Integrating Subspecialists into Group Practice

The Role of Income Distribution in Building Internal Referrals

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There are many potential clinical, strategic, and financial advantages to adding subspecialists to medical groups with established primary care bases. These include better continuity of care and convenience for patients, improved leverage with payers and hospitals, and increased group profits from tests and ancillary services.

However, realizing these potential advantages depends on effectively managing referral patterns to keep as many patient referrals as possible within the multispecialty medical group (MMG). Out-of-group referrals, or leakage, can quickly undermine the success of MMGs by creating external financial obligations and/or internal dissention.

Income distribution formulae can and should play an important role in encouraging internal referrals. The optimal arrangement is to implement a formula that is seen as fair and beneficial by all. It must reward primary care physicians without penalizing subspecialists. Maintaining this balance is essential to avoid internal resentments and the resulting lack of cooperation with the internal referral protocols that MMGs depend upon to give themselves a market advantage.

The Importance of Internal Referrals

The decision to recruit subspecialists into a largely primary care group is typically driven by clinical, strategic, and financial considerations. Clinically, internal specialists can facilitate patient care and communications. Strategically, MMGs can establish themselves as "one-stop shopping" for their patients' health care, and gain leverage in negotiating insurance contracts. Financially, overall group profits can be raised since subspecialists tend to contribute more to the corporate margin than primary care physicians, both directly through fees and indirectly through ancillary revenues generated by tests and procedures.

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Internal referrals are essential to achieve these advantages. A newly recruited subspecialist will expect and should receive enough referrals from inside the group to generate an income comparable to what he or she could make outside, usually with greater certainty and less public relations work on the part of the specialist. To achieve this goal, an internal referral protocol should be developed and shared with primary care group members, stressing the overall clinical, strategic, and financial advantages of having subspecialists in the group.

Compliance with such a protocol is especially important because a specialist recruited from the community is likely to see a reduction in referrals from primary care physicians outside the group. These outsiders often feel,

sometimes legitimately, that they are in competition with the MMG primary care base and are "feeding the enemy" if they refer patients to the group.

Why Leakage?

Clearly, failure to receive referrals from inside the group can be both financially and strategically unhealthy, as well as professionally demoralizing, to the subspecialists. So why does it happen?

Lack of physician cooperation and desire for physician autonomy even within MMGs are issues often cited in the professional literature.[1] Anecdotally, the reasons given for leakage usually fall into the following categories:

- **Availability:** The internal subspecialist cannot accommodate the patient in time.
- **Personality:** The referring physician does not get along with the subspecialist, or perceives that the patient will not.
- **Quality:** The referring physician believes the patient can be better served elsewhere.
- **Convenience:** The referring physician has a comfortable relationship outside.
- **Professionalism:** The referring physician believes the internal referral protocol inappropriately interferes with professional judgment or prerogative.
- **Inpatient Events:** The referring physician does not have the option of referring a patient in the hospital to a group member.
- **Compensation Discordance:** The referring physician is disgruntled about the way specialists are compensated in the group and expresses it by withholding referrals.

Of all these, compensation discordance is often the most provocative. In our experience, a compensation formula that is seen as unfair either by primary care physicians or subspecialists often drives professional jealousies that result in leakage, though physicians usually will give other reasons. If not addressed, these internal grudges sap both morale and profitability. Departures of both primary care and subspecialist physicians often follow. Combined with other management strategies to ensure appropriate in-group referrals, a proper compensation plan plays a central role in reducing leakage and ensuring MMG coherence and success.

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Getting Compensation Right

The key to encouraging internal referrals is to create and implement a market strategy that enhances profits for the entire group, and then develop a compensation formula that rewards all physicians for the value of internal referrals. If the compensation formula encourages internal referrals by increasing the contribution to corporate margin (hence increasing physician compensation), internal referrals are more likely to occur. In particular, practices with managed care risk contracts can generate significant profits and avoid unnecessary professional expenses paid to outside providers by keeping specialty referrals in-house.

In designing a compensation plan, it is important to resist the temptation to subsidize primary care pay by lowering subspecialist pay. Market forces usually dictate that specialists in a MMG must earn compensation equivalent to that which they could earn outside. Specialists will leave, and quickly, if they can make more elsewhere.

However, additional MMG income from ancillary services and gains on risk contracts should be shared with primary care physicians. If the extra income from these activities only benefits subspecialists, participation by primary care providers in intra-group referrals will decrease.

Ideally, a fair estimate of how much total group income goes up as a result of internal referrals should become the basis for distributing income beyond historical productivity levels. The method for determining this extra income should be transparent and clearly communicated to physicians so all can see it is fair. Making and regularly publishing such a calculation will also reinforce to all physicians the value of internal referrals, making greater compliance more likely.

