

A Tighter Bond:

California Hospitals Seek Stronger Ties with Physicians

Introduction

California hospitals, like many others across the country, have generally relied on the voluntary medical staff model to align, albeit loosely, with physicians. The model is premised on hospitals acting in ways that are beneficial to physicians, such as by acquiring new equipment, in exchange for physicians receiving hospital admitting privileges that include implied responsibilities, such as participating in quality improvement activities and providing emergency call coverage.

In recent years, however, there has been considerable erosion in the voluntary medical staff model as services shift to the ambulatory care setting, often to physician-owned facilities, and as competition between hospitals and physicians intensifies.¹ With this shift, many physicians are less dependent on hospitals to support their practices, but hospitals still rely on physicians to admit and treat patients, to provide emergency call coverage, and to support other hospital activities, such as quality-improvement efforts. Moreover, the shift dilutes the combined strength of hospitals and physicians in negotiating higher payment rates from insurers.² Pressured by these developments, California hospitals are seeking ways to gain the allegiance of physicians by tightening alignments with them.

Recent site visits to six California markets conducted by the Center for Studying Health System Change (HSC) found that hospital strategies to align with physicians often parallel those seen elsewhere in the country: joint ventures;

emergency call coverage arrangements; use of hospitalists; quality enhancements; and medical directorships. However, the study also found factors, often distinct to California, that significantly influence how these relationships are structured. Perhaps most significant is the state's corporate practice of medicine prohibition that generally precludes hospitals from directly employing physicians, an alignment strategy hospitals outside of California increasingly are using.

Some California hospitals are pursuing strategies such as establishing medical foundations to try to achieve results similar to direct physician employment. However, the complexity and costs of such efforts may preclude smaller, financially weaker, and rural hospitals from pursuing them, thus widening gaps between them and stronger, competing hospitals. To encourage hospital-physician care delivery models with the most promise to improve efficiency and care quality, California policymakers might examine whether existing laws and regulations that influence the hospital-physician relationship, which were written in a different era, might be restructured to better facilitate those goals.

This issue brief examines hospital-physician alignment in California, focusing primarily on strategies being pursued by non-Kaiser hospitals, based on findings from site visits to six California markets: Fresno, Los Angeles, Riverside/San Bernardino, Sacramento, San Diego, and the San Francisco Bay Area.³ It first examines federal and state laws that influence the structuring of hospital-physician relationships, then discusses strategies that some hospitals use

HSC's Six-Community Market Study

In fall 2008, a team of researchers from the Center for Studying Health System Change (HSC) conducted site visits to six California communities to study those markets' local health care systems and to gain insights into regional characteristics in health care affordability, access, and quality. The six markets — Fresno, Los Angeles, San Francisco Bay Area, Riverside/San Bernardino, Sacramento, and San Diego — reflect a range of economic, demographic, health care delivery, and financing conditions. Approximately 300 interviews were conducted between October and December 2008 in the six communities with representatives of hospitals, physician organizations, health plans, major employers, benefit consultants, insurance brokers, community health centers, state and local policymakers, and other stakeholder organizations.

This issue brief on hospital-physician alignment is based primarily on interviews with executives of hospitals and medical groups. A two-person research team conducted each interview, and notes were transcribed and jointly reviewed for quality and validation purposes. The interview responses were coded and analyzed using ATLAS.ti, a qualitative data management and analysis software tool.

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to work around these legal constraints. The brief goes on to consider other important ways in which hospitals are trying to tighten their alignments with physicians and concludes with a discussion of implications for policymakers and other stakeholders.

Federal and State Laws Influence Hospital-Physician Relationships

A number of federal and state laws significantly influence how hospitals can structure their relationships with physicians. These include constraints imposed under the federal Stark (self-referral) and anti-kickback laws, which are intended to prevent financial incentives, particularly through patient referrals, from inappropriately influencing providers' medical decisions.^{4,5}

There also are California laws regarding hospital-physician relationships, including most prominently, the bar

on the corporate practice of medicine.⁶ Unlike the growing trend in many other areas of the country, of hospitals directly employing physicians to provide professional (clinical) services, the California corporate practice of medicine law generally precludes corporate entities, including hospitals, from directly employing physicians. The intent of California's physician employment prohibition is to prevent corporate entities, which are not licensed to practice medicine, from providing incentives that may unduly influence physicians' independent medical judgment, and may negatively affect the care patients receive.⁷ California is one of only a few states that explicitly prohibit the direct employment of physicians by hospitals.

