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Specialty Clinics: Surviving In A For-Profit Healthcare World

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Introduction

Dr. Mike Waxman just concluded an interview with another candidate to possibly join his Kansas City Pulmonology Clinic, LLC (KCPC), a prominent specialist physician group in Kansas City. How the interview ended was what concerned him most. The candidate, a particularly good one, candidly revealed that while he loved the practice, "You work too hard for the money you make or don't make as much as you should for the work you do." Unfortunately, this sentiment was probably shared by other candidates as the once stable practice was having little luck replacing the four pulmonologists lost over the past 18 months.

While Waxman preferred that KCPC keep its current group together and continue its long relationship with Research Medical Center, he was also now seriously thinking about other options. He had recently made job inquiries with another independent pulmonologist group in a nearby city. He had also talked to his partners about the potential of becoming employees of HCA, the new for-profit owner of the hospital. The burden of working with a short staff of doctors was taking a toll on him, his fellow doctors, and each of their families and if something was not done soon the practice may have to be dissolved. Waxman would need time to think about what he would do in the future, but with only five physicians now on the clinic's staff, his heavy workload was making this very difficult.

History of the KCPC

In the mid-1970s, a pulmonologist physician founded the Kansas City Pulmonology Clinic (KCPC) and by 1984 had grown the practice to five pulmonary specialist physicians. In 1985, Mike Waxman joined the practice as the sixth physician in the group. The clinic had established a close partnership with Research Medical Center (RMC), located in a prime urban area. Over the next few years, KCPC would grow to eight full-time and one part-time physician and was one of the premier pulmonary clinics in the region. (See Appendix for a glossary of selected healthcare key terms.)

During this growth phase, KCPC was able to provide a large variety of technologically expanding services, which included the first certified sleep lab in the area and innovative pulmonary interventional work such as laser and stenting and critical care intensivist services. Additionally, as part of the RMC initiative to serve a larger region of patients, KCPC was active in outreach programs. For example, as part of the practice's rotations, physicians would participate in clinics and hospital consultations in towns surrounding Kansas City.

KCPC was a physician-owned Professional Association and operated under a fee-for-service model for its medical services. The physician owners found tremendous satisfaction in working with a full-service hospital, rotating through cycles of inpatient care, outpatient care, outpatient diagnostic services, and call to satellite clinics from which referrals would feed more patients into the acute care hospital system. With almost no turnover and most of the founders still with the practice, the group acted much like a family outside of work.

At work, KCPC operated as a team of equals. First, the partners all agreed to equal salaries, based on the net proceeds of the practice. Second, workloads were scheduled so that partners shared all the various activities equally—no one specialized in just one area of the practice such as ICU or making rounds. The sentiment of the group was that "we take care of patients." Furthermore, they felt fortunate to be part of a hospital that performed a wide range of services such as sleep disorders, critical care, and innovative interventional procedures.

One of the physicians acted as the managing partner. This managing partner led in decisions on scheduling, physician workload, operational matters, and new partner recruitment. The partners met monthly to review the business and make necessary decisions; often these decisions were based on a vote of the partners who were all voting equals. The partners strongly believed their practice was not the type where physicians simply shared office space and rotated call responsibilities. Instead they had to work together and any work that was added had to go through the practice for allocation decisions.

Scheduling

An important operational task of the independent owner physicians was scheduling. Over the course of time, all the physicians practiced all the services. In effect they did "central planning" by creating three-month templated schedules. This method of scheduling was considered extremely efficient because each physician could focus on one thing for several weeks and not have to try and divide his/her time (see Figure 1 for a sample schedule). They felt this provided superior service to their patients and they never had an excuse not to do a consult or see a new patient because of other duties.

It did not matter at any one time which individuals were generating the most revenue because all activities were divided evenly over a three-month schedule. While one physician might spend a great deal of time doing call over a short period (a low revenue producing activity) another might be in critical care (a higher revenue activity). No accounting was done as to individual physician productivity as is often done with lawyers (billable hours) or salespeople (commissions).

Workload

November 2014, Vol. 32, No 2, p. 33-48
ISSN 2162-3171

In 1999, Waxman took on the role of managing partner. While enjoying the responsibility of leadership, he found one of the biggest challenges was managing the work load. In the past, the group would increase workloads until it became unbearable; they then could decide whether to take on another physician or reduce the work. For the most part, the practice enjoyed lucrative contracts with the hospital during the 1980s and into the 1990s, which provided sufficient cushion for the group to grow and still maintain physician salaries.