Addressing Other Leakage Causes

Once the value of internal referrals is established through the compensation formula, unnecessary out-of-group referrals will almost certainly decline. However, some issues may continue to drive referral leakage.

One is volume. MMGs usually do not have all the subspecialists needed to be all-inclusive. In an era of super sub-specialization, it may be more practical, appropriate, and cost-effective to include in the group only those specialties with a relatively high referral rate. To do otherwise, even though fulfilling clinical or strategic needs, may result in a net income loss. Such losses will limit or even eliminate the group's ability to create financial incentives for internal referrals.

Even with strong economic incentives in place, personality issues can develop between referring physicians and subspecialists. In some cases, there may be an assumption by the referring physician that the patient and the subspecialist will have personality conflicts. Lack of group identity may also contribute.

Customary referral behavior

and community standards also are leakage factors for new primary care physicians. If physicians who join a MMG are in the habit of referring to a particular specialist practitioner or the community has a longstanding, recognized specialist in a given clinical area, old patterns of practice may resist pressure to change.

Improvement in quality is cited as a major reason for joining a MMG.[2] However, desire for high quality also can create conflict if physicians do not believe that the internal subspecialists meet quality standards. Leakage can result from mistrust by the referring physician of other physicians' clinical skill, or a belief that there is a better-quality physician outside the group. This is one of the most difficult issues to deal with, since there is always an ethical and fiduciary responsibility on the part of physicians to refer patients to clinicians who, in their clinical judgment, are the best available.

Appointment availability, insurance considerations, and location convenience also play an important role in facilitating referrals. Many MMGs promote their one-stop shopping approach. However, while internal referrals support the spirit of one-stop shopping, making a patient wait for an appointment with an internal specialist undermines timely and convenient care.

Professional issues with a peer in a medical group can also result in leakage. Often, different practice styles or process-related problems such as inconsistent record keeping, even if

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they do not compromise quality of care, challenge relationships. Some MMG members may resent having to send their referrals to someone rather than being able to exercise their clinical judgment as they might outside the group.

The current healthcare environment also has created numerous circumstances in which primary care physicians have no control over who provides care to their patients. Hospitalization is often a problem. If a MMG does not take care of its own inpatients, either by rotation, call, or employing hospitalists, or does not have a working relationship with those who do care for its inpatients, leakage may readily occur during hospitalization.

None of these factors is easy to address. But focusing on them can provide some relief to leakage. While some of these issues may be related to the size and physician makeup of a group,[3] establishing an organizational identity and culture, or so-called "group think," is critical to reduce leakage.

Some strategies for building a culture and reducing leakage include:

- Establish within the physician organization a policy on leakage and empower a committee or group to monitor compliance, including number of referrals to outside specialists and internal source of these referrals.
- Regularly evaluate the mix of subspecialists and evaluate recruitment opportunities for new physicians as volume requirements warrant.
- Establish opportunities for telephone "triage" by specialists who cannot commit to in-person availability.
- Mandate educational sessions with all subspecialists for primary care physicians and formalize criteria for appropriate referrals and ongoing monitoring.
- Create an "Internal Referral Coordinator" position to be responsible exclusively for all external referrals and have the coordinator report statistics regularly to the quality assurance committee and Medical Director.
- Have the Medical Director meet regularly with repeat offenders. Legitimate clinical concerns and convenience issues should be accepted as reasons for outside referrals, but "soft" or collegial reasons should be questioned.
- Aggressively evaluate claims of lower quality made against internal subspecialists and take action as appropriate.
- Review inpatient leakage trends and execute a strategy to minimize opportunities for loss of control of hospitalized patients, such as instituting a hospitalist program.

Physician communication is key to resolving issues with quality assurance and leakage. Feedback to specialists and collaboration between primary care physicians and specialists on MMG quality assurance committees are critical to this process.

Conclusion

MMGs continue to exist as a common care delivery model even if single-specialty groups have seen growth recently.[4] Indeed, recent reimbursement cuts are driving a resurgence in interest in organizing MMGs as a method for legally enhancing group revenues by offering ancillary services. In such circumstances, an appropriately managed compensation formula becomes an essential tool for incentivizing internal referrals to achieve the strategic goals of forming an MMG.

While some legitimate leakage is to be expected, MMGs need to set a target, acceptable amount and evaluate referral protocol compliance regularly. The target should be modified as needed, and regular feedback on referral performance and standards should be provided to the MMG primary care physicians, specialists, and management. The strategies outlined above are well suited to reducing leakage in MMGs by encouraging a constructive dialogue on the value of internal referrals and rewarding physicians for compliance. These strategies can improve intra-group professional relationships, provide more-inclusive and better-quality patient care, improve corporate margins, raise MMG provider compensation, and increase MMG stability.

References

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