Physician Integration and Sustainable Health Care Delivery Models — Financial Implications

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I. Challenges for Rural Providers

- US Census Bureau defines “Rural Areas” as:
  - Open country and settlements with fewer than 2,500 residents
  - Territories outside of urban areas with at least 1 person and a maximum of 999 persons per square mile
  - Roughly 20%-25% of the population live in rural areas
I. Challenges for Rural Providers

HPSA Designation (for purposes of AKS)
• Designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility)

MUA/MUP Designation (for purposes of AKS)
• Medically Underserved Areas/Populations are areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty and/or high elderly population

• Stark Definition of “Rural Area”
  – Rural area defined as area outside Metropolitan Statistical Area (“MSA”)
  – Office of Management and Budget publishes counties designated as MSAs
  – County included in MSA based on proximity to a geographical area with population of at least 50,000
I. Challenges for Rural Providers

- Challenge: Positioning a Fragmented Delivery System for a Post-Reform Environment
  - Major Themes of Health Reform:
    - Expanded Coverage
    - Improved Quality of Care
    - Reduced Costs
    - Coordination of Care
    - Compliance

- The Patient Protection and Affordable Care Act (ACA) specifies several pilot programs, which include:
  - Value-based purchasing
  - Payment bundling initiatives among hospitals, rehab, long-term care, home health, and skilled nursing
  - Patient-centered medical homes
  - Accountable Care Organizations

- Generally, an ACO describes a partnership of providers jointly accountable for improving health care quality and slowing the growth of health care costs

- Accountable Care Organizations
  - An ACO is an entity that is clinically and fiscally accountable for the entire continuum of care that a given population of patients may need

I. Challenges for Rural Providers

Core Principles of Accountable Care

- Move away from fee-for-service payment methodology and independent delivery systems to an approach that rewards high performance
- Current system promotes high-volume and high-intensity health services, regardless of quality and whether care is coordinated

Characteristics of an ACO, whether inside or outside Medicare Shared Savings Plan:

- Emphasis on evidence-based clinical care
- Close monitoring and reporting of quality and cost savings
- Coordinated care
  - Clinical protocols and integrated health information technology

II. Affiliation Options and Goals
II. Affiliation Options and Goals

Range of Affiliation Models

- Contractual Arrangements
- Joint Ventures
- Employment

DEGREE OF ALIGNMENT & INTEGRATION

- Service Contracts
- Medical Directorships
- Income Guarantees
- Practice Support
- Gainsharing
- Clinically Integrated PHOs
- Clinical Practice Plan & Institutes

III. Highly Integrated Models
III. Highly Integrated Models

1. Strategic Considerations
2. California Corporate Practice of Medicine Doctrine
3. Foundation Model
4. Approaches to Compensation

Fundamentals for Successful Integration

1. Know what you are … and what you are not
2. Know what you are building
3. Know who you are employing

Know what you are

- There is no one-size-fits-all strategy
- Have an honest sense of what you are and what you want to become.
- Tailor your approach
III. Highly Integrated Models

Know what you are building

Are you building a foundation based on quality?
Or on economics?

Determine whom to Align

- Evaluate
  - Community need
  - Retention
  - Preservation of ancillary income
  - Failing practice economics (e.g., professional liability, payer mix)
  - Call coverage
- Stay up to date on “Declining Specialties”
III. Highly Integrated Models

2. California Corporate Practice of Medicine Doctrine
   - General prohibition on the employment of physicians by hospitals
   - Rationale:
     - A physician’s loyalty should be with the patient only
     - Concern that corporate control can lead to the exploitation of the practice of medicine

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III. Highly Integrated Models

California Corporate Practice of Medicine Doctrine

*California Business & Professions Code*

Section 2052: Criminal sanctions including fines up to $10,000 or imprisonment for up to 1 year to practice medicine without a medical license

Section 2499: Corporations and other artificial legal entities have no professional rights, privileges, or powers

California Attorney General Opinion (1977): Hospitals cannot practice medicine and therefore cannot employ physicians

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III. Highly Integrated Models

California Corporate Practice of Medicine Doctrine

*Primary Exceptions:*

- Licensed charitable organizations, foundations and clinics provided that there is no charge to patients
- University of California may employ physicians serving as faculty in medical education programs
- Hospitals owned and operated by a health care district meeting criteria in the Health and Safety Code
- Community clinics if the clinic is licensed, services a defined population (i.e., low income), is operated as a non-profit and charges based on ability to pay
III. Highly Integrated Models