November 2014, Vol. 32, No 2, p. 33-48
ISSN 2162-3171

Figure 1. Example of a KCPC physician work schedule template

	DOCTOR					
	Doc 1	Doc 2	Doc 3	Doc 4	Doc 5	Doc 6
WEEK	1	2	3	4	5	6
1	4W	H2	ICU	Vacation	Outreach	Office
2	4W	Outreach	Office	ICU	Office	H2
3	Office	4W	H2	ICU	Vacation	Outreach
4	H2	4W	Outreach	Office	ICU	Office
5	Outreach	Office	4W	H2	ICU	Vacation
6	Office	H2	4W	Outreach	Office	ICU
7	Vacation	Outreach	Office	4W	H2	ICU
8	ICU	Office	H2	4W	Outreach	Office
9	ICU	Vacation	Outreach	Office	4W	H2
10	Office	ICU	Office	H2	4W	Outreach
11	H2	ICU	Vacation	Outreach	Office	4W
12	Outreach	Office	ICU	Office	H2	4W

Long Call between 1st and 2nd week of either ICU or 4W rotation

Short Call at end of H2 rotation

Key:

ICU – Intensive Care and the toughest rotation; patient to nurse ratio of 2:1

4W – Critical care unit, which was a step down from ICU; patient to nurse ratio of 4:1

H2 – Rounds everywhere else in the hospital

Outreach – Seeing patients up to 2 hours away in town like Nevada, Bethany, and Chillicothe.

Office – seeing patients in the office.

Long Call – Friday call, rounds on Saturday and Sunday, Sunday on Call

Short Call – Saturday and Sunday rounds; Call on Saturday

Source: Mike Waxman

Negotiation with third party carriers, however, had become more difficult. Insurance companies and other providers could always find somewhere else to send their patients. Waxman remembered one meeting with the partners where he wondered why they didn't have more negotiating power. One of the partners stated, "It's not that there are a lot of pulmonologists but there are just enough that they [third party payers] have other options. It just seems like they always have the upper hand with us." With Medicare and Medicaid rates typically much lower than private insurance rates, the only way for the physicians to increase revenue was to do more work. Unfortunately, a majority of the work the practice did was lower compensated cognitive work such as consults, office visits, etc. Only 15% of their time was spent performing the more lucrative procedural work such as performing a bronchoscopy, inserting a chest tube, or putting in a central venous catheter.

Managing Operations

The operating costs of running the clinic were also significant. Although the physicians tended to important tasks related to their schedule and workload, most other operational tasks were performed by office staff. The clinic employed a full-time office manager, receptionist, billing clerk, and registered nurse to perform these non-revenue producing tasks. They also outsourced tasks critical to insurance claims and patient documentation (e.g., typing). While these overhead costs were expensive, these expenditures allowed the doctors to focus on their work, which they always had plenty of.

Geography also contributed to the constraint on revenues and profits. In Kansas City, Missouri the rates paid by carriers across the board were lower than in outlying areas and in the bordering state of Kansas. The KCPC physicians were proud to work in the city, but only about 30% of their patients were covered by private insurers—the highest payers. The rest were Medicare (55%), Medicaid (8%), and uninsured (7%)—this payer mix had been constant during Waxman's tenure as managing partner. Their collection rate was 70%, meaning that 30% of their work was uncompensated (often patients were billed more than insurance companies or government insurers would pay). (See Table 1 for a more detailed description of third party payers.) The practice was located in a high-rent area. Although they considered moving to a less expensive area for office space, the distance from the hospital would have been problematic for serving their large inpatient population. Malpractice insurance premiums were higher in Missouri than in neighboring Kansas, which also put a drain on net profits.

Bringing in New Partners

When a new physician was hired into the practice, he or she would come in with a two-year trial employment period. During this time the new physician performed the same work as everyone else but was paid less. After the two-year period, if both sides were agreeable, the physician would become a full partner. The buy-in costs to become a partner were fairly modest compared to other practices. The new partner paid a percentage of the hard assets (e.g., furniture and equipment) of the firm as a buy-in. In addition, the physician would pay a percentage of the accounts receivable expected to be collected. For example, if the incoming partner was now one of six, he or she would pay one-sixth of the hard assets and the same percent of accounts receivable, which tended to be the more significant amount. Once in as a partner the physician

November 2014, Vol. 32, No 2, p. 33-48
ISSN 2162-3171

was paid the same amount as everyone else. Any profits earned in excess of salary payments were equally divided as bonuses.

Table 1. Third Party Payers to Hospitals and Physicians

Essentially doctors and hospitals receive payment for their services from:
1. Insurance Companies
2. Government
3. Uninsured

Insurance Companies	Employers, employees of employers and individuals purchase health insurance policies from insurance companies (Blue Cross, Aetna, Assurant health, Kaiser Permanente). The more policy holders an insurance company can accumulate the more leverage it has with doctors and hospitals in regards to discounting their services.
Government	The two health insurance programs provided by the government are referred to as Medicare and Medicaid. Medicare is a federal health insurance program in which all Americans are eligible if they are 65 years or older. Additionally Americans younger than 65 who have certain disabilities (e.g., end-stage renal disease) are also eligible for Medicare. The two major parts of Medicare covered by the federal government are Medicare Part A – hospital insurance and Medicare Part B – medical insurance. Medicaid is a federal health insurance program which was created by the federal government but is administrated by the states. The purpose of Medicaid is to provide health insurance for low income individuals and families. Since it is administered by the states each state has different qualifications as to who is eligible. A. Covers inpatient hospital stays, hospice and rehab facilities B. Doctor visits, preventative services
Uninsured	There are a number of individuals who, for varying reasons, choose not to have health insurance. These individuals therefore pay their health care expenses directly out of pocket. Without a health insurance company or government agency to represent them they are charged the full cost of services provided by doctors or hospitals.

