

PHYSICIAN-HOSPITAL ALIGNMENT MODELS AND INVOLVING PHYSICIANS IN THE ALIGNMENT PROCESS

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Disclaimer

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- **Coker Group and Medical Associates have produced this material as an informational reference for conference attendees. Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Medical Group Association.**

Learning Objectives

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- Examine industry factors and trends that are resulting in an increase in physician alignment
- Review various alignment models and associated compensation frameworks
- Outline the typical process that a practice/hospital encounters to align
- Explore the Medical Associates' experience
- Describe how to effectively engage physician leaders in alignment discussions and the transition planning process
- Discuss compliance and the process for ensuring compliance

Alignment Drivers and Response

Alignment Drivers: Healthcare Reform

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Reimbursement Paradigm is Changing

Less focus on productivity

Sharing of savings

Risk Sharing

Quality Collaboratives/
ACO/CINs

Bundled payments

Capitation

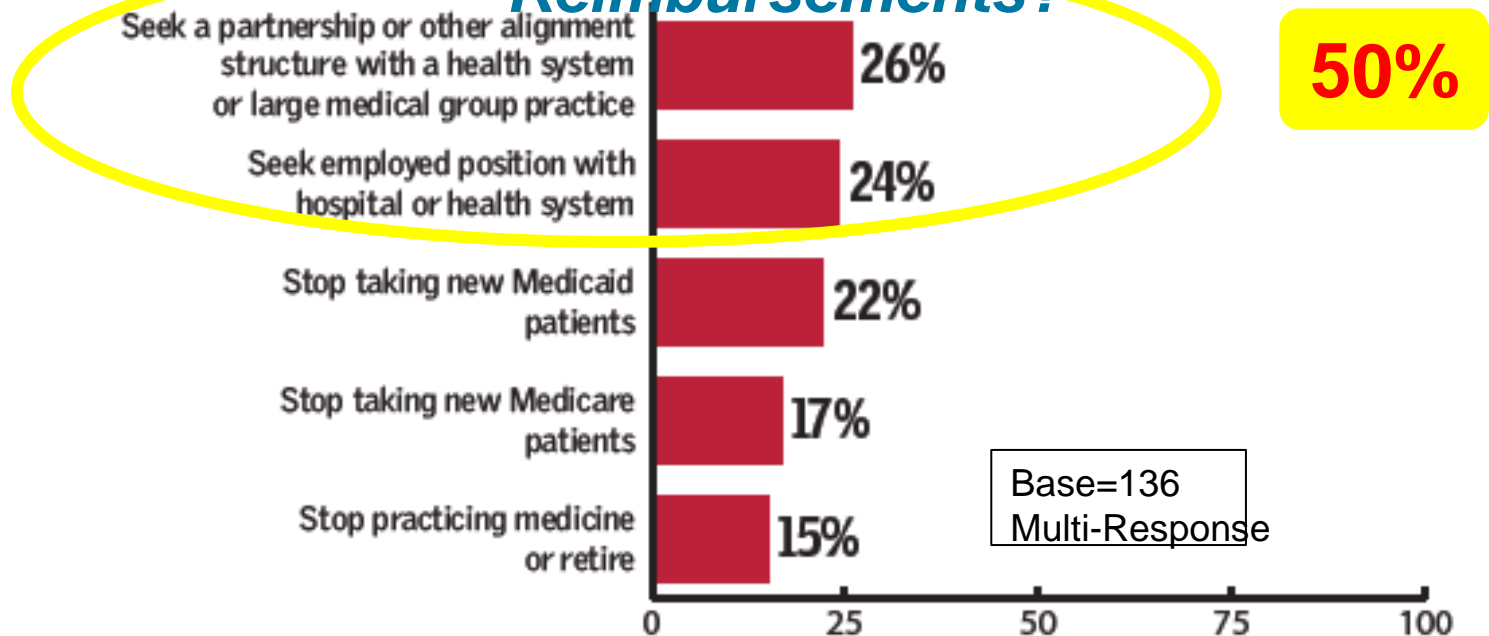
Note: All of the above changes affect both rural and urban markets

Alignment Drivers/Current Trends

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SURVEY OF HEALTHCARE LEADERS

How will you respond to low Medicare/Medicaid Reimbursements?



Note: Hospital-physician alignment ranked among the top 5 priorities for healthcare organizations for the next 3 years

Alignment Drivers: Hospitals

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Financial Performance – Improved bottom line

Recruitment and Retention – Keep physicians in the community

Medical Staff Relations – Demonstrates commitment to medical staff

Infrastructure Support — Hospitals have greater “bench”

Preparation – Most future strategies require alignment

Firm Referral Base – PCPs and specialists both desirable

Service Line Stability – Stabilize weak or waning departments

Alignment Drivers: Practices

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Financial Stability — Improved compensation

Malpractice Insurance — Shared risk

Lifestyle — Improved quality of life

Infrastructure Support — Administrative hassles off-loaded

Practice Style — Shift variances to hospital

Recruitment and Retention — Private practices cannot compete

Succession Strategy — No “cash-out” value in private practices

Alignment Drivers/Current Trends (cont'd)

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NATIONAL

PROJECTIONS

- 3 in 4 doctors hired in 2014 will work for hospitals*
- Declining number of independent physicians: 33% projected in 2013 vs. 43% in 2009**

