Exempt Debt Markets:

According to Steve Proeschel, Head of Healthcare Finance at Piper Jaffray, Minneapolis, Minnesota, health care revenue bond volume continues to climb. “We have seen a 20% increase in capital spending for not-for-profit health systems between 2005 and 2006 (Source: Moody’s Special Report, March 2007). This trend shows no sign of abating. For the first ten months of 2007, health care revenue bond volume has increased 45% over the same time period in 2006 (source: Thomson Financial, November 6, 2007). A recent survey of hospital executives showed that 38% expected health care bond volume to increase between 5% and 20% in 2008 (Source: The Bond Buyer, October 31, 2007).

Bottom line, not-for-profit, community-based health systems will assume increasing amounts of tax-exempt debt risk to finance new capital and related strategic investments.

The Risk of Private Equity Investments:

In a recent report by Cain Brothers, the risk of “private equity” in health care was highlighted; the risk that large, private equity investors will begin to

favor health services delivery as a capital investment target. Why health care services? Health care is a growth industry, likely moving to 20% of GDP over the next decade. Health care provider entities have stable cash flows. Health care profitability will benefit from new business models, new financing models and information technology solutions. So what is the risk to community-based not-for-profits? Physicians who are not integrated or otherwise not “off-the-market” are subject to reorganization and investment by private equity firms looking for five-to-ten year return horizons.

So, as not-for-profit, community-based health systems are assuming increased levels of debt risk, private equity investors may start competing for the “unaligned” physicians; most likely the specialties that are most financially and strategically productive for health systems and community-based hospitals.

How Are the Medical Staff’s Business Structures The “Ninth Standard Deviation Risk”?:

The answer to the question lies in an understanding of the operating economics of the private medical practice business model, small and large independent medical practices¹.

1. **The Economics of the Clinical Specialties:** Individual clinical specialties affect the operating economics of medical practices variously. General surgeons are valuable to hospitals for obvious reasons; they generate considerable technical services (inpatient and outpatient revenues). Unless an independent medical practice owns its own surgery center, general surgeons principally generate professional fees for the practice with most of these net-operating revenues supporting physician compensation and overhead. Specialties that are highly productive for hospitals may be financially unproductive for clinics; especially the larger multispecialty specialty clinics. These clinics depend more upon margins earned from ancillary clinical services to support the practice operating expense and physician compensation.
2. **The Economics of Working Capital Risk:** Whereas hospitals and health systems may need medical practices to recruit aggressively and grow to meet their individualized strategic plans, growth means working capital risk to medical practices; investments that are difficult to recover. A hospital may need more cardiologists to meet its plan; the cardiology practice responds with “and you want us to assume the financial risk of the new recruits.” Independent practices may not be willing to assume the financial risk of growth, despite the value to affiliated hospitals.
3. **The Economics of the Contribution Margins:** The operating revenue structure of medical groups is composed of far fewer contributors as compared to hospitals. The contribution margins of these services differ (margins after direct expenses are deducted from operating revenues); each is affected by payer reimbursements and

specific, related expense structures. Physicians’ take-home pay is affected by these margins. As payers pressure reimbursements for professional fees and ambulatory technical fees, physician compensation can be affected quickly and significantly. The large medical groups with relatively high fixed-expense structures are at greater risk. Specialties with disproportionately high exposures to Medicare reimbursements are especially vulnerable. Consequently, the economics of medical groups can be affected significantly by a few reimbursement policy changes. For example, larger cardiology practices rely upon a few ambulatory ancillary services to contribute to physicians’ compensation; e.g., cardiac imaging services. If payers (especially CMS) reduce reimbursement for nuclear imaging, practice economics suffer quickly.

4. **The Economics of Geographic Outreach:** Community hospitals will hope that members of the medical staff reach out geographically. The advantages to hospitals are obvious. These hospitals will frequently expect the physicians to self-finance outreach efforts. Unless the physicians own profitable ancillary services, or their own hospital, geographic outreach is not profitable; not very motivating.
5. **The Economics of Medical Practice Infrastructure Costs:** As the economics of private practices are pressured, independent physicians are less able to afford the costs associated with practice infrastructure recapitalization; electronic medical record, information systems and facilities. Physicians, notably the younger, are unlikely to welcome the invitation to take on personal financial risk to capitalize a private practice business model that may be at-risk; especially as larger, not-for-profit health systems offer them the opportunity for employment without personal capital risk.