Until the early 2000s the physicians of KCPC operated strictly as equal partners being paid equal amounts and using the rotation schedule to spread work evenly over every three-month period. In 2000 they allowed one partner to take on a sleep study lab—something the other physicians had no expertise in—on his own. The agreement allowed him to operate the lab outside his normal KCPC duties. This was the first time ever that the practice had deviated from their completely egalitarian system.

In 2004 the practice experienced a shock when one of the partners died suddenly. This loss soon exposed an underlying vulnerability of the practice, notably its growing inability to compete in the market for new physicians. Over the next several months three other physicians left the practice but the group was able to hire only one replacement.

The challenge faced by Waxman and KCPC was the competitive market for physicians. Aggressive new hospitals and hospital systems were providing lucrative options for new physicians. In 2004, Waxman and his partners figured they were paid about 10% less than newly minted doctors hired at other places.

Research Medical Center and Health Midwest

Research Medical Center was established in 1886 (originally named German Hospital) and had a long track record for serving both a diverse set of patients and providing innovative health care services in Kansas City and the surrounding area. RMC had "introduced the area's first health insurance plan, one of the first community blood banks, and brought the first EKG and Cobalt-60 unit to Kansas City." William Volker, a local philanthropist, was instrumental in helping RMC continue to advance and, in 1963, to build the modern facility where RMC was still located (125 Years of Pioneering Healthcare).

During the 1960s through the 1990s, RMC continued to expand into new areas, many of them cutting edge, such as the area's first electrophysiology program and Level III neonatal intensive care unit. RMC, through its use of satellite or feeder hospitals in outlying areas, was able to boost referrals thereby increasing key metrics such as number of office visits, number of outpatient procedures and number of hospital beds. This strategy was aligned with KCPC's routine practice of outreach activities. By the mid-2000s, RMC was a comprehensive, 511-bed facility and tertiary care regional referral hospital serving patients within a 150-mile radius.

In collaboration with eleven other not-for-profit hospitals within the region, RMC became part of the Health Midwest organization during the 1990s. This not-for-profit holding company sought to achieve economies of scale for its member hospitals by collectively negotiating with managed care organizations.

Joining organizations like Health Midwest was critical for independent not-for profit hospitals during this era. The move was designed to help reduce costs by achieving operating efficiencies, negotiating managed care contracts as a collective, and competing during a time when high rates of medical cost inflation were fueling a subsequent rise in Health Maintenance Organizations (HMOs). Competing for-profit hospitals and surgery centers were also beginning to take a larger share of the hospital market.

Health Midwest utilized many of the same tactics that other independent not-for-profit hospitals throughout the US had been deploying. Specifically, Health Midwest developed its collaborative network and satellite hospitals in the rural areas surrounding the Kansas City marketplace to support medical practices such as KCPC with additional volumes of fee-for-service patients. Additionally, the network helped fuel ongoing growth for both member hospitals and associated

November 2014, Vol. 32, No 2, p. 33-48
ISSN 2162-3171

physician practices. During this time, however, physician practices according to the Lewin Group (2003) were beginning to face a number of difficult economic hardships such as:

- reduced negotiated payments from HMOs and regional insurance companies;
- frozen or reduced payments from governmental payers such as Medicare and Medicaid;
- increased paperwork burdens and the need for computerized patient records systems;
- increased professional liability malpractice premiums;
- increased labor and benefit costs for medical practice employees.

During the 1990s, hospitals saw a steady erosion in rates third party payers would pay for services. Nationwide, according to an American Hospital Association study, the ratio of private payer receipts to costs went from a high of 132% in 1992 to 115% in 1999 (Lewin Group, 2003). That is, independent clinics and hospitals were receiving $1.32 of revenue for $1.00 of cost in 1992 and by 1999 revenue had dropped to $1.15 cents per dollar of costs. The HMO environment contributed to this decrease in payments. Furthermore, by the late 1990s hospitals were seeing shortfalls of payments relative to costs from government payers. By 2005, both Medicare and Medicaid showed significant aggregate deficits for all U.S. hospitals (see Table 2).

