Hospitals Acquiring Practices: Déjà Vu All over Again?

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Seattle, Washington
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AGENDA

- Alignment Trends
- Overview of Alignment Strategies and Models
- Compensation Trends
- Compensation Models
- Governance
ALIGNMENT TRENDS
ALIGNMENT STRATEGIES

THEN

• In the 90’s, hospitals focused on purchasing existing practices to build their referral network; often the purchase price was for large amounts, including goodwill.
• Capitation drove this desire to employ physicians.
• Physicians were compensated via salary guarantees; there was little requirement for productivity.
• Hospitals often managed physicians and their practices like “just another hospital department”.
• Hospitals failed to “partner” with physicians in decision making process that affected the practices.
• Physicians resented the hospital’s focus on cost cutting programs.
**ALIGNMENT STRATEGIES**

**Now**

- Hospitals are purchasing practices for Fair Market Value (FMV), entailing little up-front payments and virtually no goodwill.
- Physician productivity is a key matrix in provider compensation.
- Hospitals and physicians are striving to form true “partnerships” that focus on quality of patient care, delivery of services, and cost effective management.
- Non-employment models (like PSAs) are frequently viable alternatives and preferred.
- Hospitals often realize a value proposition by acquiring the ancillaries and being able to realize greater reimbursement.
- There is an emphasis on information technology (IT) integration and continuity of care; clinical integration is primary goal.
ALIGNMENT STRATEGIES

Now (continued)

• Little, if any, intangible value is being paid to physicians under current agreements
• Tangible assets and possibly sign-on / retention bonuses are the norm (at FMV)
• Accountable Care Organizations are being piloted for managing care of Medicare patients and for reimbursement
**REASONS FOR ALIGNMENT - PHYSICIAN PERSPECTIVE**

1. **Malpractice**
   - High cost of insurance making it unaffordable for some physicians

2. **Financial Stability**
   - Cost of operating a practice is increasing while reimbursement is lowering
   - Offset reduced reimbursements for cardiology

3. **Infrastructure Support**
   - Many burdens associated with managing a practice
   - Physicians want to focus on delivery of patient care

4. **Lifestyle**
   - Many physicians want to spend more time with family
   - Desire a better balance of life between work & home
REASONS FOR ALIGNMENT - HOSPITAL PERSPECTIVE

- Response to competition
- Managed care/reimbursement
- Growth strategy
- Centralizing purchases (IT, supplies)
- Cost containment
- Provider recruitment/retention
- Ancillary services development
- Information sharing (data)
## Challenges to Alignment

- Differing cultures
- Loss of provider ownership/control
- Loss of provider incentive
- Autonomy issues
- Trust issues
- Competition mentality
- Splitting a limited size revenue pie
- Clinical performance standards differ
GOALS OF ALIGNMENT

- Aligns strategic initiatives
- Builds upon growth/expansion strategies
- Manages change and creates a systematic affiliation
- Responds to resource allocation priorities
- Documents (and maintains) a course for the organization(s)
- Responds to community healthcare needs
- Responds to payer demands
- Conforms with regulatory requirements
**ALIGNMENT STRATEGIES**

- Physicians and hospitals face unprecedented challenges to their ability to maintain viability.

- Partnering alternatives are without question the best solutions to respond to these challenging issues and to the new federal themes.

- Most practices (and definitely all hospitals) should assume a pluralistic approach to alignment:
  - Merge operations
  - Service stipends
  - Clinical co-management/service line management
  - Different forms of employment
OVERVIEW OF ALIGNMENT STRATEGIES AND MODELS
# Overview of Models

## Limited Integration

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Networks</td>
<td>Loose alliances for contracting purposes</td>
</tr>
<tr>
<td>Call Coverage Stipends</td>
<td>Pay for unassigned ED call</td>
</tr>
<tr>
<td>Medical Directorships</td>
<td>Specific clinical oversight duties</td>
</tr>
<tr>
<td>Gain Sharing</td>
<td>Economic benefits for hospitals and physicians; isolated and targeted initiatives</td>
</tr>
</tbody>
</table>
OVERVIEW OF MODELS