3. Foundation Model

California CPOM Doctrine has resulted in the proliferation of comprehensive “independent contractor” arrangements called

*The Foundation Model*

Foundation Model – Requirements of Section 1206(l) of California Health and Safety Code

Law allows certain “medical clinics” to operate without a license if:

- Non-Profit organization exempt from federal income taxation under 501(c)(3)
- Conducts clinical care, research and education
- At least 40 physicians representing 10 board certified specialties
- At least 2/3 of the physicians must practice on a full-time basis at the clinic
- Physicians must be independent contractors

III. Highly Integrated Models

<table>
<thead>
<tr>
<th>Foundation Model</th>
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<tr>
<td>Hospital</td>
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<tr>
<td>Ownership</td>
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<tr>
<td>Non-Profit Affiliate</td>
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<td>Affiliate Owns Assets and Infrastructure</td>
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<td>Physician Group</td>
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<tr>
<td>Support Services</td>
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<tr>
<td>Employs physicians</td>
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<tr>
<td>Manages clinical operation</td>
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Diagram: Diagram showing the relationships and responsibilities within the Foundation Model.
III. Highly Integrated Models

Foundation Model: Roles of Foundation and Physician Group

<table>
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<tr>
<th>Foundation</th>
<th>Physician Group</th>
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<tbody>
<tr>
<td>• Infrastructure</td>
<td>• Self governed</td>
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<tr>
<td>• Capital</td>
<td>• Employs Physicians</td>
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<tr>
<td>• Non-physician personnel</td>
<td>• Distributes payments to physicians</td>
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<tr>
<td>• Information Technology</td>
<td>• Sets physician benefits</td>
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<tr>
<td>• Payer Contracting</td>
<td>• Negotiates PSA with Foundation</td>
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<td>• Recruitment</td>
<td>• Potential for representation on Foundation Board</td>
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<td>• Strategic Planning</td>
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<td>• Billing</td>
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III. Highly Integrated Models

Foundation Model: Comprehensive PSAs

• The arrangement is set out in writing, is signed by the parties, and specifies the services covered by the arrangement
• The arrangement covers all of the services to be furnished by the physician (or an immediate family member of the physician) to the entity
• The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement

III. Highly Integrated Models

Foundation Model: Comprehensive PSAs (cont.)

• Term of at least 1 year
• The compensation to be paid over the term of each arrangement is set in advance, does not exceed FMV, and, except in the case of a physician incentive plan (as defined at Sec. 411.351 of this subpart), is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.
III. Highly Integrated Models

Foundation Model: Comprehensive PSAs
Percentage based compensation allowable for services “personally performed” by a physician
• CMS’s policy is that “personally performed” services are not “referrals” for purposes of Stark
• Percentage must be:
  – Established with specificity prospectively
  – Objectively verifiable
  – May not be changed over the course of the agreement between the parties

III. Highly Integrated Models

Comprehensive PSAs: Special Rules for:
• Method 2 Billing – CAHs
• Physician Ownership of Hospitals – ACA
• Provider Based Billing – Stark
• Non-Management Personnel – OPPS

III. Highly Integrated Models

4. COMPENSATION MODELS AND INCENTIVES

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<th>Productivity</th>
<th>Payer Mix</th>
<th>Billing and Collections</th>
<th>Practice Expenses</th>
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<td>Fixed Salary</td>
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<td>RVU’s</td>
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<td>Collections</td>
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<td>Net Income</td>
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- Physician Has Incentive to Manage
- Physician Has No Incentive to Manage
III. Highly Integrated Models

Fixed Compensation

• No incentive to increase productivity, collections or efficiency
• Limited utility in 2010s
• Limited ability to promote quality goals of the hospital

wRVU Model

• Physicians not in competition with the system
• Compensation not tied to managed care rates/payor mix
• Physicians "control" productivity and compensation

wRVU Model

• Facilitates physician decision-making on basis of quality, efficiency and patient convenience
• No expense management component unless added to model
II. Highly Integrated Models

wRVUModel

- wRVUs easily benchmarked (MGMA)
- Easily standardized among groups
- Physicians largely control factors in compensation