Table 2. Hospital Payment Shortfall Relative to Costs for Government Payers – 1997-2005

Year	Medicare (Billions)	Medicaid (Billions)	Other Government
1997	$4.3	$-1.6	$-0.7
1998	2.3	-1.4	-0.6
1999	-.01	-1.8	-0.4
2000	-1.3	-2.5	-.04
2001	-2.3	-2.0	-0.6
2002	-3.3	-2.3	-.06
2003	-8.1	-4.9	-.05
2004	-15.0	-7.1	-.05
2005	-15.5	-9.8	-0.4

Source: Avalere health analysis of the American Hospital Association Annual Survey data for community hospitals (Trendwatch Chartbook, 2012).

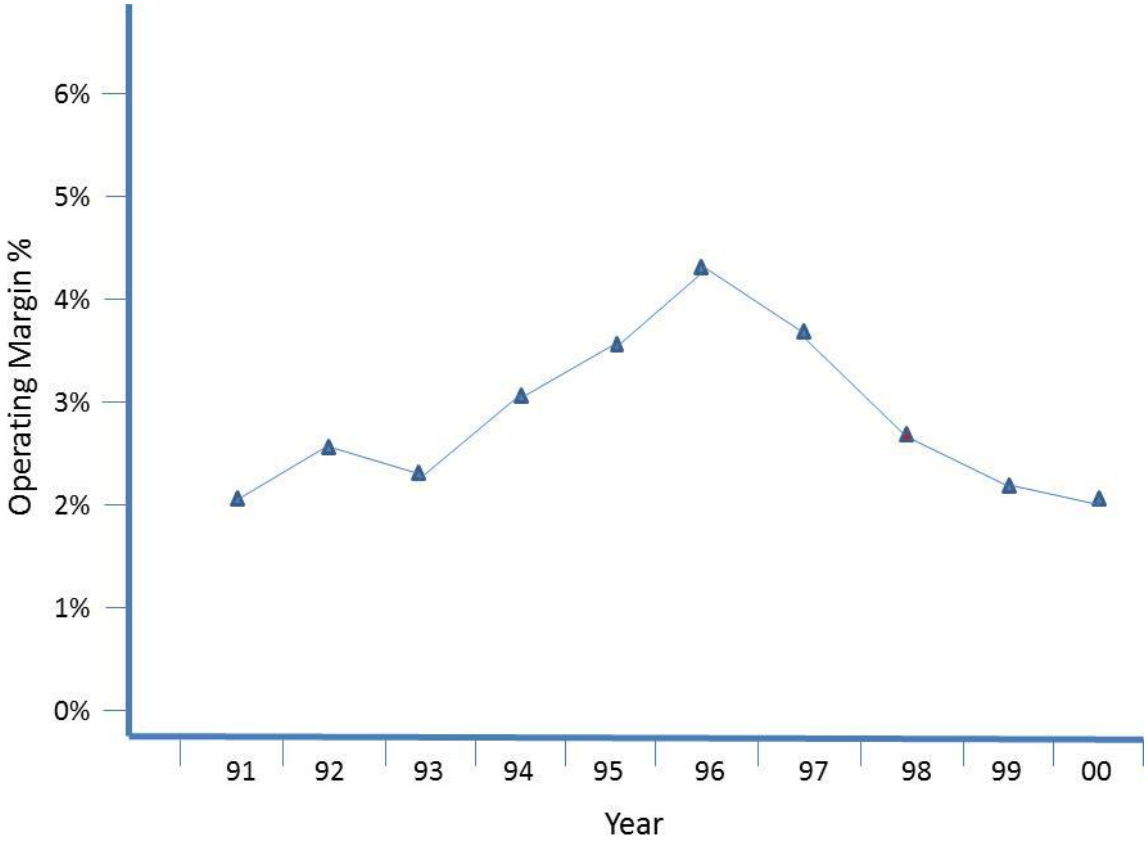
After peaking in the mid-90s, hospital margins fell to half by 2000. That is, operating margins at over 4% in 1996 dropped to 2% in 2000 (see Figure 2). Total margins saw a similar drop, though not as large.

KCPC had been a proud participant in RMC's growth and involvement in cutting-edge patient care. In fact, the difficulty the practice had in replacing its lost physicians in 2005 and 2006 was

November 2014, Vol. 32, No 2, p. 33-48
ISSN 2162-3171

especially troubling because of the great affiliation the members had with the hospital and the long history they had of serving patients.

Figure 2. Operating Margins in Hospital Sector



Data from Lewin Group's AHA TrendWatch, June 2003, p. 7.

Hospital Corporation of America (HCA) Steps In

HCA was founded in the 1960s and represented the trend in healthcare of for-profit entities that operated clusters of community hospitals in order to create economies of scale to more effectively and efficiently deliver health care to communities. By 2006, HCA had become the nation's largest provider of healthcare services, including 176 hospitals and 92 freestanding surgery centers throughout the United States and England. 2005 revenues were more than $24.5 billion and the company employed approximately 190,000 people.