MODERATE INTEGRATION

Service Line Management Agreement – Management of all specialty services within the hospital

Management Service Organizations – Ties hospitals to physician’s business (also information service organizations)

Joint Ventures – Unites parties under common enterprise; difficult to structure; legal hurdles

Co-management of Clinical/Service Offerings – Strong economic and strategic alignment; relatively minor return
OVERVIEW OF MODELS

FULL INTEGRATION—EMPLOYMENT

**Physician Employment** – Strongest alignment; minimizes economic risk for physicians

FULL INTEGRATION—EMPLOYMENT “LITE”

*Professional services agreements (PSAs)* and other similar models (such as the practice management arrangement) – self-employed independent contractor
EMPLOYMENT

- **W2**: Employee – Employment Contract
- **1099**: Contractor – Professional Services Agreement (PSA)
EMPLOYMENT

Under contract to hospital

Less flexibility; potentially more job security

Employee withholds taxes & social security

Standard employee regulations apply

Full benefits
EMPLOYMENT

PHYSICIAN/HOSPITAL ALIGNMENT IS AGAIN ON THE RISE

• Common reasons for employment
  ▪ Rising malpractice costs
  ▪ Management/administrative stresses
  ▪ Declining reimbursement
  ▪ Declining payer mix
  ▪ Specialty shortages
  ▪ Importance of downstream revenue
  ▪ Competition
  ▪ Succession planning
  ▪ Maintaining service line market share/strength
  ▪ Quality of life issues
  ▪ Physician compensation
EMPLOYMENT

BENEFITS OF THIS ALIGNMENT STRATEGY:

• Physicians gain stability in volatile market

• Physician compensation is generally held at lower level of risk
  ▪ Opportunities for additional incentive compensation often exist

  ▪ Physicians can focus on the clinical aspects of medicine, rather than the business operations

  ▪ Ancillaries which are not as profitable for private practices can be sold to hospitals who generally receive much higher reimbursement
EMPLOYMENT

- Compensation provided to a physician employee must be within FMV and commercially reasonable
- Employed physicians usually receive higher levels of compensation

*Example: MGMA 2010 PCPS Median Compensation*

<table>
<thead>
<tr>
<th></th>
<th>Hospital Owned</th>
<th>Not Hospital Owned</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology: Noninvasive</td>
<td>$468,970</td>
<td>$396,738</td>
<td>($72,232)</td>
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<tr>
<td>Family Medicine</td>
<td>$183,152</td>
<td>$183,999</td>
<td>$847</td>
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<tr>
<td>Orthopaedic Surgery:</td>
<td>$516,413</td>
<td>$473,770</td>
<td>($39,643)</td>
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<tr>
<td>General</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>$410,045</td>
<td>$390,678</td>
<td>($19,367)</td>
</tr>
</tbody>
</table>
PSA – EMPLOYMENT “LITE”

FOUR POSSIBLE SCENARIOS OF PSA MODEL

1. **Global Payment PSA**: Hospital contracts with practice for Global Payment; practice retains all management responsibilities
2. Hospital employs physicians; practice entity retained and contracts with hospital; for administrative management—staff not employed by hospital
3. **Traditional PSA**: Hospital contracts with physicians for professional services; hospital employs staff and “owns” administrative structure
4. Hospital employs/contracts with physicians; practice entity spun-off into a jointly-owned MSO/ISO
Hospital contracts with physicians for professional services
  - As such, the physicians are not employed by the hospital, but remain employed by the practice
• However, the hospital does employ all support staff
  - This typically includes practice administrators/management staff
• Under this model, many of the operational and administrative duties become the responsibility of the hospital, as opposed to the practice
PSA — TRADITIONAL EXAMPLE

ABC Health System “System”

- Professional and technical fees

Payers

DEF Medical Group (“Group”)