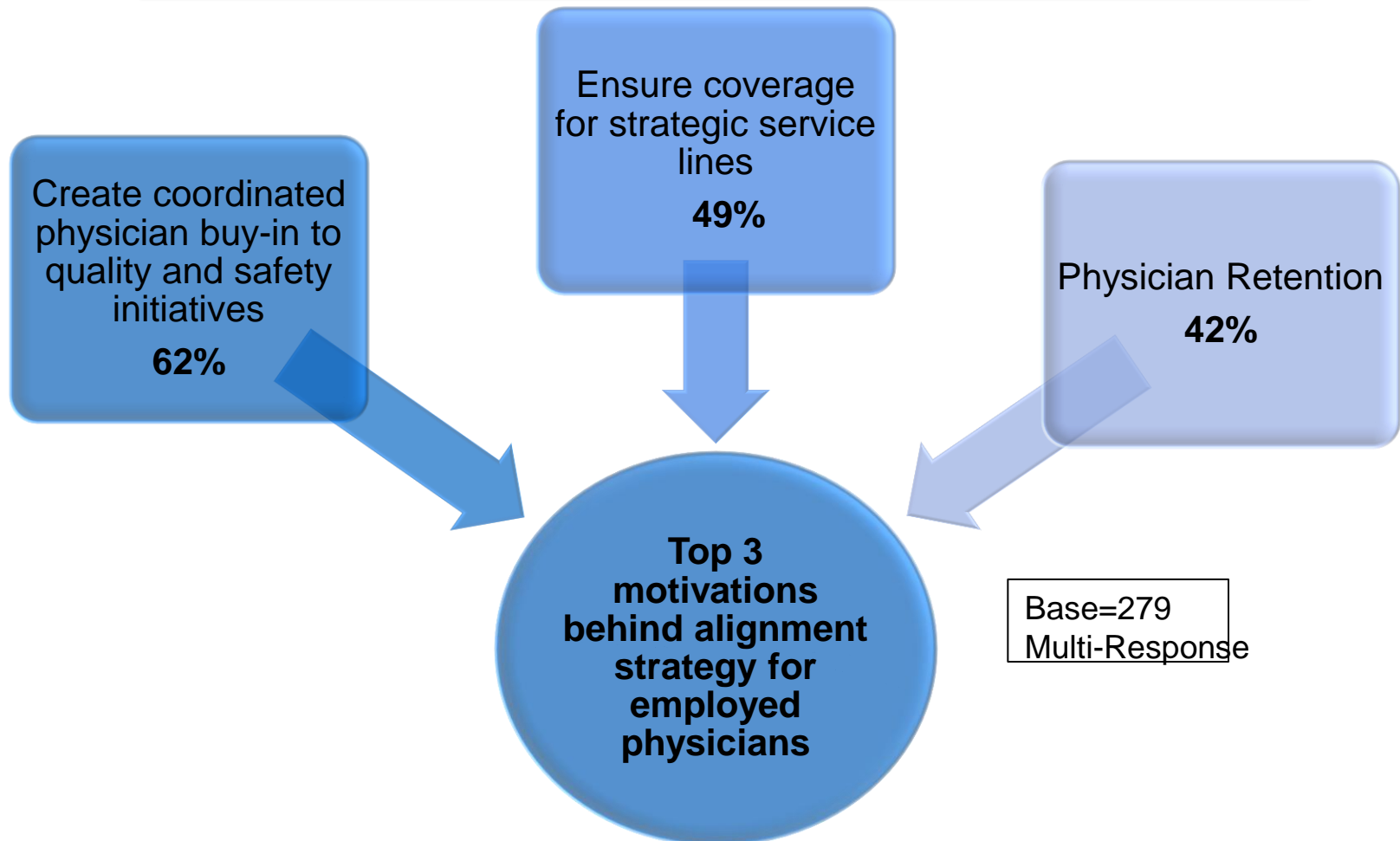
Sources: *Merritt Hawkins Annual 2012 Report

** The Physicians Foundation, September 2012

Alignment Drivers/Current Trends (cont'd)

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SURVEY OF HEALTHCARE LEADERS



Alignment Drivers/Current Trends (cont'd)

KEY INDUSTRY TREND

Stronger collaboration between health systems and physicians/practices

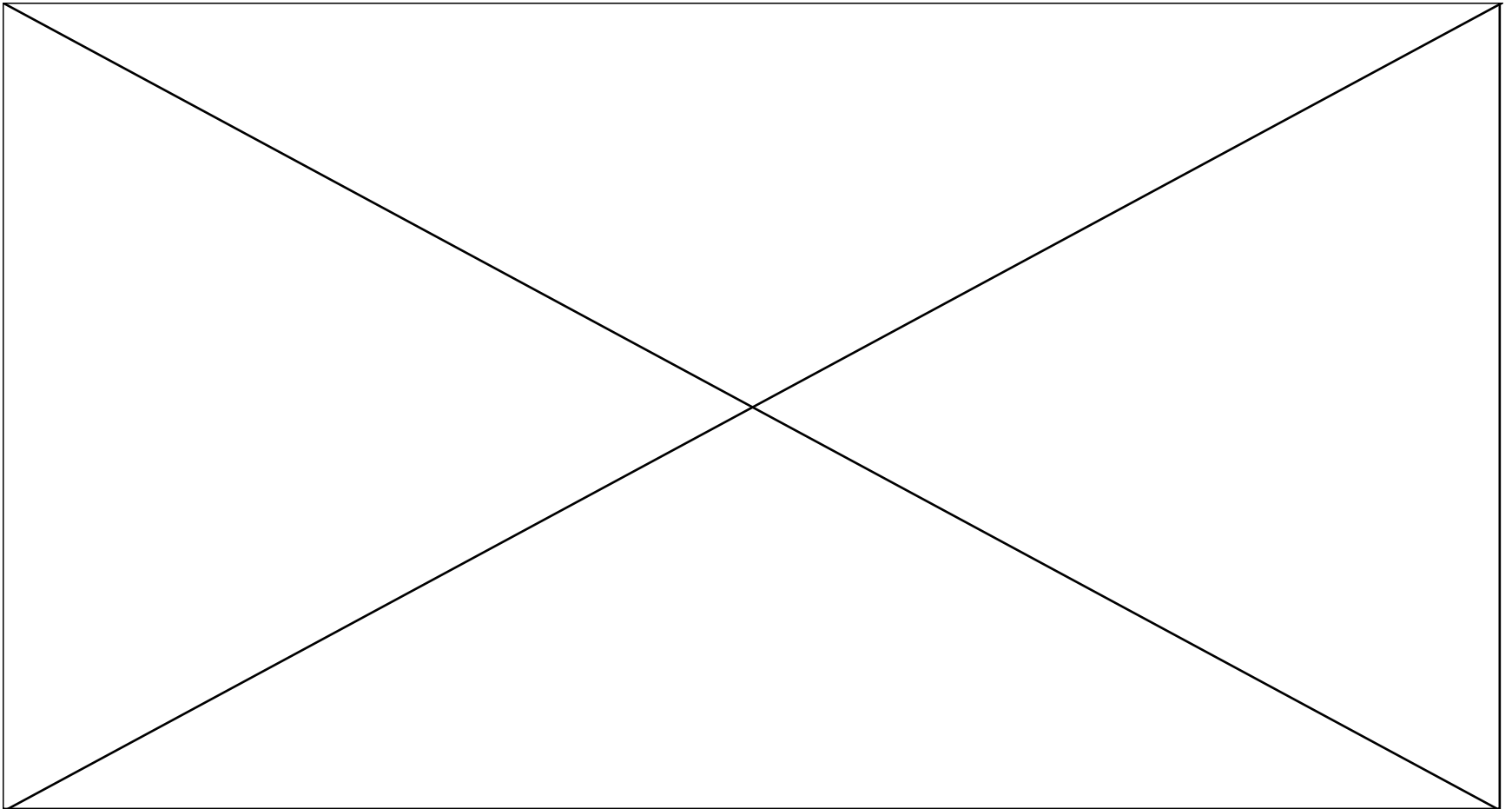
It is a fact that alignment is occurring in a variety of ways and that this not only impacts the care delivery model, but also internal operational factors, such as physician compensation