In 1997 HCA faced several problems. Jack Bovender had just been called out of retirement by the founding Frist family of Nashville to help HCA successfully reverse problematic trends that were plaguing both for-profit and not-for-profit hospital systems. Bovender had served at HCA for over twenty years as a senior executive through the company's strongest growth phase and had subsequently retired at the time of the Columbia/HCA merger. He was called back into service, however, by the company's board to take on duties as the organization's President and

Chief Operating Officer after CEO Richard Scott's resignation. Besides needing a strong, respected leader to "right the ship" after the large financial settlement related to Scott's exit, HCA needed to rein in what had become a collection of disparate companies (due to acquisition) with no coherent corporate infrastructure or culture (Cashill, 2002). The lack of coordination and standardization resulted in inefficiencies, including ineffectiveness when negotiating with insurance providers and suppliers.

Bovender had begun to make that infrastructure more centralized and better at negotiating more favorable supplier and buyer contracts. At one point, Bovender pledged to put a stop to accepting unsustainable deep discounts being pushed by managed-care firms. He stated this firmly in one report: "I won't sell our services below cost. If we lose business, so be it." Bovender was able to test this strategy in a 1999 Florida confrontation between HCA and managed-care power, Humana. Humana demanded discounts of up to 50% for its 50,000 members state-wide. Bovender refused to yield and instead insisted on a renegotiated contract and risked losing a massive amount of business. Fortunately for HCA, Humana blinked by backing off the demand. "Humana became our poster child," said Bovender, "the hallmark of our new strategy" (Cashill, 2002).

HCA Enters the Kansas City Market

In 2003 HCA purchased the twelve not-for-profit Health Midwest Kansas City hospitals for $1.125 billion. The purchase by HCA was not surprising. Health Midwest had continued to struggle to meet its cash flow demands and effectively organize and operate its network of hospitals throughout the late 1990s and early 2000s. HCA sought to overcome these problems through centralization and efficiency as well as the strong financial leverage of a publicly-traded company that could effectively raise capital for improvements and acquisitions.

During the 90s, the health care industry had experienced some major changes involving the compensation of both doctors and hospitals. The fee-for-service model, which had been most lucrative for physicians, was being pinched in a reimbursement system that more closely scrutinized expenses. Furthermore, past efforts at geographic expansion and service portfolio expansion, such as the strategies deployed by Health Midwest, were now much less valuable in a system that more closely measured the actual value of activities and set accountabilities according to these values.

HCA and Employment of Physicians

The changing economics of hospitals along with heightened regulatory requirements were challenging independent physician clinics. Waxman's group, for example, was feeling this shift with its outreach program. While the program was once valued by RMC because of the downstream referrals it created for its tertiary care, it was very time intensive (serving small clinics two hours away) for the number of patients seen and procedures performed. The hospital received a major referral program from the outreach while it subsidized the pulmonary group to enable it to keep 8 - 9 physicians.

It became impossible, however, for hospitals to subsidize private specialist medical group practices like KCPC to operate like they had in the past. When KCPC lost physicians in 2004-05, they had to cut out half their outreach hospitals, which also cut their subsidies. Especially under HCA, costly functions like outreach were viewed as increasing costs and decreasing profits.

The two primary factors determining value—quality of care and cost of care—were shifting more towards a concern for controlling cost. HCA used its large number of hospitals to drive down costs as well as negotiate more favorable contracts with large health insurance companies. Through this process HCA was able to perform the same activities as other hospitals but at a lower cost and therefore generate a higher return. Thus, HCA because of its size potentially got the same quality at lower costs instead of pursuing higher quality at the same or slightly higher costs.