- Independent contractors as a Group
- Group includes all providers
- Payment to Group for professional services equal to net collections less direct costs paid by System
- Includes site of service differential for professional services
- Annual fixed amount to be paid to Group for value of ancillary services
  - set in advance
  - not based on volume of referrals

System Employees

System Outpatient Services

Independent Contractor

Lease

Purchase or Lease

Group Staff

- System employees
- Fully loaded expense deducted from professional service revenue to be paid to Group

Group Ancillary Services

- System hospital outpatient based services
- Ancillary staff are employees of System
- Not purchased by System, but included in comp via an annual fixed payment to Group set in advance

Real Estate

- Lease paid by System
- Lease expense deducted from professional service revenue to be paid to Group

Operating Expenses

- Includes:
  - lease / depreciation expense
  - Other direct operating expenses
  - Deducted from professional service revenue to be paid to Group
PSA – GLOBAL PAYMENT MODEL

- Practice is Independent Contractor
- Physicians still “employed” by practice
- Self-employed status: no benefits from hospital
- Practice invoices hospital for actual services rendered
  - Usually in wRVUs, converted to dollars
- Hospital pays practice directly without any withholding
- Files 1099 with IRS: practice responsible for withholding taxes from physician
PSA – Global Payment Model

- Characteristics of employment but stops significantly short of employment
- Comprehensive alignment strategy requiring less integration than employment
- Hospital engages practice who continues to employ physicians to provide comprehensive services through a PSA
  - Practice is compensated on a global basis
  - Independent practice maintained
PSA – GLOBAL PAYMENT MODEL

- Services to be provided could include:
  - Multi-specialty diagnostic and procedural services
  - Clinical management and coordination
  - Administrative, supervisory teaching and research functions
  - Medical directorships
  - Complete service line and clinical co-management
  - Call responsibilities
  - Gainsharing
  - Quality incentives
PSA – Global Payment Model

- Hospital compensates practice for professional fees and other services performed at and for the hospital
  - Medical directorships, call, service line/clinical co-management, etc.
    - Paid at FMV/commercially reasonable rates
- Ancillaries may be sold/leased to hospital who bills at HOPD rates
- Hospital bills at PBR (provider based rates)
PSA – Global Payment Model

- Accounts receivable owned by hospital
- Fee structure established by hospital
- Payer contracts negotiated by hospital
- Practice continues to perform the billing services for the hospital (at FMV rates)
PSA – GLOBAL PAYMENT MODEL

- Overhead expenses paid by practice
- Hospital provides base fee that should cover all expenses including physician compensation* 
  - Potential for bonuses in addition to base fee 
  - Ancillary services included (if included in hospital revenue base, must be considered in physicians’ compensation, but not directly tied to same)

* At wRVU conversion factor rates, tiered for higher production levels, separately calculated by specialty
# PSA – Global Payment Model

## Global Payment Model

<table>
<thead>
<tr>
<th></th>
<th>Practice</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real Estate Ownership</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Medical Equipment Ownership (Non-Ancillary)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Medical Equipment Ownership (Ancillary)</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Employees’ Employer</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Billing Tax ID</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Recipient of Insurance Payments</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Owner of Ancillary Profits/Income</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Party Responsible for Billing/Collections</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Provider of Malpractice Insurance</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Managed Care Contracting Negotiations</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>MD Employment Status</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

*Depends upon negotiated agreement*
• Benefits of this alignment strategy:
  ▪ Provides many of the goals of employment without such
  ▪ Physicians maintain independence from hospital
  ▪ Flexibility in structure
  ▪ Opportunities to increase and enhance bottom-line for both hospital and the practice
PSA – GLOBAL PAYMENT MODEL

- Benefits of this alignment strategy (cont’d):
  - Bonus opportunities for exceptional performance
  - Stability in relationship with hospital
  - Opportunities to expand services together without being fully aligned (i.e., employment)
  - Easy segue to full employment
PSA – GLOBAL PAYMENT EXAMPLE

Hospital Board

- Asset Ownership/Lease
- Contracting
- A/R Owned

Hospital (Integrated With Physician Division Infrastructure)