Alignment Models

Audience Survey: Alignment

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COKER SURVEY OF HEALTHCARE LEADERS



Alignment Models and Compensation

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STRATEGY	BASIC CONCEPT	COMPENSATION FRAMEWORK
Managed Care Networks (IPAs, PHOs) LIMITED	<ul style="list-style-type: none"> • Loosely formed alliances • Primarily for contracting purposes • Limited in ability unless clinically integrated • Being used as a platform for ACO development 	<ul style="list-style-type: none"> • No true impact on pay unless through improved payer contracts • If used as platform for ACO, could result in distribution of incentives received
Call Coverage Stipends LIMITED	<ul style="list-style-type: none"> • Compensation for the personal, financial and risk burden associated with ED coverage 	<ul style="list-style-type: none"> • Payment can come in the form of a daily stipend, fee for service payment or hybrid payment
Medical Directorships LIMITED	<ul style="list-style-type: none"> • Payment for defined administrative services • Must be a true need for the services 	<ul style="list-style-type: none"> • Typically paid via a market-based hourly rate
Recruitment/Incubation LIMITED	<ul style="list-style-type: none"> • Traditional style of a hospital financially supporting a new recruit 	<ul style="list-style-type: none"> • Allows existing physicians in practice to not see a decrease in their pay as a new physician comes on board

Alignment Models and Compensation (*cont'd*)

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STRATEGY	BASIC CONCEPT	COMPENSATION FRAMEWORK
Management Services Organization (MSO) MODERATE	<ul style="list-style-type: none"> •Services such as revenue cycle, human resources, IT, etc. •Can be hospital-owned, joint venture, private practice owned 	<ul style="list-style-type: none"> •Can provide an additional revenue stream
Equity Model Assimilation MODERATE	<ul style="list-style-type: none"> •Ties all entities via legal agreements •Can jointly contract with payers •May be with a hospital partner; may be with a private group 	<ul style="list-style-type: none"> •Can result in increased profitability through better payer contracts and other efficiencies
Provider Equity (Joint ventures, investments) MODERATE	<ul style="list-style-type: none"> •Joint ventures such as specialty hospitals, surgery centers, etc. 	<ul style="list-style-type: none"> •Can provide an additional revenue stream to private practice physicians

Alignment Models and Compensation (*cont'd*)

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STRATEGY	BASIC CONCEPT	COMPENSATION FRAMEWORK
Target Cost Objectives MODERATE	<ul style="list-style-type: none"> •Focus to ensure delivery of cost effective care while still maintaining quality 	<ul style="list-style-type: none"> •Savings shared with providers <ul style="list-style-type: none"> •Percentage •Hourly fee •Fixed fee
Clinical co-management/ service line management MODERATE	<ul style="list-style-type: none"> •Provision of administrative services and work toward certain strategic initiatives within a service line •May include pay-for-call, medical directorships, etc. 	<ul style="list-style-type: none"> •Involves hourly payment for administrative time and incentive payment for achieving established metrics

Alignment Models and Compensation (*cont'd*)

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STRATEGY	BASIC CONCEPT	COMPENSATION FRAMEWORK
Employment lite (“PSA model”) HIGH	<ul style="list-style-type: none">•Allows practice to remain private, but hedge payer risk•Hospital owns receivables•Hospital owns payer contracts•Contract with practice for professional services	<ul style="list-style-type: none">•Hospital provides payment, often on wRVU basis, which is intended to provide FMV compensation, benefits and other overhead costs incurred by practice
Employment (“W-2”)- Traditional HIGH	<ul style="list-style-type: none">•Traditional employment arrangement with a hospital	<ul style="list-style-type: none">•Typically includes productivity payment and potentially some other incentives for quality, cost control

Alignment Models and Compensation (*cont'd*)

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STRATEGY	BASIC CONCEPT	COMPENSATION FRAMEWORK
<p>Employment – Group Practice Subsidiary (GPS)</p> <p>HIGH</p>	<ul style="list-style-type: none"> •The larger single or multispecialty practice operates as a standalone wholly owned subsidiary of the hospital 	<ul style="list-style-type: none"> •Entails a group income distribution plan (IDP) wherein entity dynamics remain at play
<p>Employment – Physician Enterprise Model (PEM)</p> <p>HIGH</p>	<ul style="list-style-type: none"> •Hospital/health system employs practice physicians via a separate legal entity (typically a subsidiary of the hospital/system). Physicians retain practice ownership, which serves as an MSO for the new legal entity. 	<ul style="list-style-type: none"> •Physicians are compensated as employees, but also receive a management fee for administrative duties related to the MSO services provided by the ongoing practice entity

Alignment and Beyond

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- With increasing healthcare costs and shifts in the reimbursement paradigm, accountable care is the 'hot' topic at this time
- The concepts of clinical and financial integration are also quickly gaining momentum as a response to the paradigm shift
- Providers are considering a number of functional models of care to adapt to the changing marketplace
- Basically, alignment should **not** be the terminal goal

Alignment and Beyond (*cont'd*)