There are some exceptions in California to the corporate practice of medicine bar.⁸ For example, professional medical corporations, University of California hospitals, county hospitals, narcotic treatment programs, some nonprofit

organizations such as community clinics, and Knox-Keene-licensed health maintenance organizations (HMOs) are allowed to employ physicians directly. Also, a small, state-sanctioned pilot program, scheduled to run until January 2011, allows some health care district hospitals operating in underserved rural or remote communities to employ up to two physicians, though it limits the total number of physicians employed by all participating hospitals to 20.⁹

Views about the corporate practice of medicine bar vary widely among California providers. The California Medical Association is vehemently opposed to hospitals employing physicians, while the California Hospital Association believes the prohibition is outdated. Despite that apparently clear divergence of opinion on the issue between physicians and hospitals, respondents in this study expressed various views that were not simply delineated along physician-hospital lines. Respondents across markets reported an increasing number of physicians—particularly those in solo or small practices—who do not want the burden of operating a private practice and are amenable to, even eager for, some type of employment arrangement via a medical group or other entity, such as a hospital. As a San Diego hospital CEO said, “They [physicians] don’t want to hang up a shingle and do private practice. Physicians want benefits, a 9 to 5 job, and weekends off—just a job.”

The trend toward physicians wanting employment rather than an independent practice is not limited to younger physicians just starting their careers. According to a San Francisco medical group executive, “Physicians with more mature practices, particularly on the primary care side, find it untenable to practice as an independent physician. Our growth is not new graduates out of residency programs, but people in the community joining groups to have a more predictable life.” Employment is attractive to physicians to the extent that it alleviates reimbursement pressures and provides a predictable income. These factors are likely to become even more important as health plan enrollment in California shifts from HMOs to preferred provider

organizations (PPOs) and reimbursement shifts from capitation (per-member, per month basis) to fee-for-service, leaving many independent physicians with little negotiating leverage.¹⁰ Other benefits of employment may include reduced complexity due to the limiting of practice to one hospital or system, relief from high malpractice premiums, access to capital, and a better overall work-life balance.

Strategies to Bypass the Direct Employment Prohibition

A number of hospitals in California have begun to pursue several strategies, including the use of medical foundations and outpatient departments, to achieve the benefits of direct physician employment, including tighter clinical integration and joint contracting with insurers. The state’s corporate practice of medicine law generally precludes corporate entities from employing physicians because the medical care rendered by physicians would then be attributable to an unlicensed employer. However, medical foundations and outpatient departments offer legal exemptions from licensure, which leaves them outside the reach of the corporate practice of medicine law.

MEDICAL FOUNDATIONS

Many hospital executives are enthusiastic about the use of hospital-affiliated medical foundations to permit a hospital to more closely align with physicians. According to a San Diego hospital CEO, the medical foundation model “can get you to a similar end result [as employment].” The legal basis for medical foundations is Section 1206(l) of the California Health and Safety Code, which exempts from licensure clinics operated by a nonprofit corporation (such as a medical foundation) if they meet certain requirements. To qualify for this exemption, a medical foundation must conduct medical research and health education, and provide medical care through a group of 40 or more independent contractor physicians and surgeons. These doctors must represent not less than 10 board-certified specialties, with not less than

two-thirds of the group practicing on a full-time basis at the foundation's clinic.

To establish a medical foundation, a hospital must form a 501(c)(3) nonprofit corporation to buy the assets of physician practices. The foundation can be either a hospital affiliate with a common parent organization or a hospital subsidiary.¹¹ The foundation's board must consist of physician, hospital, and local community representatives, with affiliated physicians making up no more than 20 percent of the board's members. The foundation is responsible for practice administration and contracts with physicians for professional services, with the physicians remaining independent contractors. As a San Diego medical group executive with a foundation affiliation described, "In the foundation model, it has to be through the medical group. The foundation contracts with the physician entity, and they hold the health plan contracts, and we have a professional services agreement to tie each party to the other. We [the medical group] provide the employment relationship."