PSA

- Aggregate Compensation (Rate per w RVU)
- Membership
- Compensation
- Clinical Services & Non-compete Agreement

Management Committee

- Approves Strategy/Finances
- Oversees Operations/Business Planning
- Establishes Compensation Principles
- Achieves Value-Exchange Objectives
- Is Typically Split 50/50 Between Hospital and Medical Group

Medical Group Board

- Group Governance
- Physician Hiring/Termination
- Income Distribution
- Clinical Practice/Quality
- Malpractice
- Management and Staffing
- Billing
- IT Support

Medical Group (For-Profit Entity)
PSA – Sale/Lease of Ancillaries

• A practice could sell or lease their diagnostics to a hospital in accordance with FMV limitations and commercial reasonableness.

• When properly structured, there are no legal impediments to such a transaction.
PSA – SALE/LEASE OF ANCILLARIES

Benefits of this particular alignment strategy:

• A practice is relieved of the expense of diagnostic services
  ▪ These services are experiencing rapidly declining reimbursement and could become an expense, rather than a source of income, to the practice
• Ideally, a practice is made “whole” through compensation from the PSA
  ▪ Such compensation can include a guaranteed base as well as incentive compensation based on performance
• Physicians maintain flexibility and independence
• Stability in relationship between the practice and the hospital
COMPENSATION TRENDS
CURRENT COMPENSATION TRENDS

• Compensation programs are in a state of flux, in response to changes in the market environment
  ▪ Most current plans have been in place less than 5 years
  ▪ Many practice administrators expect to modify or re-design their plan every few years*

• Hospital networks continue to be more proactive with their physician compensation plans (i.e., greater incentives, performance requirements)

*This is not necessarily bad!
CURRENT COMPENSATION TRENDS

• Hospitals are heavily into employment and are designing more incentive-based IDPs
• Compensation in forms of other services (not necessarily “W-2” employment) becoming prevalent
  ▪ “Wraparound” pay plans
CURRENT COMPENSATION TRENDS

• **Current State:** Productivity-based compensation programs are most prevalent
  - Strongly preferred by many physicians
  - Simple to design, administer and communicate

• **Near Future:** Non-productivity based incentives will continue to become more prevalent
  - Difficult to manage and administer, not objective
  - Cautiously sought by physicians
  - Will need to be addressed in any accountable care environment
INDUSTRY TRENDS FOR EMPLOYED PHYSICIANS

- Hospitals have provided significant subsidies to employed physicians & networks
- Current financial challenges will require them to review these employment strategies
- Hospitals need to focus on reducing losses and improving performance by their employed physician networks
- Ancillary reimbursement may not always be better within hospitals – justifying the deals will be more difficult
CHARACTERISTICS OF SUCCESSFUL PLANS

• A combination of educational and monetary initiatives should be used
• Physicians are shown where they stand compared with peers within the group/organization
• Comparing physicians of common specialties is also important
• Physicians should also review each other
• Quality incentives are, and will be, significant

*Very Important* - keep it as simple as possible!
# Aligning Incentives

<table>
<thead>
<tr>
<th>Aligning Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give physicians personal ability to increase production</td>
</tr>
<tr>
<td>Motivate toward decreased overhead</td>
</tr>
<tr>
<td>Harmonize physician productivity with ancillary services</td>
</tr>
<tr>
<td>Complement alignment strategy/initiative(s)</td>
</tr>
<tr>
<td>Consider quality metrics</td>
</tr>
</tbody>
</table>
wRVU Model

• How the wRVU model works
  ▪ Physician’s accumulated wRVUs are multiplied by a conversion factor (compensation to wRVU ratio) which translates wRVUs into actual cash compensation

• Base compensation
  ▪ Can be guaranteed or a “draw”
  ▪ % of historical compensation (75% to 90%)
  ▪ Amount agreed to by hospital/network management
  ▪ Updated at least annually based on historical productivity

• Productivity-based compensation and base compensation are reconciled quarterly on a year-to-date basis
wRVU Model