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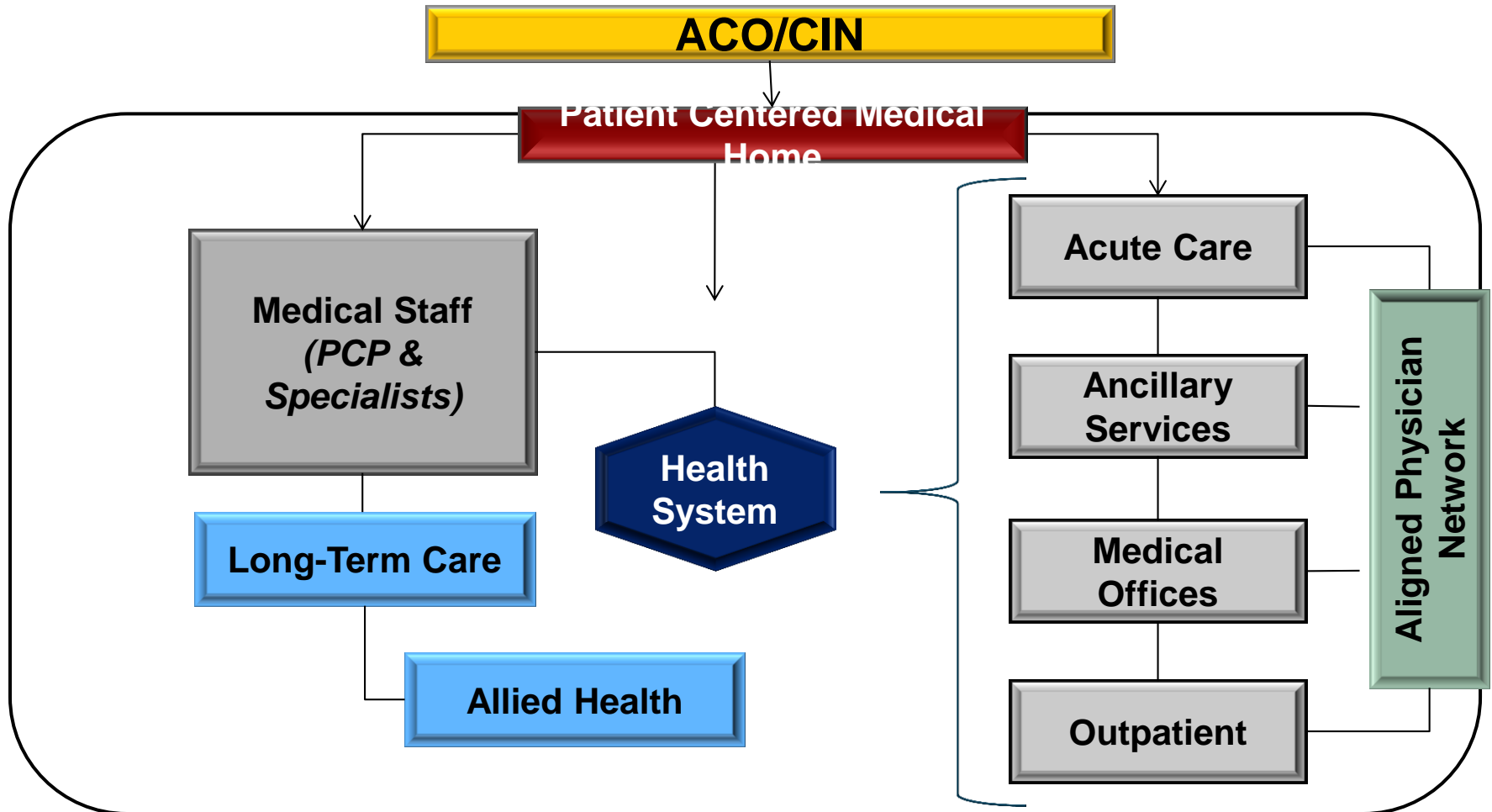
Alignment is a foundation to respond to the changing paradigm

STRATEGY	BASIC CONCEPT	COMPENSATION FRAMEWORK
Patient-Centered Medical Homes	<ul style="list-style-type: none">•Team of providers and medical individuals collaborating to provide patient-centric care in a focused ambulatory care environment; can be part of ACO/CIN model	<ul style="list-style-type: none">•Varying incentives based on contractual relationships with payers
Quality Collaboratives	<ul style="list-style-type: none">•Consortium of providers focused on furthering the quality outcomes for a defined population	<ul style="list-style-type: none">•Internal or external funding sources determine scope and structure of available funds
Clinically Integrated Networks	<ul style="list-style-type: none">•Interdependent healthcare facilities form a network with providers that collaboratively develop and sustain clinical initiatives	<ul style="list-style-type: none">•Incentive (i.e. at-risk) compensation based on achievement of pre-determined measures
Accountable Care Organizations	<ul style="list-style-type: none">•Participating hospitals, providers, and other healthcare professionals collaborating to	<ul style="list-style-type: none">•Incentive (and punitive) financial impacts based on cost savings and quality

The Future: ACOs/CINs/PCMHs

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- Evolving towards an integrated health system



What Does This All Mean for Private Practices?

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- Accountable care is here to stay
- It does **not** mean all physicians have to be employed! But it does mean you need a strategy that responds to alignment
- Independent providers need to plan for how they will respond, and when they will respond

Steps to Align

Steps to Align – Decision Making

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Economic/Financial Considerations

Level of Investment

- How much are the physicians/hospital willing to invest in this process?
- Is a one-time or daily/monthly/annual investment expected?

Return on Investment

- What level of return is expected?
- What is the timeframe for earning back the initial investment? For realizing a profit?

Due Diligence

- Before either party commits to a model, how will they assess whether or not they are financially capable of making such an investment?

