Is Systemic Healthcare Reform Possible Without a High Degree of Physician Integration?

- A new paradigm for delivering better-coordinated, safer and more affordable care is needed
- Bona fide efforts to achieve efficiency, connectivity and quality are becoming more common but are not yet the norm
- Traditional hospital physician alignment was largely ineffective in a payment system that rewarded greater volumes of service
- In contrast, paying for results or at least proven practices will force providers into new, sustainable relationships
Traditional Drivers of Physician Employment by Hospitals

- Growing volumes and increasing market share have been the primary reasons
- 51% of hospitals say they employ doctors to further growth of their business
- 42% say they employ doctors to stabilize their ability to serve patients
- Only 7% say they employ doctors to transform how healthcare is delivered

Why Is the Employment of Physicians Back in Vogue Again?

- 1990s employment was mostly a response to managed care
- Changing demographics of the medical profession and economic pressures have created a different environment in the 2000s and made hospital employment an attractive alternative
- However, physicians remain distrustful
- Hospitals remain equally unsure about the productivity of physician employees
- Yet, healthcare reform makes bona fide integration an essential strategy
- Hospitals are beginning to see physicians as partners not customers
- Physicians are only willing to join a model that gives them a meaningful stake in governance and the ability to produce high quality care and strong financial results

What Has Changed This Time Around?

- Alignment is being seen as an offensive strategy, not merely as a defensive one
- Large single and multi-specialty groups are becoming more common and are often considered necessary to achieve optimal results
- The loss of autonomy is seen as a fair trade-off for the benefits of being an employee
- Much more experimentation
- Direct employment is no longer the only option
**Common Elements of All Alternative Physician-Hospital Models**

- Foundation of trust
- Shared vision and strategic plan
- Meaningful physician input in governance
- Effective practice management mechanisms
- Compensation that is equitable, market-based and aligned with system objectives
- Integrated models will win out over traditional models

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**Direct Employment — A Fresh Look at an Old Concept**

- In most states, the corporate practice of medicine prohibition is no longer an issue
- The advent of PPMOs opened the doors to physicians working for corporate entities not controlled by physicians
- Lessons learned from the 90s have caused today's employment to look more like a business venture, and less like a master-servant relationship
- In a dicey regulatory environment, the safety of employment allays many of the risks associated with JVs and other arrangements

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**Direct Employment — A Fresh Look at an Old Concept**

- Hospitals like the ability to require employees to use their facilities (except when patient needs dictate otherwise)
- Employment supports the use of clinical guidelines and emerging concepts such as the medical home
- Provider-based reimbursement is sometimes available
- Easier to invest in EMR technology
- Avoids some of the more difficult aspects of Stark, e.g., the severe limits placed on under arrangement deals
<table>
<thead>
<tr>
<th>Key Steps in Acquiring a Practice and Employing a Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Practice assessment</td>
</tr>
<tr>
<td>• Valuation of practice assets</td>
</tr>
<tr>
<td>• Structuring the deal (identity of the purchaser, legal form, carve-outs)</td>
</tr>
<tr>
<td>• Negotiation of employment terms including compensation and benefits</td>
</tr>
<tr>
<td>• Due diligence</td>
</tr>
<tr>
<td>• Drafting legal documents</td>
</tr>
<tr>
<td>• Preparation of legal opinion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Compensation: The Cornerstone of Every Successful Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Planning considerations</td>
</tr>
<tr>
<td>• Emphasis on future performance</td>
</tr>
<tr>
<td>• Proper weight given to productivity without violating applicable legal and business principles</td>
</tr>
<tr>
<td>• Changing reimbursement policies</td>
</tr>
<tr>
<td>• Changing overhead costs</td>
</tr>
<tr>
<td>• Charity care and bad debt</td>
</tr>
<tr>
<td>• Ancillary income streams</td>
</tr>
</tbody>
</table>

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>• Planning Considerations (cont’d)</td>
</tr>
<tr>
<td>• Recognized benchmarks</td>
</tr>
<tr>
<td>• Retain valued physicians</td>
</tr>
<tr>
<td>• Sufficient base salary</td>
</tr>
<tr>
<td>• Financial viability of the organization</td>
</tr>
<tr>
<td>• Easy to understand</td>
</tr>
<tr>
<td>• Risk sharing promoted</td>
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<tr>
<td>• Long term commitment encouraged</td>
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<tr>
<td>• Feedback provided to physicians</td>
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**Physician Compensation Must be Reasonable**

- Compensation cannot be a disguised way to distribute profits
- IRS Guidelines are very specific and must be followed
- But don’t expect the IRS to give advance rulings on physician comp plans
- Incentive compensation is okay so long as it aligns physician performance with the legitimate business interests of the exempt organization, especially the provision of charitable care

**How to Avoid Problems with Private Inurement and Private Benefit**

- Compensation plan should be overseen by an independent board or board committee that adheres to an up to date conflict of interest policy
- Total compensation must be reasonable in light of physician’s background, experience, comparable salaries, availability of skills
- Based upon arm’s length relationships
- There’s a ceiling or cap on total compensation
- Plan considers quality and patient satisfaction
- Plan serves real business objectives
- Plan rewards actual performance
- Plan promotes charity care