- Two Approaches
  - Single Tier
    - All wRVUs generated are compensated using the same conversion factor
  - Multiple Tiers
    - The conversion factor increases as productivity increases
# WRVU Model

## Multiple Tier Example

<table>
<thead>
<tr>
<th>Tier</th>
<th>From</th>
<th>To</th>
<th>Incremental</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>-</td>
<td>3,500</td>
<td>3,500</td>
<td>$31.00</td>
</tr>
<tr>
<td>II</td>
<td>3,500</td>
<td>4,200</td>
<td>700</td>
<td>$33.00</td>
</tr>
<tr>
<td>III</td>
<td>4,200</td>
<td>4,900</td>
<td>700</td>
<td>$35.00</td>
</tr>
<tr>
<td>IV</td>
<td>4,900</td>
<td>5,600</td>
<td>700</td>
<td>$37.00</td>
</tr>
<tr>
<td>V</td>
<td>5,600</td>
<td>5,600</td>
<td>-</td>
<td>$40.00</td>
</tr>
</tbody>
</table>

- Assume a physician generates 4,500 wRVUs
  
  Tier I: \(3,500 \text{ wRVUs} \times $31.00 = $108,500\)
  
  Tier II: \(700 \text{ wRVUs} \times $33.00 = $23,100\)
  
  Tier III: \(300 \text{ wRVUs} \times $35.00 = $10,500\)

  **Total:** \($108,500 + $23,100 + $10,500 = $142,100\)
PAY BAND/ZONE MODEL

• Components
  ▪ Base Salary (tied to corresponding pay band)
  ▪ Incentive- individual (productivity – in excess of pay band total)
  ▪ Incentive- individual (non-productivity – based upon specific criteria)

• Compensation
  ▪ Salary based on last twelve month’s rolling average net collections per physician
    ✓ Pay bands/zones compare to productivity average
    ✓ Benchmarking standards (e.g., MGMA, etc.) used to establish pay band dollars (salary and productivity)
Another model that uses wRVUs or net revenue in determining compensation

Productivity level (percentile) directly impacts compensation percentile

Guaranteed compensation can be established at a certain threshold with additional compensation only being paid once productivity exceeds threshold.

Most basic alignment:

\[ \text{wRVU benchmark} = \text{compensation benchmark} \]

For example:

\[ 48\text{th percentile wRVUs} = 48\text{th percentile compensation} \]
**PAY BAND/ZONE MODEL**

<table>
<thead>
<tr>
<th></th>
<th>wRVUs</th>
<th>12 Month Rolling wRVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4- 2008</td>
<td>1,200</td>
<td></td>
</tr>
<tr>
<td>Q1- 2009</td>
<td>1,125</td>
<td></td>
</tr>
<tr>
<td>Q2- 2009</td>
<td>1,070</td>
<td></td>
</tr>
<tr>
<td>Q3- 2009</td>
<td>1,150</td>
<td>4,545</td>
</tr>
<tr>
<td>Q4- 2009</td>
<td>980</td>
<td>4,325</td>
</tr>
<tr>
<td>Q1- 2010</td>
<td>1,250</td>
<td>4,450</td>
</tr>
</tbody>
</table>

**Beginning of Q3- 2009**

<table>
<thead>
<tr>
<th>Past 12 Month wRVUs</th>
<th>4,545</th>
</tr>
</thead>
<tbody>
<tr>
<td>wRVU %tile</td>
<td>45th %tile</td>
</tr>
<tr>
<td>Compensation %tile</td>
<td>45th %tile</td>
</tr>
<tr>
<td>Annual Compensation</td>
<td>$171,801</td>
</tr>
<tr>
<td><strong>Quarterly Compensation</strong></td>
<td><strong>$42,950</strong></td>
</tr>
</tbody>
</table>