Steps to Align – Decision Making (*cont'd*)

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Operational/Strategic Considerations

Commitment to Common Vision/Mission

Ability to Merge Operations

Culture to Adapt to Strategies

Shared Vision for Future of Service Line(s)

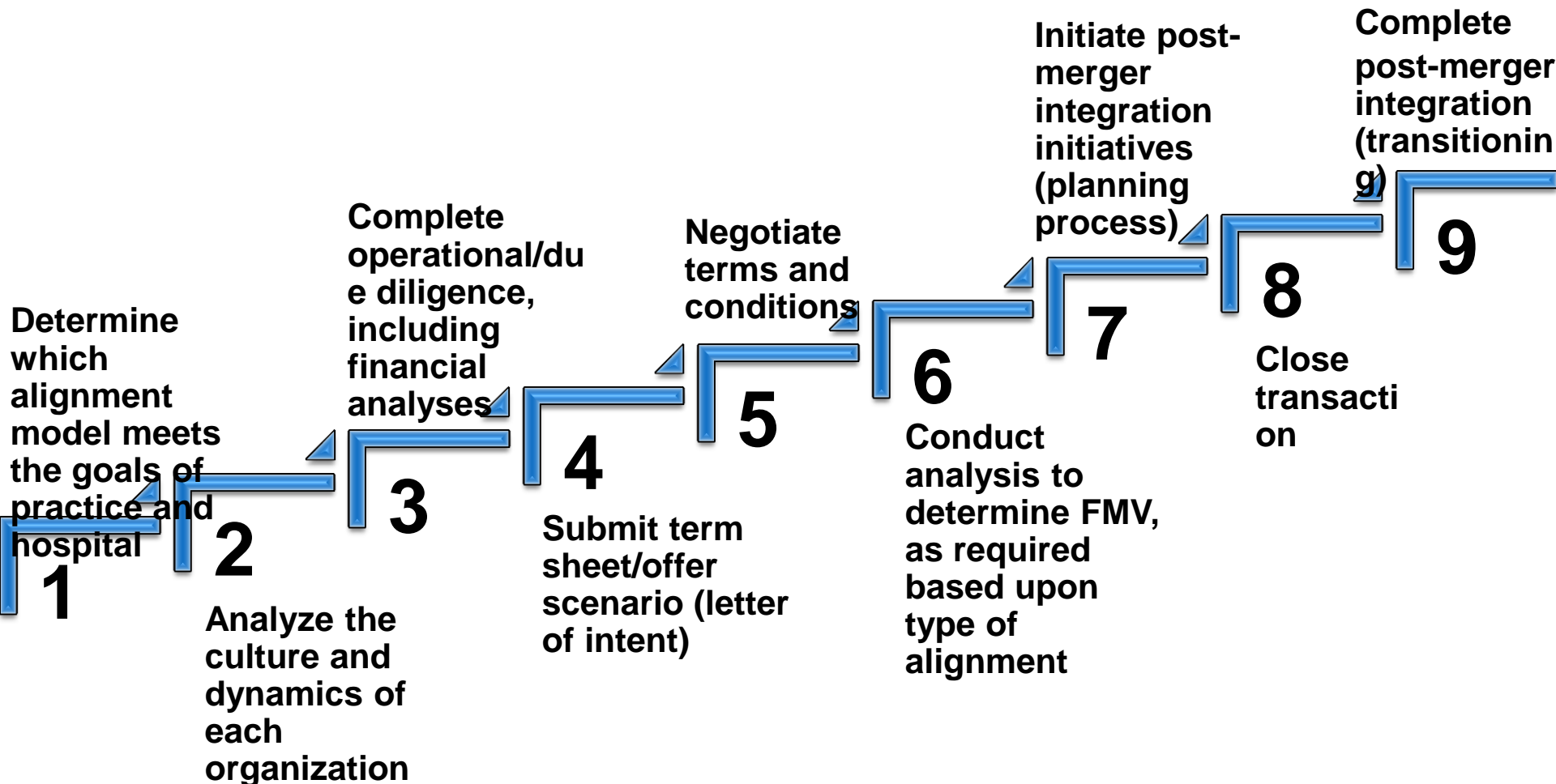
**Legal and Governance Structure in Compliance with
Vision**