Net Collections Model

- Compensation directly proportional to group’s net collections (cannot include DHS unless personally performed)
- Compensation at risk for production and collections
- Physicians may end up competing with system for revenues

Net Income Model

- “Income less expenses”
- Potentially unattractive for specialties that generate significant ancillary revenues
- Favored by risk-averse health systems
III. Highly Integrated Models

Incentive Compensation

- Opportunity for additional compensation based on:
  - Clinical quality/outcomes
  - Efficiency
  - Patient satisfaction
  - Referring physician satisfaction
  - Successful recruitment and retention
  - New program development/enhancement

TVUs???
IV. Partially Integrated Models

IV. Partially Integrated Physician Alignment

1. PHOs
2. MSOs
3. Real Estate Joint Ventures
4. Equipment Joint Ventures
5. Gainsharing
6. Clinical Co-Management
7. EMR

1. Physician – Hospital Organization (PHO)
   - PHO acts as clearinghouse for managed care contracting and administrative functions
   - Allows hospital and physicians to maintain autonomy over operations, but reduces some administrative costs
IV. Partially Integrated Physician Alignment

1. Physician – Hospital Organization (PHO)
   FTC & Clinical Integration
   “an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality”

2. Management Services Organization (MSO)
   - MSO owned by hospital or hospital and group of physicians
   - Provides administrative services, non-physician personnel, and decision-making support in exchange for a flat-fee or percentage of revenues
   - Services provided on a comprehensive (“turn-key”) or “a la carte” basis

2. Management Services Organization (MSO) (cont.)
   - Within the comprehensive model, the physician retains control over his/her compensation/benefits, call coverage responsibilities, professional liability coverage and other personal physician matters; however, the turn-key MSO provides all other support through internal or secured/purchased capabilities
   - May foster physician loyalty by providing reasonably priced assistance
IV. Partially Integrated Physician Alignment

Management Services Organization

Hospital  Physicians

Physician Practice

Management Services Organization

MSO provides administrative, management and non-physician staffing services, as needed by a physician practice. Physician practice maintains ultimate control over practice operation, provision of physicians and other clinical services.

3. Real Estate Joint Ventures

- Hospital builds office building and physicians are offered opportunity to purchase ownership interests
- Incentivizes physicians to locate practice in hospital’s community and will likely influence referrals
- Attractive for physicians who lack capital to purchase their own building, but who desire to own real estate

JOINT VENTURES – REAL ESTATE

Real Estate Joint Venture

Hospital  Physicians/Group

Real Estate Joint Venture (MOB)

Third Parties
IV. Partially Integrated Physician Alignment

4. Equipment Joint Venture

- Jointly-owned entity leases or purchases major equipment and leased to physician’s office practice or to hospital (or both)
- JV enables physicians to bill for ancillaries that would have been too expensive but not for the hospital's partnership
- Physician will not open a competing facility
- Recent changes to Stark law make this arrangement very difficult to implement
  - Anti-Markup removes profitability
  - Leases must be block leases
  - The JV cannot bill and Hospital/Physicians cannot refer to an entity that performs DHS (no under arrangements).

5. Gainsharing

- Hospital offers program to allow physicians to share hospital's increased profits resulting from physicians’ adherence to cost-saving measures
- Anti-kickback and Stark concerns

6. Clinical Co-Management

- Physicians and hospital form LLC to provide management services to hospital/hospital department
- Management company oversees operations, protocols, personnel, budget, and strategic planning, and frequently provides a medical director, nursing director, and/or administrator
- Hospital has significant reserved powers
- Management company is paid FMV for services which are divided based upon ownership interests
- Often restrict physician-investors from involvement with entity providing competing services
- Must structure to comply with Stark
IV. Partially Integrated Physician Alignment

Clinical Co-Management

Pros

- Quick to execute. No facility construction or new provider enrollment
- Provides flexibility to Hospital and Physicians for future collaborative initiatives
- Provides income outside normal Physician reimbursement
- Creates mechanism for physicians to play an active role in managing the service line

Pros (cont.)