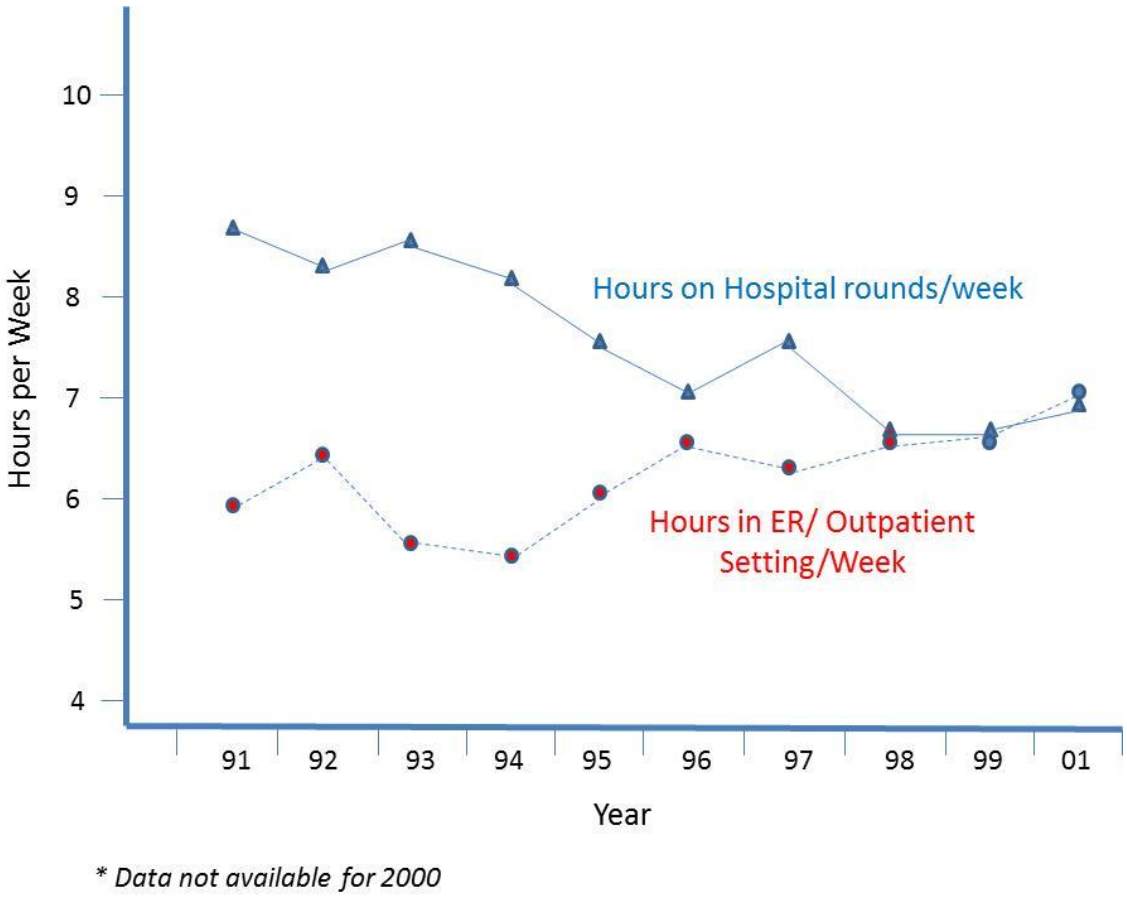
Doctor-owned practices were finding it harder to survive as independent entities. Costs of the practice were becoming more onerous. Specifically, office expenses, liability premiums, and cost of more sophisticated medical equipment all increased putting a drain on net incomes. While nominal net incomes increased during the 1990s, the actual or real incomes remained flat. Additionally, regulatory burdens were increasing; the 1996 Health Insurance Portability and Accountability Act (HIPAA) was just one measure that added expenses to the practice.

Trends in payer mix were also squeezing independent practices. While very few physicians turned down either privately insured or Medicare patients, they did turn down Medicaid and uninsured patients. Increasing expenses and decreasing opportunities for higher revenue activities like hospital rounds made it much harder for physician practices to cross-subsidize Medicaid and uninsured patient populations. Having the right payer mix that was not top-heavy in Medicaid and uninsured patients was even more critical for physician groups, yet this was difficult especially for comprehensive urban hospitals like Research.

With costs rising, more and more physicians were choosing to become employees of hospitals to avoid the headaches of running a practice. By 2005, independent physicians declined to under 49%, an 8% decrease from 2000 (Accenture, 2011). This shift was caused in part by the changing mix of patient care activities. According to The Lewin Group (2003), "Physicians [were] spending less time on hospital rounds and more time treating patients in outpatient settings" (see Figure 3). Hospitalists were now more common, taking on the rounds once done by the clinic physicians. In the evolving healthcare reimbursement system where payments by insurers were being reduced or capped, self-employed physicians had to take on greater patient loads at the same time they had to process increasing administrative paperwork. By 2000, it was estimated that physicians had to re-file up to 30% of claims, which increased expenses and further diluted profits and diverted time away from actual patient care.

November 2014, Vol. 32, No 2, p. 33-48
ISSN 2162-3171

Figure 3. Physician Hours Spent on Hospital Rounds per Week vs. Hours in ER or Outpatient Settings



** Data not available for 2000*

Data from Lewin Group, AHA TrendWatch, June 2003, p. 3.

Forecasts indicated a continued trend toward more hospital employed physicians into the next decade. Nearly all of these trends tended to dampen the enthusiasm physicians had for practicing medicine, with 60% reporting a decrease in enthusiasm for practicing medicine over the prior five years (Lewin Group, 2003).