Quality Initiatives to Assure Efficiency

**Commitment to Adapt and Respond to the Market's
“Culture”**

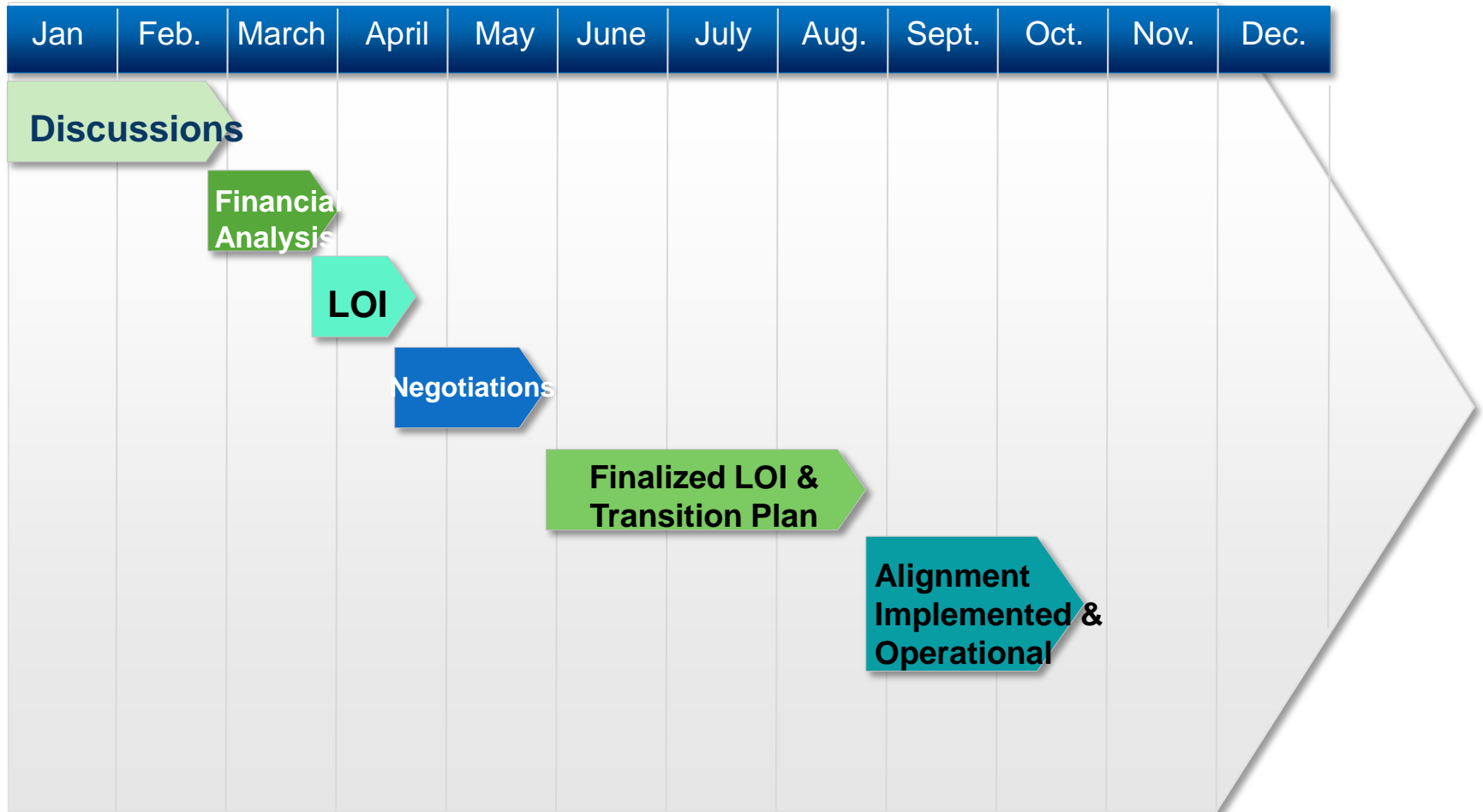
Steps to Align – Typical Structure

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Steps to Align – Sample Timeline

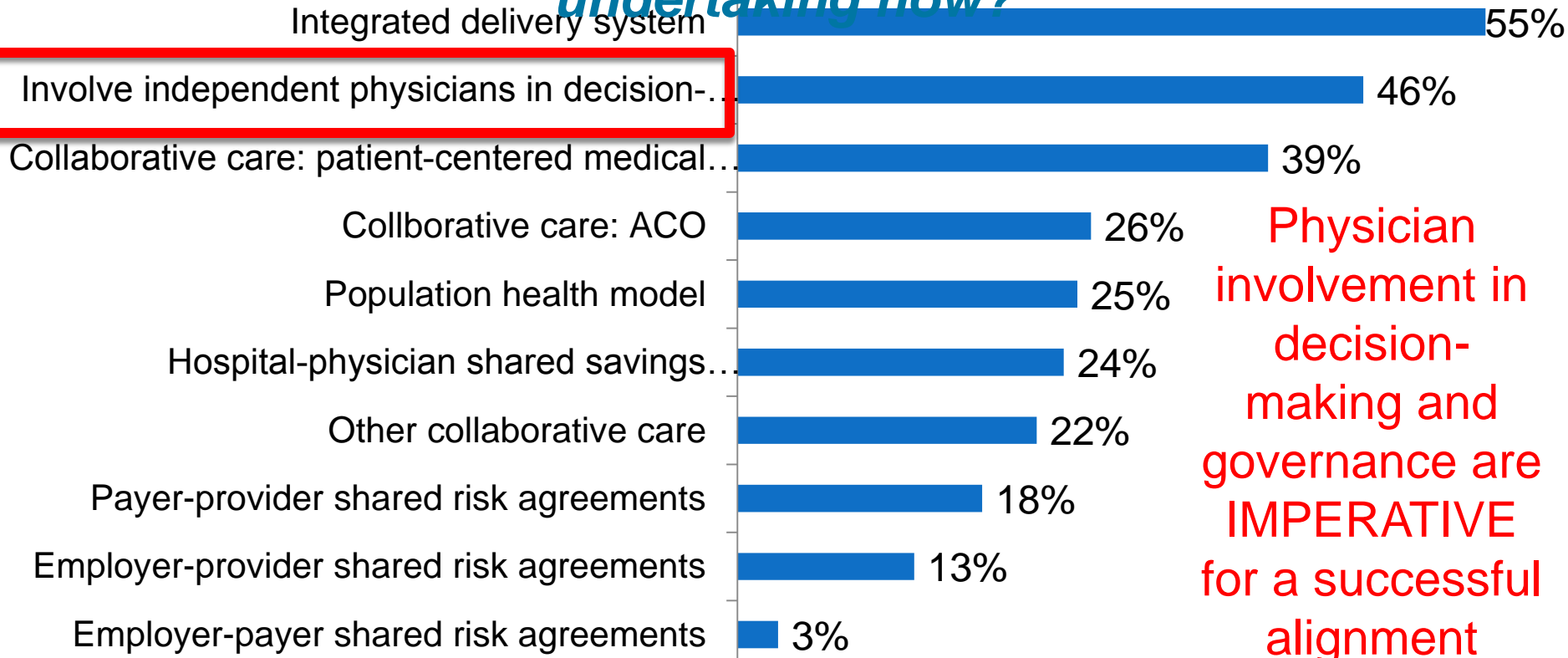
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Ensuring Successful Alignment

SURVEY OF HEALTHCARE LEADERS

Which of the following initiatives is your organization undertaking now?



Physician involvement in decision-making and governance are IMPERATIVE for a successful alignment strategy

*Source: HealthLeaders Media – 2012 Intelligence Survey: Physician Alignment: Integration over Independence

The Medical Associates Experience

Medical Associates Overview

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Physician-owned
Multispecialty Clinic,
established in 1964

Governance: Four (4)
Member Management
Committee, with limited
authority

41 physicians, 11
midlevel providers, 300
non-physician staff

Dominant Medical Group
in Clinton regional
market

\$40 million in net
revenues

Main Clinic in Clinton, IA.
Satellite Locations:
DeWitt, IA, Fulton, IL. &
Morrison, IL

Located 45 minutes
north of the Quad Cities,
and 2 ½ hours west of
Chicago

Full range of ancillaries,
including: Ambulatory
Surgery Center,
Laboratory, Diagnostic
Imaging & Heart Center
Diagnostics

Factors Motivating Integration

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- Declining profitability, and resulting drops in physician incomes
- Distrust among providers
- Belief that we couldn't solve our own problems, but that someone else could
- Significant buy-ins to professional and real estate corporations
- Dissatisfaction with Clinic Governance/Ability to make timely decisions

Factors Motivating Integration

(cont'd)

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- Compensation model that penalized high producers, and was not market competitive for some specialists
- Challenges recruiting/retaining specialists
- Employee unrest due to lack of communication, physician dynamics & two year pay freeze
- Healthcare Reform Fears
- Turnover at Senior Management Level