The economic risks associated with the private practice of medicine directly affect the not-for-profit, community-based hospital organizations to the extent these organizations rely upon the long-term stability and renewability of the private medical practice business model. This risk is best summarized by a community health system CFO who was asked about an upcoming \$400 million debt offering directed to the funding of a new, “greenfield” hospital construction project; “I’m concerned principally with our medical staff business model. In excess of 60% of our hospital admissions are provided by a medical staff composed of independent practices of five physicians or less, with an average age of 50 yrs. +, which haven’t recruited with sufficient success in the last five years”.

Full Integration As A Plausible Answer:

So if the traditional, private medical staff business model is at-risk (for small and larger medical group practices) what should not-for-profit, community-based health systems do? The answer may be pursuit of fully integrated clinical and

¹ Zisner, D.K., Person, P., “What Does the Future Hold for the Larger, Independent, Multispecialty Medical Group?”, American Medical Group Association, *Group Practice Journal*, April 2007, Volume 56, No. 4

business models. For purpose of definition, at least for this paper, a “fully integrated” health system model is one where most, if not all, physicians needed to fulfill the health system’s mission, vision and strategic goals are employed by the health system. Employed physicians serve as clinical services providers, co-leaders and co-managers of the health system. While integrated models come in several forms, they all aspire to the same end-game; the availability of clinical service and business models that provide the highest levels of: stability, durability, renewability and economic and strategic flexibility over time, regardless of health markets pressures from payers, customers and competitors^{2,3,4}.

How Does Full Integration Correct For The Vulnerabilities of The Private Medical Practice Business Model?

In the fully integrated community-based health system business model, all work for the same enterprise; or at least controlled subsidiaries or operating divisions of the health system (typically a not-for-profit, tax-exempt health system). Physicians, as employees of the integrated organization, qualify for a “safe harbor”, safe from the restrictions imposed by the federal “anti-kickback” law. Physicians’ incomes are not, necessarily, affected negatively by:

- the differing operating economics of select clinical services provided by the health system; (e.g. all operating revenues are available to fund the aggregate physician compensation pool);
- the recruiting of new physicians (i.e., existing physicians do not stand the working capital expense associated with the addition of new physicians);
- operating expense associated with geographic outreach strategies;
- new clinical program start-up expense;
- capital investments; routine and strategic investments.

Compensation paid to employed physicians is typically productivity-based⁵ meaning physicians are paid a fair-market rate for their clinical efforts and assigned management and leadership responsibilities. Unlike private practice, compensation is not based upon a “net pool” created from the remainder of physician services revenues less practice operating expense.

Consequently, the size, specialty mix and geographic placement of physicians are not influenced by the potential effects of such strategies on the take-home pay of physicians.

Additionally, within the fully integrated model physicians assume no personal risk for debt (liabilities for tax-exempt debt

obligations are held at the system level) and capital is deployed freely within the integrated structure; i.e., the business model allows the leadership to move capital to controlled divisions or subsidiaries according to an approved capital plan. For all intents and purposes, the organization operates from a single, consolidated balance sheet.

Will Regulators Likely Favor Fully Integrated Models Long-Term?:

By all indications, the likelihood that fully integrated, community-based health system business models will stand the test of a changing health care legal and regulatory climate is strong.

“In 2007, both CMS and the HHS Office of Inspector General clearly took a more aggressive stance toward prohibiting activity they perceive as abusive of governmental program dollars,” states David Melloh, Chair of the Healthcare Practice Group at the Minneapolis Law Firm of Lindquist & Vennum. “However, neither CMS or the OIG (or the antitrust enforcement agencies) have made any attempt to restrict full integration models. In effect, full integration has become relatively more attractive,” Melloh points out. The fully integrated model removes many of the legal and regulatory barriers caused by the nature of the tax-exempt not-for-profit attempting to create business relationships with private practice enterprise business models.