**Beginning of Q4- 2009**

<table>
<thead>
<tr>
<th>Past 12 Month wRVUs</th>
<th>4,325</th>
</tr>
</thead>
<tbody>
<tr>
<td>wRVU %tile</td>
<td>38th %tile</td>
</tr>
<tr>
<td>Compensation %tile</td>
<td>38th %tile</td>
</tr>
<tr>
<td>Annual Compensation</td>
<td>$162,999</td>
</tr>
<tr>
<td><strong>Quarterly Compensation</strong></td>
<td><strong>$40,750</strong></td>
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</tbody>
</table>

**Beginning of Q1- 2010**

<table>
<thead>
<tr>
<th>Past 12 Month wRVUs</th>
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<tbody>
<tr>
<td>wRVU %tile</td>
<td>42nd %tile</td>
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<tr>
<td>Compensation %tile</td>
<td>42nd %tile</td>
</tr>
<tr>
<td>Annual Compensation</td>
<td>$167,651</td>
</tr>
<tr>
<td><strong>Quarterly Compensation</strong></td>
<td><strong>$41,913</strong></td>
</tr>
</tbody>
</table>

- Family Practice w/o OB
- This illustration includes compensation aligned directly with productivity
- Compensation is calculated based on past 12 months of wRVUs
**Distributable Net Income (DNI) Model**

- Employer/employees “share” in performance results with some limits or ceilings placed upon expenses
  
  + Gross Charges
  - Contractual Allowances
  - Bad Debts

  \[ \text{Net Charges} = \text{Gross Charges} - (\text{Contractual Allowances} + \text{Bad Debts}) \]

- Expenses (Defined Expenses)

+ Subsidy

\[ \text{Compensation (Net Distributable Income)} = \text{Net Charges} - \text{Expenses} + \text{Subsidy} \]

- Subsidy is often the key component of this model for hospital networks

- Distributable Net Income may have a physician base pay and benefit component with the “Expenses” total
## Distributable Net Income (DNI) Model

### Revenue Calculation:

- **Professional Production** – all professional billings and credits

### DNI Model

<table>
<thead>
<tr>
<th></th>
<th>FYTD 2009 (11 Months)</th>
<th>Support</th>
<th>No Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Revenue</td>
<td>$357,318</td>
<td>$389,801</td>
<td>$389,801</td>
</tr>
<tr>
<td>Salaries and Wages</td>
<td>$353,478</td>
<td>$385,612</td>
<td>$385,612</td>
</tr>
<tr>
<td>Supplies</td>
<td>$4,596</td>
<td>$5,014</td>
<td>$5,014</td>
</tr>
<tr>
<td>Purchased Services</td>
<td>$12,871</td>
<td>$14,041</td>
<td>$14,041</td>
</tr>
<tr>
<td>Leases/Rentals</td>
<td>$775</td>
<td>$845</td>
<td>$845</td>
</tr>
<tr>
<td>Other Expenses</td>
<td>$3,209</td>
<td>$3,501</td>
<td>$3,501</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$374,929</strong></td>
<td><strong>$409,013</strong></td>
<td><strong>$409,013</strong></td>
</tr>
<tr>
<td><strong>Net Income</strong></td>
<td><strong>($17,611)</strong></td>
<td><strong>($19,212)</strong></td>
<td><strong>($19,212)</strong></td>
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<tr>
<td>Subsidy/Support</td>
<td></td>
<td>$25,000</td>
<td>$0</td>
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<tr>
<td><strong>Adjusted Net Income</strong></td>
<td><strong>$5,788</strong></td>
<td></td>
<td><strong>($19,212)</strong></td>
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<tr>
<td>Adjusted Compensation</td>
<td><strong>$181,770</strong></td>
<td><strong>$156,770</strong></td>
<td></td>
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<tr>
<td>Current Compensation</td>
<td><strong>$175,982</strong></td>
<td><strong>$175,982</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Variance</strong></td>
<td><strong>$5,788</strong></td>
<td></td>
<td><strong>($19,212)</strong></td>
</tr>
</tbody>
</table>

Less: Contractual Allowances – historical actual or benchmark percentage

Equals: Net Revenue

Alternatively, actual cash collections can be used.