- Lower capital investment requirements with minimal investment risk
- Limited regulatory risk – but watch compensation structure
- Creates collaborative working environment between Hospital and Physicians
- Flexibility in scope of services provided and personnel (medical direction, staffing, clinical development)

Cons

- Not a passive investment, requires active participation of Physicians
- Lack of familiarity with the management company concept can create apprehension
- Changes to Stark law may limit alternatives for compensation structure
- May not provide as significant a return as other joint ventures based on compensation structure limitations
- Need to structure around provider-based rules (e.g., financial and clinical integration)
IV. Partially Integrated Physician Alignment

Joint Venture

Management Company

Hospital Service Line Management Agreement

Physicians/Physicians' Group

Hospital

III. Partially Integrated Physician Alignment

7. Electronic Medical Records (EMR)

- Allows hospitals to share with physicians the cost savings and communication benefits of a paperless fully connected system of records management
- Hospitals may offer these systems to employed physicians as well as to independent group practices that have relationships with the Hospital

III. Partially Integrated Physician Alignment

7. Electronic Medical Records (EMR) (cont.)

- Frequently these systems include management and storage of EMR, direct access to the records of the Hospital and/or affiliated group practices, online appointment scheduling for patients, and proprietary intranet access that connects physicians to specialists and other resources
- Stark Exception and Anti-Kickback Safe Harbor for EMR
- Deemed essential to many post-reform models
V. Other Opportunities

Unique to Rural Providers: Recruitment; Retention
Malpractice Subsidies; Rural Provider Exception

V. Other Opportunities

Physician Recruitment

The Basics of the Recruitment Exception:
• Physician relocates to hospital service area
• Joins the hospital medical staff
• Physician not required to refer patients
• Not based on volume/value of referrals
• Physician may establish privileges at other hospitals
• Signed, written agreement
• Does not apply to non-physician practitioners

V. Other Opportunities

Physician Recruitment

• Physician must be relocating practice from outside of the GASH and:
  – Physician moves medical practice at least 25 miles from outside to inside the hospital's service area; OR
  – Physician moves medical practice from outside to inside the hospital's service area and at least 75% of practice revenues are from new patients
V. Other Opportunities

Physician Recruitment

- Additional rules if a recruited physician will be joining a physician group practice:
  - Practice must also sign agreement if payments made directly to it
  - Assistance must be passed through to or remain with the recruited physician, except for actual costs incurred by the physician practice in recruiting the new physician
  - In the case of an income subsidy loan, the costs allocated to the recruited physician may not exceed the actual additional incremental costs attributable to the recruited physician
- Special standards for recruitment to HPSAs/rural areas

Physician Retention In Underserved Areas

- The physician must either have a firm written offer in another area or must have a bona fide opportunity
- Where the physician has a firm written offer, payments must be limited to the lesser of the difference between the offer and current income (over 24 months) or the reasonable costs to the hospital for recruitment of a new physician

Physician Retention In Underserved Areas (cont.)

- Where retention is based on a bona fide “opportunity,” the physician must provide a certification with details regarding the opportunity
  - In circumstances when the physician provides the written certification instead of a bona fide written offer, the retention payment may not exceed the lower of:
    - An amount equal to 25% of the physician’s annual income over 24 months
    - Reasonable costs the hospital would otherwise have to expend to recruit a new physician
  - Hospital must take reasonable steps to verify the opportunity

- Assistance must be passed through to or remain with the recruited physician, except for actual costs incurred by the physician practice in recruiting the new physician
- In the case of an income subsidy loan, the costs allocated to the recruited physician may not exceed the actual additional incremental costs attributable to the recruited physician
- Special standards for recruitment to HPSAs/rural areas
### V. Other Opportunities

#### Stark Rural Provider Exception

Ownership interest by a physician in a "rural provider" does not constitute a "financial relationship" for purposes of Stark.

A rural provider is an entity that furnishes substantially at least 75% of the DHS that it furnishes to residents of a "rural area"

Health Reform – Efforts to crackdown on physician-owned hospitals

#### Stark Rural Provider Exception (cont.)

Moratorium on Medicare certification of new physician-owned hospitals that would rely on this exception unless they have a provider agreement in place as of December 31, 2010

Cap on total physician investment in existing Medicare-certified facilities at whatever total percentage physician ownership a facility had on March 23, 2010

#### Safe Harbors to the Anti-Kickback Statute to Protect Rural Providers

- Investment Interests in MUAs
- Practitioner Recruitment in HPSA
- Obstetrical Malpractice Insurance Subsidies for MUAs/HPSAs
- Sale of Practice to Hospitals in HPSA
Thank you

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