Summary:

If the “ninth standard deviation risk” for community-based health systems is the design, structure and future stability and renewability of the medical staff business model(s), then it seems reasonable to assert that management of such risk should be at the top of every community-based health system’s strategic plan.

When presented with this challenge some health systems resist on predictable grounds:

- “We’re unique; it won’t happen here.”
- “Our physicians don’t want integration.”
- “We tried it once; it didn’t work.”
- “Maybe someday, but not now ... ”

While objections to full integration are understandable, there is no denying observable and forecasted market trends. The only logical alternative to physicians integrating with community-based health systems is accelerating competition between the parties. In a world of pressures on health care resources (capital and people) coupled with payers leverage over reimbursements one should question this path.

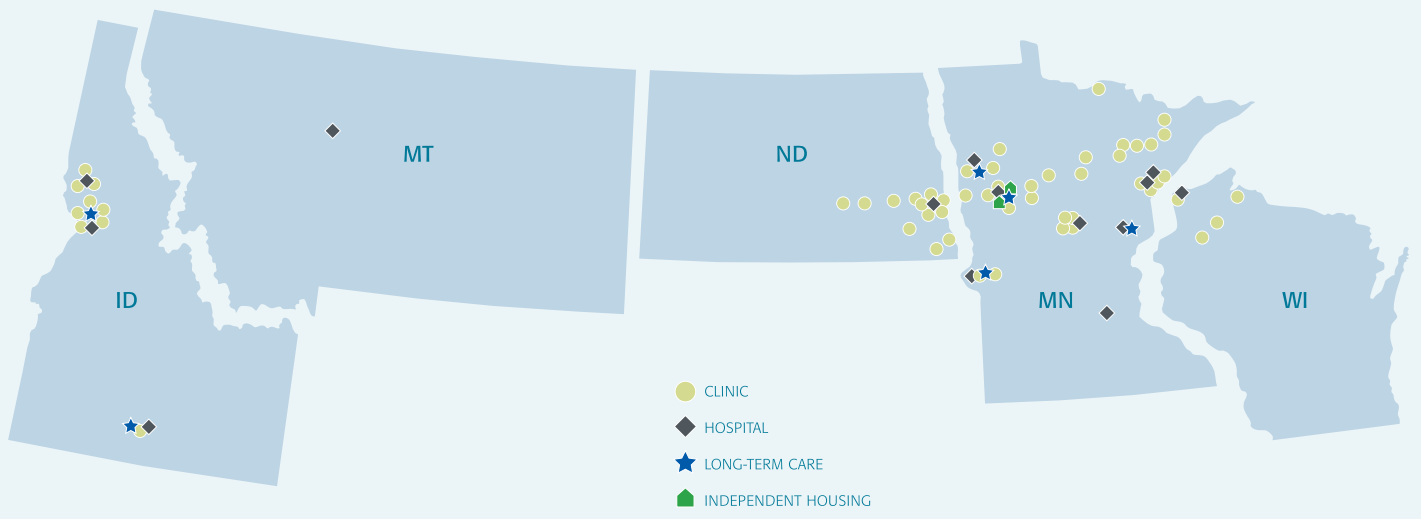
² Zismer, D.K., “Market Pressures On Community Health Systems And Physicians To Consolidate And Integrate,” *Perspective*, Essentia Health Consulting, February 2007

³ Zismer, D.K., “Integration as an Answer to the Challenges of the Legacy U.S. Not-For-Profit Community Health Systems,” *Perspective*, Essentia Health Consulting, September 2006

⁴ Zismer, D.K., Person, P., “Integrated Specialty Care: Pursuing a Convergent Path with Medical Staff,” *Healthcare Executive*, American College of Healthcare Executives, Volume 21, Number 4, July/August 2006

⁵ Zismer, D.K., “Managing Physician Compensation in Integrated Health Systems: A Focus On The Clinical Specialties,” *Perspective*, Essentia Health Consulting, September 2007

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Essentia Health Consulting 502 East Second Street | Duluth, MN 55805 | 218.786.3175 | www.essentiahealth.org

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