Alternatively, actual cash collections can be used.

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NON-PRODUCTIVITY BASED COMPENSATION

Key Elements of Non-Productivity Based Compensation

- Mutually identify specific areas of potential savings
- Outline goals for savings and estimated amounts to clearly define objectives
- Establish a bonus pool for savings
- Identify treatment protocols for clinical staff and how success will be measured

- The concept of accountable care and patient-centered medical homes will also have to be addressed

Quality of patient care and level of service must not be compromised in any way.
**NON-PRODUCTIVITY PERFORMANCE METRICS**

- **Quality**: appropriate referrals for diagnostic testing, following practice’s treatment protocols (scripts, treatment, etc.)

- **Expense Control**: ability to manage internal expenses for supplies, staffing, etc.

- **Patient Satisfaction**: many practices conduct semi-annual patient satisfaction surveys and physicians are rated accordingly.

- **Quasi Co-Management**: some employment agreements include administrative duties and service line performance incentives
NON-PRODUCTIVITY PERFORMANCE METRICS

- **Call Coverage:** very common form of additional compensation for specialists, usually a stipend
- **Medical Directorships:** opportunity to work with hospital in management position for a time-based fee
- **Coding/Compliance:** incentive bonus for acceptable scores for coding audits and compliance reviews
- **Good Citizenship:** this can include attending practice meetings, giving free health presentations/screening to the community, serving on community boards, etc.
Non-Productivity Performance Metrics

• The value associated with non-productivity metrics largely depends on the implied value to the hospital
  ▪ Example: Quality metrics and expense control measures on the outpatient side have much less “value” than on the inpatient side

• Other measures must be valued independently based on market data
  ▪ Call coverage, medical directorships, etc.
OPERATIONAL GOVERNANCE

• Employ physician practices, normally under the practice
• The practice supports separate governance and operating structure of the hospital
• Multi-specialty group model supports single unified structure within the practice
• Multi-specialty group governed by physician-led board
**OPERATIONAL GOVERNANCE (continued)**

- Connection to the hospital allows growing infrastructure to be supported
- Hybrid structure for the hospital allows for the JOC to make decisions to drive success of overall Institute including day-to-day operations
  - Clinical settings
  - Strategy
  - Marketing
  - Clinical quality
- Hybrid structure allows the hospital to address issues applicable to all employed physicians
Joint Operating Committee

**Functions**

- Provide oversight and overall policy direction
- Develop evidence-based performance standards
- Undertake measures to enhance financial and operational performance
- Develop and maintain collegial practice environment
- Undertake strategic financial resource and operational planning/marketing in business development
- Develop budget for provision of clinical services to be approved by the practice
- Develop and recommend the practice facilities, IS and technology-related plans
- Ensure Institute services delivered consistently
- Oversee organization’s professional resources’ development

**Members**

- 5 Physicians
- 4 Hospital representatives

**Subcommittees**

- Specialty
- Quality
- Operations
- Compensation

**Executive Director and Clinic (Plus Practice) Directors/Organizational Structure**

**JOC**
JOINT OPERATING COMMITTEE

Functions (continued)

- Oversee new clinical program development
- Develop and operate an internal peer review
- Provide input concerning leadership qualities for Institute
- Monitor and maintain positive relationships with referring physicians
- Provide input into evaluation of clinical technologies, medical devices, etc.
- Develop annual report and work plan for the Institute
- Consider, review and approve to Board applicable medical research projects
- Approve and authorize expenditures consistent with the budget.
- Elect a chairperson and vice chairperson to oversee the JOC
The hospital/JOC subject to the practice and hospital reserved powers

- Operating and capital budgets related to the hospital
- Strategic plans related to the hospital
- Contracts for purchase or provision of services (legally-binding agreements)
- Expenditure on behalf of the practice not previously approved within budget
- Any action that may jeopardize the practice’s tax exempt status
- Any action inconsistent with powers granted to the practice board
- Physician and other professional compensation*
- Final decisions regarding recruitment and discipline of physicians