Compensating Physician Employees

As hospital systems continued to employ more physicians and sought to control the cost of hospital-owned physician practices, significant shifts occurred in the way that doctors were paid once they became employees. Hospital employment of physicians was costly for hospitals. During the 1990s, some hospitals found that physician productivity decreased after their practices were purchased by hospitals. An analysis in the *New England Journal of Medicine* estimated that hospitals lost $150,000 to $250,000 per year over the first three years they employed a doctor, as physicians adapted to the new system (Kirchhoff, 2013). Other data indicated that even though a number of hospitals were prepared to make the transition to a

coordinated system such as Physician-Hospital Organizations (PHOs) and Medical Services Organizations (MSOs), they were still basing physician compensation on a volume basis—offering new hires a salary with a productivity bonus. For organizations like HCA that employed many physicians, these costs could mount up in a hurry and pay tied to productivity metrics, such as relative value units (RVUs), were seen as key ways to reduce costs and improve productivity as well as increase billable physician units of service.

RVUs, a derivative of the resource-based relative value scale first developed in the 1980s, had become an important scorecard for health maintenance organizations like HCA to squeeze out inefficiencies. In effect, the relative value scale served as a pricing list for government insurers like Medicare and also guided private insurers in determining the price for physician services. For example, in 2005 the code set a relative value of 1.39 (adjustable to different regions in the U.S.) for a certain service. That service might have a base factor of $37.90. Medicare would then reimburse that amount times the factor (1.39). Most specialties charged anywhere from 200-400% of Medicare rates. For example, if Medicare paid $52.68 for a procedure or service (1.39 x 37.90), specialty groups valued this service at anywhere between $105.36 up to $210.72 or two to four times Medicare reimbursement. [A fuller explanation of RVUs can be found at this link: http://www.nhpf.org/library/the-basics/Basics_RVUs_02-12-09.pdf]

RVUs were now used as a standard for evaluating the revenue value of the various activities of the hospital. Hospitals valued high RVU activities over lower RVUs. Thus, activities like preparing for lectures or doing outreach that once were seen as important "marketing" activities were now viewed as low RVUs and were a drain on profits.

Newer reimbursement methodologies such as compensation for diagnosis-related groups and capitated payments were changing the priorities of hospitals and physicians. Surgical procedures with highly regimented "cookbooks" and limited numbers of days for inpatient stays were highly valued because they produced large profit margins. Internal medicine and pulmonary specialty cases where patients had highly variable lengths of stay that could run beyond days and weeks—and even into months—became costly medical misadventures in the eyes of for-profit shareholder medicine. Thus, the key role of a pulmonary physician performing inpatient care moved to the role of expediting a patient's journey from the ER through the ICU and into an acute care inpatient bed to home in the shortest possible time. The previous incentive of creating more bed days was now anathema in the for-profit healthcare system.

Moving Forward

Unable to bring in new physicians, Waxman and his partners concluded that they had at least three options: keep the practice intact but change the workload, find a new job with another group or hospital, or become employees of HCA.

Keep practice intact

Waxman and the group had been understaffed for over a year; he knew they could not continue this same workload with the current staff. In order to keep the practice intact, major changes had to be made. They had to cut back further on the number of outreach clinics served, limit the

number of outpatient follow-ups (refer patients back to their primary physicians) and reduce the number of Medicaid patients they treated. Thus, he concluded, to maximize profit with fewer physicians the group had to increase procedures that generate more revenue per hour and change the patient mix to reduce the thirty percent of receivables uncollected.

For Waxman the option of simply reducing their workload or shifting away from much of their cognitive work such as outreach to fit a smaller group was problematic. He had become used to a group of eight that was large enough that they could share weekend calls but only have to do that once a month (two physicians worked per weekend). With only 5-6 doctors or less, each doctor was on call nearly twice a month.

Find jobs elsewhere

The KCPC doctors had established both professional and social bonds over a 25-year period that were very strong but at this point they had to consider jobs elsewhere. Dissolution of the practice would be more than breaking up a professional organization; it would be breaking up a close-knit family. Finding a practice similar to KCPC with the same values towards patient care might be a better option than working at a for-profit hospital where those values would not be guaranteed. While Waxman was looking at alternatives to keep the group together, he had already interviewed with another group.

Become employees of HCA

They knew HCA needed the practice. As managing partner, Waxman was charged by the group to look at this possibility. As Waxman mulled over working for HCA, he saw some benefits, not the least of which was to allow the group to stay together. But as an independent group, KCPC had also had the benefit of controlling things like schedule and compensation that likely would change as a result of a new employment status. "We would now have less say about our business while working with a corporation that didn't necessarily consider the patient first." Of further concern for Waxman was the rampant use of RVUs to value doctor compensation. Although the clinic had not changed the nature of its work, Waxman knew that the new rating measures like RVUs were changing the way doctors and hospitals were being valued and paid. Nonetheless, he realized that, "This option allows me to keep working with some of the best physicians I have ever known and in a hospital and for patients for whom I felt it was an honor to serve." He wanted to consult the other partners—four of them had been his colleagues for nearly 20 years—to consider this difficult choice.

