Recruiting “superstar” doctors from competing hospitals has been a concern in the past decade because of confusion over Stark laws relating to the size and scope of financial packages that can be offered and the size of the geographic area in which top doctors can be recruited. But with the final regulations issued for Stark II in 2004 and a greater need by hospitals to recruit superstar doctors—who bring potential business along with their reputations—experts believe in-town recruiting is beginning to flourish once again.

Case in point: In December 2005, the 585-bed University of Chicago Hospitals pulled off a major coup when it recruited seven members of the 12-member lung transplant team at 505-bed Loyola University Medical Center, Maywood, Ill. The two hospitals, which are approximately 18 miles apart, offer the only lung-transplant services in Chicago.
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The team includes Medical Director Edward Garrity, M.D., Associate Medical Director Sangeeta Bhorade, M.D., surgeon Wickii Vigneswaran, M.D., anesthesiologist Irene White, M.D., and three nurses.

Recruited by James Madara, M.D., dean of the university’s Pritzker School of Medicine, and Joe “Skip” Garcia, M.D., chairman of the school’s department of medicine, the team’s hiring was a strategic move to improve the hospital’s financial, quality and research activities. “Lung transplantation is a good investment of resources,” Garcia says. “Only major academic medical centers can offer these unique treatments.”

“UCH offered us a much larger infrastructure, and the research side was a big draw,” Garrity says. “We hope to conduct a wide range of pulmonary research” focusing on ameliorating the effects of lung transplantation.

Madara says the hospital expects to recoup the $3.35 million initial investment in the new lung transplant program within three years. The funding would help cover anticipated financial losses over that time along with supporting the salaries of the transplant team. “This is a program that has the potential, over time, to operate in the black,” Madara says. Garrity’s team “is known not just for getting good clinical results but also for using resources efficiently.”

Garrity says initially he was not interested in leaving Loyola when contacted by two University of Chicago Hospitals physicians about relocating. “I felt for a number of years I had reached the top of the learning curve at what I was doing at Loyola,” he says. Over 23 years, Garrity’s team had conducted more than 500 transplants. Their one-year survival rate of 90% is above the national average of 80%, he says.

Greg Spencer, a physician recruiter with Kendall & Davis, says using a go-between to initiate contact with a potential recruit is a good tactic. “A little distance can allow the hospital to maintain some confidentiality and not feel like they poached another hospital’s doctor,” Spencer says.

Garrity says he doesn’t believe there was any bad blood over his departure at Loyola. “Sure, there were questions about why and why now,” he says. “As often happens, when you have been at a place for a long time, word of discussions gets out. When I made the decision, I talked with my department chair. … I didn’t feel any hostility.”

Madara says that several years ago Loyola recruited one of the University of Chicago Hospitals’ top electrophysiologists to head its cardiology section. “We remained cordial throughout,” he says, adding: “All academic medical centers share common concerns … yet we compete with each other for patients, staff and faculty.”

Recruiting superstar physicians—cardiologists, heart surgeons, neurologists, orthopedic surgeons or other big patient-admitters—from a competitor across town is hardly new. For years, doctors have been offered a variety of financial and work-related recruiting arrangements, including higher salaries, low-interest loans, relocation expenses, a department chairmanship or a more extensive work environment.

But during the early ’90s, the dual effect of the physician self-referral prohibitions of Stark I and the so-called 100-mile Hermann Hospital rule—actually a 1993 opinion from HHS’ inspector general’s office on doctor-stealing incidents—put a chill on in-town recruiting, say legal and recruiting experts.

The Hermann rule began in 1994, when what is now called Memorial Hermann Hospital in Houston entered into a closing agreement with the Internal Revenue Service to pay nearly $1 million in fines and to stop paying recruited physicians excessive incentives and tying those payments to referrals. Hermann admitted providing newly recruited physicians in their market area such free incentives as income guarantees, office personnel salary support, free office space, subsidized parking, malpractice insurance and phone allowances.

“Recruiting competing doctors from competitors used to happen all the time,” says Brian Rogers, executive vice president and principal with Jackson & Coker, a physician search firm. “For the longest time, Stark and the Hermann Hospital rule caused administrators to instruct us to build a hedge around physician recruitment and not even call or submit a doctor within 100 miles.”

Jed Morrison, a partner with law firm Jackson Walker, says the Stark
laws made administrators skittish about recruiting “because providers began to realize that (the CMS) was serious about fraud and abuse.”

In 2004, the CMS clarified some of its existing rules on physician recruitment under Stark II. For example, the CMS created a “bright line” test that clearly defines what a hospital may offer a physician to relocate. It re-emphasizes the existing prohibition on requiring physicians to refer patients to the hospital and the ban on tying recruiting payments to referrals.

But new language in the final Stark II regulation redefined physician “relocation” to mean where the practice is located rather than where the physician lives. Now, a physician is considered to be relocated if the practice is moved at least 25 miles, or if at least 75% of patients in the new area are new.

“For years you rarely heard of a hospital recruiting from a competitor across town,” Rogers says. Now, however, he says in-town recruiting has picked up. “It is more common, but a recruited doctor can’t bring more than 25% of their patient base,” he adds.

Morrison says Stark II created specific rules that can be built into recruitment contracts to protect hospitals and physicians. “It is still problematic to recruit people from within the same practice area, but there are rules to follow now,” he says. “The (1987) anti-kickback statute has always lurked out there as a check on egregious arrangements.”

In the first case to apply the federal anti-kickback law to physician recruiting, Tenet Healthcare Corp.’s 151-bed Alvarado Hospital Medical Center, San Diego, agreed to pay $21 million in May to settle charges it paid “excessive amounts” to recruited physicians.

Rogers says he has had clients tell him: “We cannot pay relocation costs for this doctor, and they blamed Alvarado. … They are overly concerned.”

Once Garrity accepted the University of Chicago Hospitals’ offer, he sent letters to patients about the move. “We have not gone out of our way to re-contact patients. Our practice plan at Loyola would be shocked, and we would be overstepping our bounds if we did that,” he says.

Rogers says recruiting star doctors is still more likely to occur in larger cities than in smaller or medium-sized towns. “Hospitals still are leery of recruiting a local doctor and ending up with a lawsuit,” he says.

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