* This takes into account recommendations of the hospital executive committee and the hospital professional compensation committee
QUESTIONS AND ANSWERS
MANAGED CARE NETWORKS (IPAs, PHOs)

• “Loosely” formed alliances
• Primarily for contracting purposes
• Limited in ability unless clinically integrated
• Normally, no more than a messenger model
• Limited collaborative usefulness
CALL COVERAGE STIPENDS

- Pay for unassigned ED call
  - Fixed stipend
  - Fee for service structure
  - Hybrid approach

- Private practice physicians seeing all patients (paying and non-paying), causing them to request additional compensation from hospitals
- Other forms of alignment are becoming a reasonable alternative as there is not enough “bang for the buck” simply paying for call
- Most primary care physicians are not subject to these as hospitalist programs satisfy their needs
Medical Directorships

- Common alternative payment arrangement for a physician’s administrative duties associated with their particular specialty and/or department
- Should document hours worked and services provided
- Separate from employment compensation contract
- Subject to Stark provisions and corresponding fair market value determinations
GAIN SHARING

• Program works to ensure delivery of cost effective care while still maintaining quality and patient satisfaction

• Savings are shared with providers
  ▪ Percentage payment
  ▪ Hourly fee
  ▪ Fixed fee

• Physicians are integral in the planning process to determine how these savings can be actualized

• This model is limited in duration
  ▪ Not meant as a long term alignment solution
SERVICE LINE MANAGEMENT

- Compensation for service line management is held to FMV limitations and must be commercially reasonable.
- The scope of services (hospital size, complexity of duties performed, time/FTEs required) is the largest driver for the level of compensation.
- Comprehensive alignment strategy requiring less integration than employment.
SERVICE LINE MANAGEMENT

• Hospital engages applicable physicians to provide comprehensive services through a PSA
  ▪ Physicians are compensated on a global basis
  ▪ Independent practice maintained

• Services to be provided could include:
  ▪ Professional medical and surgical services
  ▪ Clinical management and coordination
  ▪ Administrative, supervisory teaching, and research functions
  ▪ Medical directorships
Management Services Organization (MSO); or Information Services Organization (ISO)

- Management processes provided to practices
  - Revenue cycle
  - Personnel/human resources
  - Information technology
  - Compliance

- MSO ownership
  - Joint hospital/provider
  - Hospital only
  - Private investors

- Strategy to align with providers
- Also may be in the form of an ISO
**JOINT VENTURES**

**Structures**
- Specialty Hospitals
- Management Services Arrangements
- Real estate developments
- Freestanding Centers
- Pay for Performance
- Block Leases
- Medical Directorships

**“Laws” to Consider**
- Stark
- Anti-Kickback
- Reimbursement
- Tax Implications
- State Law
Joint Ventures

Legally permissible if one of the following is met:

- The physicians must contribute financial capital
- The physicians must provide business expertise
- The physicians must have a business risk
CLINICAL CO-MANAGEMENT

**Provider(s)**

Provide medical management services for specific IP or OP service line

**Hospital**

Provide compensation at FMV, partly performance–based, tied to specific objectives
CO-MANAGEMENT: MODEL A

Existing Physician Professional Corporation

Management Agreement

Hospital (Service Line)

Management Fees

Management Services
EXAMPLE: ORTHOPEDIC SURGERY
CO-MANAGEMENT: MODEL B

- Physician Ownership
- Newly-Created Management Entity
- Management Agreement
- Hospital (Service Line)

Management Fees
Management Services
Co-Management: Model C

- Hospital Ownership
- Physician Ownership
- Joint Venture Management Entity
- Management Agreement
- Hospital (Service Line)
  - Management Fees
  - Management Services
Co-Management: Model D

Management Agreement between Hospital and Physician Group for a subset of management services and payment of a part of the total service line management fees

Joint Oversight Committee

Hospital

Management Agreement between Hospital and Physician Group for a subset of management services and payment of a part of the total service line management fees