Medical Associates' Goals/Desired Outcomes

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- Maintain active Physician Leadership & Group autonomy
- Ensure market-competitive compensation for Providers and Staff
- Maintain a close working relationship with local hospital
- Position the Group to be market-competitive under healthcare reform & value-based contracting
- Economic Tension for both parties & ability to unwind

Mercy Overview

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Owned by Trinity Health System in Novi, Michigan

Part of Mercy Health Network, Des Moines, IA

Recipient of National Awards:

Full Service Hospital with 175 acute care beds and 183 long-term care beds

Joint Commission *Top Performer on Key Quality Measures™* - 2012

Iowa Healthcare Collaborative "Patient Safety Award" - Perinatal Patient Safety Initiative 2012

National patient safety award, 2006 - 2009

National Quality Award for Mercy Living Center - North

Named to Top 100 of HomeCare Elite - Mercy Home Care and Hospice

Platinum Start! Fit Friendly Award from American Heart Association

Welcoa Well Workplace Award

Models Considered

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- Global Payment Professional Services Agreement
 - Hospital contracts with the Practice in exchange for payment (largely based on wRVU production); Practice retains all management responsibilities

- Traditional Professional Services Agreement
 - Hospital contracts with physicians for professional services; Hospital employs staff and “owns” administrative structure

- Employment
 - Hospital employs all providers and staff, and Practice is owned by the Hospital; management of the Practice and oversight of the staff is at the discretion of the Hospital (to a large extent)

Obstacles to Success

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Lack of Trust & history of poor communications

Centralized approach to negotiations by Parent Corporation
(The Wizard of Oz Phenomenon)

Protracted Negotiations

Focus on Employment

Limited Physician Governance

Resolution of real estate issue

Supermajority (75%) vote required to approve any deal & lack of consensus

The Decision to End Discussions

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- Inability to resolve real estate issue
- Significantly improved group financial performance & physician incomes
- Physician Leadership and Governance
- Perceived inflexibility on the Part of Mercy

Our Current Status and Direction

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- Current status:
 - ▣ Significantly improved financial performance
 - ▣ Discussions with other Regional Health Systems
 - ▣ Mercy decision to pursue primary care & efforts to get the relationship back on track

Direction

Commitment to Independence

Newly Adopted Mission Statement:
To be the physician-owned and led healthcare provider of choice through the provision of quality, high value, compassionate care

Iowa Multispecialty Group Initiative & Stratum Med Membership

Realization that we can be "Switzerland"

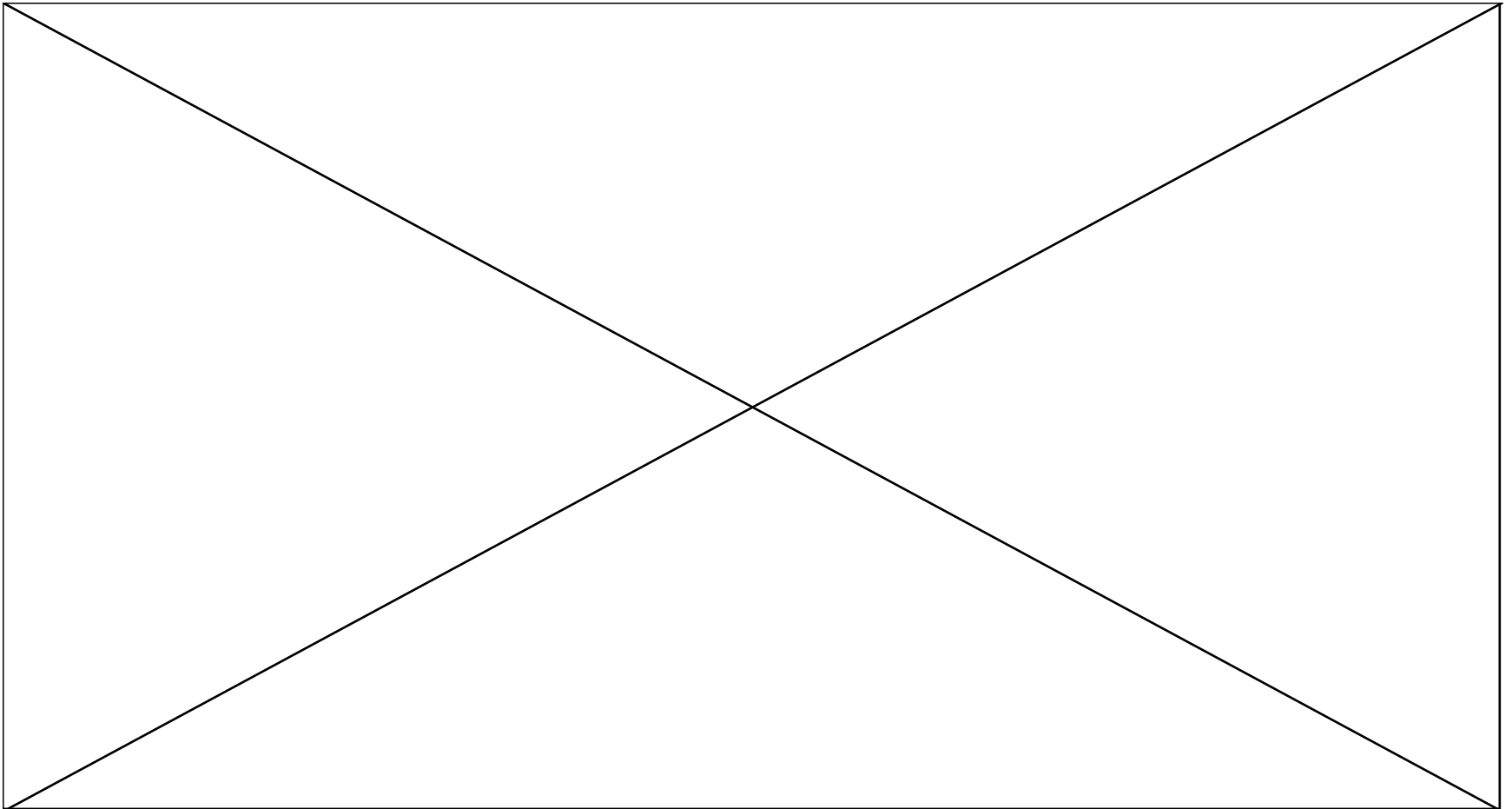
Focus on new service development, patient satisfaction, quality improvement, preparations for incentive-based contracting, physician recruitment along with provider/staff engagement