Medical foundations have existed in California for nearly two decades, though they are still limited in number. The foundations are located in markets throughout the state but are more prevalent in northern California (Sacramento and San Francisco) and San Diego, where there is a high level of hospital and physician concentration.¹² Respondents in the present study reported a growing interest on the part of hospitals statewide in exploring the feasibility of sponsoring a medical foundation as a key component of their physician alignment strategies. As a San Diego hospital chief medical officer (CMO) said, "It's the foundation model that is key to partnering and legally sharing capital."

In areas where physicians are in particularly short supply and medical foundations do not currently exist, such as in Fresno, several respondents discussed the potential benefits of such foundations in helping facilitate recruitment through income guarantees and other practice support. Respondents also discussed the value of medical foundations in helping

hospitals compete with Kaiser Permanente for physician recruitment and retention. Kaiser's unique integrated delivery model allows it to align hospitals and physicians in ways that other hospitals in the state cannot: Kaiser's Permanente Medical Groups employ physicians who exclusively serve Kaiser's hospitals, which reportedly contributes to it increasingly becoming the destination of choice for many California physicians, particularly primary care physicians.

Establishing a medical foundation in California, however, can be complex and costly. As a result, it is likely to be a less viable alignment strategy for smaller and financially weaker hospitals, as well as for hospitals located in rural areas where the supply of physicians, particularly specialists, may be inadequate for establishing a medical foundation.

OUTPATIENT DEPARTMENTS

Outpatient departments are another strategy some hospitals use to work around the state's direct employment prohibition. Outpatient departments are under the purview of Section 1206(d) of the California Health and Safety Code, which authorizes hospital outpatient departments to operate as clinics without a license. In this model, there typically exists a professional services agreement between the hospital and individual physicians, physician groups, or medical professional corporations that employ physicians. The hospital provides the necessary infrastructure and support for operating the clinics, including the physical space, management, support staff, equipment, supplies, medical records, patient registration, and facility billing. Under this type of arrangement, physicians bill third-party payers for professional services only.

Compared to medical foundations, however, the outpatient department model was not identified by respondents as an equally viable physician alignment strategy. Further, there is considerably more opposition to this model, including from the California Medical Association, which asserts along with others that some of these arrangements are illegal under the state's corporate practice of medicine bar.

Despite potential legal challenges, however, some hospitals are using the outpatient department model. For example, a hospital in the Fresno area operates a rural health clinic network of primary care physicians using this model, and the model also exists in some Los Angeles hospitals.

Additional Alignment Strategies

California hospitals use several other, more traditional strategies—also used by hospitals outside of California—to align with physicians. These include joint ventures, emergency call coverage arrangements, quality enhancements, and medical directorships.¹³ Hospitals often use more than one of these strategies, sometimes in conjunction with operation of medical foundations or outpatient departments. The specific strategies that an individual hospital pursues may be limited by individual circumstances, including the hospital's ability to finance them. Hospitals use these various strategies to address specific challenges: competitive threats from physicians and other hospitals; poor patient flow, especially in emergency departments (EDs); and differentiation of their facilities in order to increase bargaining power with insurers.

JOINT VENTURES TO REDUCE COMPETITIVE THREATS

Hospitals often seek alignment with physicians to reduce competitive threats from physician-owned facilities and other hospitals. Several respondents noted, for example, that strained hospital-physician relationships and the potential for increased earnings may prompt physicians to operate their own clinics or otherwise directly compete with the hospital. According to a Fresno hospital CEO, “Years ago, the management wasn't very physician-oriented, and [wasn't focused on] trying to develop models that worked well with the medical staff and making sure physicians could get good OR [operating room] times and turn cases over quickly... and the competitive pressures and financial incentives to make money led many physicians to open their own businesses.”