Appendix: Glossary of Key Terms

1996 Health Insurance Portability and Accountability Act (HIPAA): HIPAA is a federal law that establishes standards for the privacy and security of health information, as well as standards for electronic data interchange (EDI) of health information.

HIPAA has two main goals:

1. Making health insurance more portable when persons change employers.

2. Making the health care system more accountable for costs by trying to reduce waste and fraud.

Capitation Payments: Capitation payments are a fixed amount of money per patient per unit of time paid in advance to the physician for the delivery of health care services (acponline.org).

Fee-for-service: Traditional method of paying for medical services whereby a practitioner bills for each encounter or service rendered, also known as indemnity insurance. This system contrasts with salary, per capita, or pre-payment systems, in which the payment is not changed with the number of services actually provided.

For-Profit Hospitals: Investor owned hospitals which attempt to make a profit for their shareholders (Wikipedia.org).

Managed care: Health care systems that integrate the financing and delivery of appropriate health care services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health care services, explicit standards for selection of the care providers, formal programs for ongoing quality assurance and utilization review, and significant financial incentives for members to use providers and procedures associated with the plan.

Medicaid: Jointly funded federal and state program that covers hospital expenses and medical expenses for low-income families with children and certain aged, blind and disabled individuals.

Medicare: Federal program established under the Social Security Act that provides health insurance for elderly and certain disabled individuals. Medicare has two parts:

> Part A: hospital insurance that helps to pay for inpatient care, skilled nursing facility (SNF) care, home health care and hospice care. Medicare pays for pharmaceuticals provided in hospitals, but not for those provided in outpatient settings.
>
> Part B: insurance that helps to pay medically necessary physician services (both inpatient and outpatient) and outpatient hospital costs not covered under Part A.

Not-For-Profit Holding Company: Corporation transfers certain assets (real estate) to a title holding corporation. This is done to protect the assets from uninsured or under insured liability claims. A title holding company is exempt from federal taxes.

Not-For-Profit Hospital: a hospital organized as a non-profit corporation. Excess revenues generated by the hospital's activities are invested in the improvements and upgrading of the hospital and its services (uslegal.com).

Primary Care: General or basic health care focusing on preventive care and the treatment of routine injuries and illnesses. Primary care is provided as the patient's first contact on an outpatient basis.

Pulmonologist: To become certified in pulmonary disease a doctor (MD-Medical Doctor or DO-Doctor of Osteopathy) must be previously certified in the field of Internal Medicine and subsequently complete a fellowship training program in pulmonary medicine. The physician

November 2014, Vol. 32, No 2, p. 33-48
ISSN 2162-3171

must then pass the Pulmonary Disease Certification Examination (www.abim.org/certification/policies/imss/pulm.aspx).

> The nature of pulmonary medicine or "chest disease" typically lends itself to a dual certification in both pulmonary disease and critical care medicine. This training typically involves three years of fellowship after the physician has completed an internal medicine residency.
>
> Typically these physicians will manage the day-to-day care of the most acutely ill patients residing in intensive care units and most of the pulmonary patients will have some type of chronic disease such as emphysema, asthma, congestive heart failure, or multiple organ system failures.

Resource-Based Relative Value Scale (RBRVS or RVUs): RVUs ("Relative Value Units") are tied to the RBRVS ("Resource-Based Relative Value Scale"). This is a methodology used by Medicare (among others) to help determine how much physicians should be paid for providing healthcare services **(**www.redlog.com/blog/?p=189).

There are three components to Relative Value:

> **Practice Expense**: This is composed of the direct costs (supplies, non-physician labor, equipment cost, etc.), and a factor accounting for the indirect costs, of providing the medical service.
>
> **Malpractice Expense**: This includes malpractice (professional liability) and other insurance expenses. These costs are separated from "normal" expenses so they can be tracked separately, and because they vary quite widely based on geography.
> **Physician Work**: This includes items such as the physician's time (salary), training, skill, judgment, etc. necessary to provide the service. If a procedure is more complex, it is assigned a higher "work" value.

Specialist Physician: A physician who devotes himself or herself to the study and treatment of a particular group of diseases.

Third Party Payers: An organization other than the patient (first party) or the health care provider (second party) involved in the financing of personal health services (usually an insurance company, Medicare, or Medicaid) (thefreedictionary.com).

Web-Based Glossaries of Medical Managed Care Terms:

Centers for Medicare & Medicaid Services Glossary:
http://www.cms.gov/apps/glossary/

Online Journal of Issues in Nursing Glossary for Managed Care:
http://t.co/WRj6LmTQL0

Managed Care Resources, Inc. Managed Care Terms and Definitions:
http://www.mcres.com/mcrdef.htm

November 2014, Vol. 32, No 2, p. 33-48
ISSN 2162-3171

Tufts Health Care Institute: Managed Care Glossary
http://www.thci.org/other_resources/glossary.htm

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