Physician Engagement (PE)

Audience Survey: Engagement

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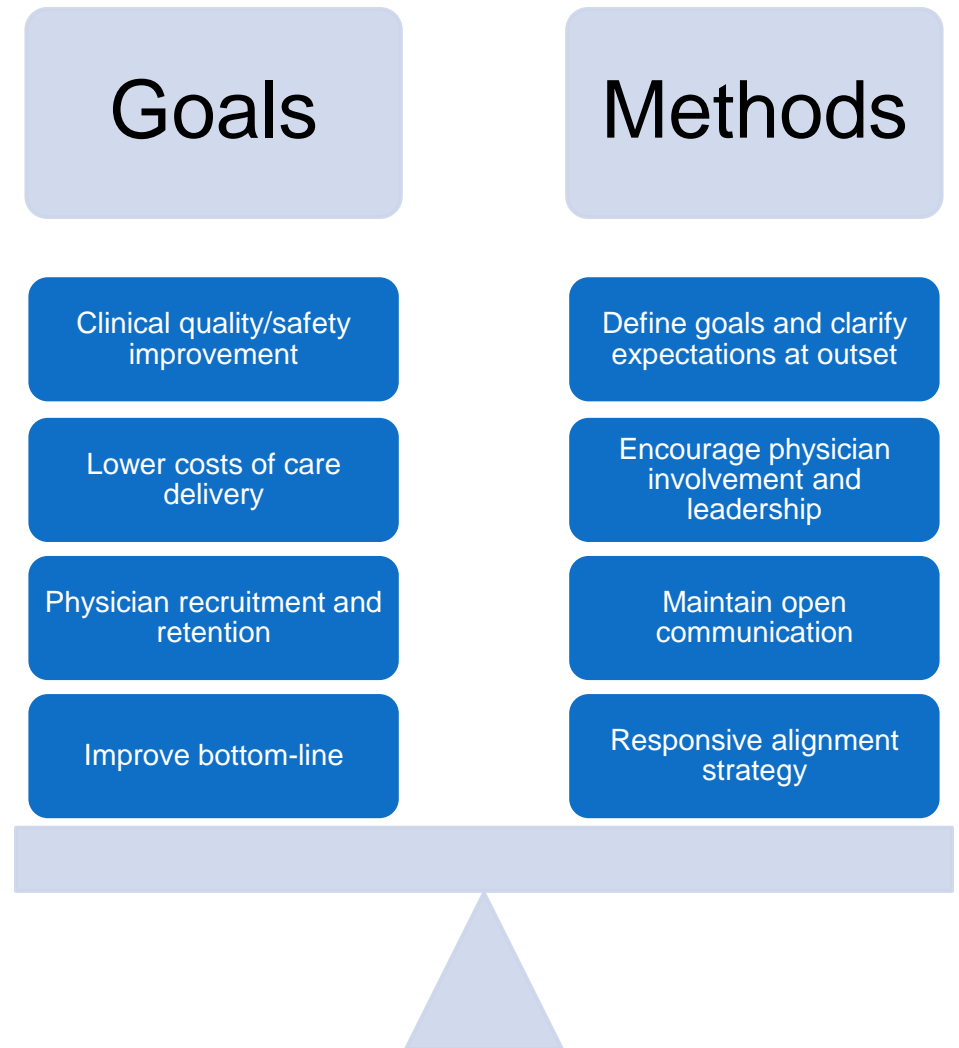
COKER SURVEY OF HEALTHCARE LEADERS



Overarching Goals/Methods for PE

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- Physician engagement encompasses an organization-wide effort
- While overall goals remain the same, new changes require new strategies
- The benefits are worth the concerted



Medical Associates' Approach to PE

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- Strategic Planning & Development of Group consensus
- Selection of the Coker Group
- Investment in AMGA
- Evaluation of Governance Structure
- Transparency in Administrative Leadership/Not being seen as choosing sides

Medical Associates' Approach to PE

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- Communication at all levels
 - ▣ 1:1 Meetings with all providers
 - ▣ Monthly Departmental & Membership Meetings
 - ▣ Quarterly Primary Care/Specialist Dinners
 - ▣ Quarterly Town Hall Meetings
 - ▣ Monthly Newsletter
 - ▣ Employee Engagement Survey

Compliance

Fair Market Value (FMV)

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□ Stark Law defines FMV as:

“Fair market value means the value in arm's-length transactions, consistent with the general market value. 'General market value' means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.”

Commercial Reasonableness (CR)

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- Stark Law defines a transaction as “commercially reasonable” if:
 - “The arrangement would make commercial sense if entered into by a reasonable party of similar type and size, and a reasonable physician of similar scope and specialty, even if there were not potential “designated health services” referrals”
- CR deals with whether the transaction makes sense
 - Business purpose
 - Overnight increase in pay
 - Supply/demand
 - Recruitment efforts
- Growing emphasis on CR
- Transactions can be FMV and NOT CR!

FMV/CR Concepts

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- Arrangements subject to FMV/CR:

•Employment	•Co-management
•Medical directorships	•Space/equipment/staff lease
•Call coverage	•Per click arrangements
•Graduate medical education	•Contract services
•Collections guarantees	•Consulting fees (DME)
•Service line management	

- **Essentially, any transaction wherein money is exchanged between hospitals and physicians**
 - Important to understand the FMV risk
 - Under or overpayment

FMV/CR Concepts (*cont'd*)

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- Ensuring Compliance
 - Use common sense (“the sniff test”)
 - Establish consistent compensation methodology where there is confidence that FMV pay will result
 - Potentially test for FMV on the compensation plan level
 - Establish internal benchmarks that trigger additional levels of review
 - FMV tests occur on the individual physician level
 - Establish ceilings on pay and the effective rate/wRVU
 - Can be “hard” or “soft”
 - Be conservative on what is guaranteed
 - Less FMV risk when pay is “at risk”

Q & A

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