Joint ventures with physician groups is an important strategy that hospitals have used to reduce such competitive threats as the creation of entirely physician-owned facilities and the migration of physicians to other facilities. These arrangements often are structured so that hospitals have an equal or majority financial interest. Joint ventures are most common with single-specialty physician groups and typically range from equipment acquisition to more complex and costly building activities, such as the development of ambulatory care centers for surgery, endoscopy, and diagnostic and imaging services. As a San Francisco hospital CMO said, “If we hadn't done it [joint ventures with physicians], we would have lost a fortune. Now, we just lose some fortune.”

However, hospital and physician respondents had mixed opinions about how effective joint ventures are as an alignment strategy. According to a Los Angeles market observer, “It [joint venturing] seems to have run its course. [It] doesn't seem to be quite as attractive. Physicians can do it on their own. Before, 20 years ago, they needed the hospital to set up imaging centers. In the last few years, the financing has been there, and the technology is available, so, they [physicians themselves] do it.” Other respondents expressed caution about entering into joint ventures because many have failed. As a Los Angeles hospital CEO said, “Other hospitals have gone through joint venture phases... and then unwound them, for [they] failed financially. We never got into that business and everyone called us stupid, but it was a wise decision.” Respondents attributed these failures to various factors, most particularly to poor management. In some markets, such as Fresno, where joint ventures have been used extensively, recent failures suggest that the market may have reached a saturation point, such that new joint ventures are financially unsustainable.

HOSPITALISTS AND INFORMATION TECHNOLOGY TO IMPROVE PATIENT FLOW

Improving patient flow is another reason for hospitals to seek better alignment with physicians. California hospitals have long struggled with insufficient physician emergency call coverage, which can result in increased wait times for ED patients and contribute to emergency room crowding. As one Los Angeles market observer noted, “In a few cases, hospitals have had to close a service on their license because they chronically can’t get anyone [a physician] in their ED.”

Physicians have become increasingly reluctant to provide emergency call coverage for a number of reasons, including the shift of services to ambulatory care settings and problems with payment for emergency care, especially for uninsured and Medi-Cal patients. California hospitals often attempt to address the issue by entering into professional services agreements with medical group practices to provide physician emergency call coverage. As hospital executives often mentioned, however, these arrangements can be financially burdensome for the hospital. For example, a Los Angeles hospital CEO reported paying surgeons \$1,500 a day to provide emergency call coverage, while a Fresno hospital CFO reported paying more than \$14 million annually for emergency and other physician coverage arrangements. Although hospitals outside of California also have difficulties securing emergency call coverage, they can employ physicians to address the issue, a strategy unavailable to most California hospitals because of the corporate practice prohibition.

A longstanding trend in California hospitals to improve throughput is the use of hospitalists—physicians who specialize in treating hospitalized patients.¹⁴ In addition to providing inpatient coverage, hospitalists’ around-the-clock availability also can help hospitals respond to emergency call coverage needs. Moreover, these arrangements reportedly help hospitals to more closely align with community-based physicians by “putting in structures to help them stay in [their office-based] practice, where they can earn more.” A recent trend noted by respondents is the evolution of

California’s hospitalist model from a focus on adult general medical care to more specialized care, including surgical and pediatric hospitalists, resulting in increased support for an even larger number of affiliated physicians.

Hospitals are also using information technology to improve alignment with physicians. Many respondents discussed the importance of providing physicians timely and easy access to patient information, such as laboratory and radiology results, to keep patients moving through the hospital toward discharge. This type of information is often made available via physician portals accessed through hospital Web sites. However, there is considerable variation among hospitals’ information technology capabilities, such as electronic medical records, often because of cost constraints, and the need to make their systems compatible with those of their physicians.

ESTABLISHING REPUTATION AND PHYSICIAN INVOLVEMENT TO DIFFERENTIATE FACILITIES

Many hospital executives discussed the importance of establishing and building good relationships with physicians so as to differentiate their hospitals from competitors, often by establishing the hospital’s reputation for quality. One approach is to establish the hospital as *the place* where physicians want to practice and patients want to receive care, which helps increase the hospital’s bargaining power with insurers over payment rates. Many hospital executives reported pursuing strategies specifically focused on enhancing their quality reputations as a way of differentiating themselves. In San Diego, for example, these strategies are manifest as Sharp HealthCare’s “The Sharp Experience” slogan and the University of California San Diego Medical Center’s (UCSD) official mission of “clinical excellence through service, innovation and education.” Sharp’s receipt of the prestigious national Malcolm Baldrige award for quality in 2007 helped the system emphasize its distinctiveness, as did UCSD’s designation as a National Cancer Institute center of excellence.

Hospitals also are affiliating with well-regarded specialists and academic medical centers as a differentiation strategy to help attract and build relationships with physicians. As a Sacramento hospital CFO stated, “We try to attract them [physicians] by quality of care and the specialist physicians they have access to.” This strategy has been particularly prominent in Fresno where hospitals are affiliating with academic medical centers, including the University of California, San Francisco, and Stanford as part of a broad set of service-line, physician-alignment, and quality-improvement strategies, in large part aimed at stemming the exodus of potential patients to other markets, such as Los Angeles and the San Francisco Bay Area.

The use of medical directorships for well-respected physicians is another hospital strategy for enhancing their quality reputation, and often are part of a larger strategy to improve specific service lines, typically neurosurgery, orthopedics, cardiology, and cardiac surgery. As a San Diego hospital CMO commented, “The other way, besides joint venturing, is active involvement in the direction of the hospital. So you have the hospital management work with its physician leadership in terms of developing its strategy and plans. Even in a community hospital, you see they’re using physician leaders from the medical groups and practices as part of their management team. Physicians do part-time in practice and part-time as a chief information officer, chief medical officer, or chief of staff so that the hospital management is not without a physician voice.”

Conclusion

California hospitals are seeking tighter alignment with physicians, but these relationships are exceedingly complex, often crafted based on the idiosyncrasies of local health care markets, including the financial wherewithal of hospitals to pursue particular strategies, and the willingness of physicians to be more tightly aligned. Some of the alignment strategies in California are used more extensively by hospitals there than elsewhere, in large part because of the state’s corporate

practice of medicine prohibition. On the one hand, this prohibition may promote tighter alignment through more clinically integrated care delivery models based in primary care-oriented, multispecialty groups—models that may also improve patient care outcomes and efficiencies. In some cases, however, the corporate practice law may preclude tighter hospital-physician alignment because it prevents most California hospitals from directly employing physicians. This situation has led to the development of strategies for working around the prohibition, such as the creation of medical foundations, which may ultimately add costs to the health care system because of the additional infrastructure required to operate them. Moreover, the complexity and costs associated with many of the physician alignment strategies currently being used by California hospitals may make them unworkable for smaller, financially weaker, and rural hospitals, which in turn may widen the gap between these hospitals and competing, financially healthier facilities.

At the national level, there is growing recognition that effective alignment between hospitals and physicians is fundamental to reforming care delivery in the United States health care system. While national reform efforts can set the stage for change in local health care markets, policymakers would do well to keep in mind that individual market characteristics and state regulations, as California illustrates, also influence the structure of hospital and physician relationships. Forging national policies, including Medicare payment reform, that encourage providers to align in order to deliver higher quality and more efficient care is critical. At the same time, policymakers need to consider the potential downsides of encouraging tighter hospital-physician alignment, such as a growing consolidation of market power that could lead to higher overall health care costs.

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ABOUT THE FOUNDATION

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

California Health Care Almanac is an online clearinghouse for key data and analysis examining the state's health care system. For more information, go to www.chcf.org/topics/almanac.

ENDNOTES

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4. 42 U.S.C. §1395nn.
5. 42 U.S.C. §1320a-7b(b).
6. California Business and Professions Code §§2052, 2400; Kim, Allegra. *The Corporate Practice of Medicine Doctrine (CRB 07-011)*. California Research Bureau, Sacramento, CA, October 2007.
7. Ibid.
8. The exceptions are established in state statutes, judicial decisions, and opinions of the California Attorney General.
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