**Revenue Based Compensation Models**

- Although not per se illegal, these arrangements must be carefully scrutinized to ensure that there are proper incentives for charity care, limitations on gross income based on recognized norms, and a clear tie between the physician’s personal work and the amount of pay received
**Stark Can Be Addressed In a Number of Ways**

- Employment exception 42 USCA Sec. 1395nn(e)(2)
- FMV exception of 42 CFR Sec. 411.357 (h)
- Productivity bonuses are permitted under Stark if they are based on the physician’s personal performance and are not determined in a manner that takes into account the value or volume of DHS
- The $4.5 million settlement in the Covenant Medical Center case raises new concerns about what the federal government considers “reasonable” and what constitutes payment for referrals

**Similarly, Anti-Kickback Risk Can Be Addressed by the Employment Exemption and Regulatory Safe Harbor**

- The statutory exemption and the employment safe harbor are fairly robust but relatively untested
- FMV compensation is not an element of the AKS exemption/safe harbor, but excess comp raises a question whether the employment relationship is “bona fide”

**Bottom Line:**

In all of these models, getting an independent FMV opinion is essential. Virtually every legal test relies to some degree upon market-based compensation. Legal opinions given without FMV analysis are inherently unreliable.
The Physician Enterprise Model:
An Entry Level Model for Physicians Not Ready to Surrender Control

- PEM is a good option for hospitals which are adversely affected by the practice acquisition mania of the 1990s
- Independent physicians are attracted to PEM’s physician-centric philosophy and relative simplicity
- PEM moves hospitals away from the traditional “feed the beast” paradigm to a cohesive system of employees all focused on achieving the same results

The Physician Enterprise Model:
How it Works

- Hospital or health system affiliate employs physician through a separate entity that is a “group practice” for Stark and other regulatory purposes (called the “Physician Enterprise”)
- Hospital does not immediately buy and may never buy the physician’s practice. Instead, the physician retains ownership of the practice as before (the “Practice Entity”)
- The Practice Entity serves as the manager of the Physician Enterprise providing a turnkey package of services, i.e., non-physician support staff, facilities, equipment, access to records – essentially acting as an MSO
- The Practice Entity and the Physician Enterprise enter into a safe-harbored management agreement for these services

The PEM Model
Why Does PEM Result in Greater Integration?

- To patients, little has changed
- Physicians still have good reason to manage the practice as they did before hospital employment
- Hospital can influence the physician's activities through an affiliated organization and expect a higher level of loyalty
- As owners of the Practice Entity, physicians are under no pressure to “sell out”
- As bona fide employees, physicians can more readily receive incentive compensation for good results
- Physicians can be paid for administrative duties
- Greater sharing of data
- Often, hospital can get higher rates for same services
- Both sides have limited downside risk if the relationship does not succeed

A Working Example of the Physician Enterprise Model

- Although there are now many of these models around the country, one that has received a great deal of public attention is Summa Physician Services, Inc., a non-profit organization which employs 200 physicians and is affiliated with the Summa Health System in Akron, OH
- See “A Hospital-Physician Alignment Case Study: Summa Health System”, at www.GreatBoards.org

What Legal Issues Are Raised by the PEM Model?

- Despite its somewhat unusual structure, the model rests on fairly well-established legal principles
- The bona fide employee exemption in the AKS is satisfied notwithstanding the physician’s continued ownership of the Practice Entity
- FMV compensation is not an element of the AKS safe harbor, but excessive comp could be a red flag for a sham relationship
- Adhere to the IRS definition of bona fide employment
- Clearly delineate the physician’s dual roles as clinical employee and contract manager
What Legal Issues Are Raised By the PEM Model?

- Payments made under a turnkey services agreement should comply with safe harbors for equipment and space leases, and for management services
- Compliance with Stark can be achieved by satisfying exceptions for FMV compensation and group practices
- “SITS” generally not a problem
- Careful attention must be paid to IRS compensation guidelines

Professional Services Agreements — Another Transitional Model

- PSAs are essentially what previously have been called “medical directorships”
- Useful in building programs and service lines around key doctors
- May be FT or PT
- Ensure that physicians provide leadership in the development and enforcement of clinical guidelines
- There is regulatory risk if the PSA is really an attempt to pay for referrals

Other Alternative Models of Employment

- Most of the other alternative models involve ownership of the physician’s practice either by the hospital or a hospital affiliate
- Unlike traditional models, however, the new forms give physician-employees a larger voice in the governance of these entities
Other Alternative Models of Employment

- **System-Owned Multi-Specialty Group**
  - Often, the consolidation of several private practices into a single entity, with hospital/health system as the sole corporate member.
  - Even when physicians retain some degree of ownership, the hospital/health system has reserved powers that ensure alignment with system goals.
  - Characterized by high levels of physician involvement, integration with the hospital, and excellent reputations.
  - Examples: St. John’s Clinic, Springfield, MO; Aurora Medical Group, Milwaukee, WI.

- **Medical Foundation**
  - Not a foundation in ordinary sense; may not even be a for-profit.
  - Not merely a means to avoid the corporate practice of medicine prohibition, as in the past.
  - Instead the medical services arm of integrated system often combining multiple disciplines under one roof.
  - Often has responsibility for inpatient services within the affiliated hospital.
  - Physicians function at a much higher level than in private practices.
  - Example: OhioHealth Medical Specialty Foundation, Columbus, Ohio.

- **Clinical Institute Model**
  - Usually the outgrowth of a medical clinic that became a hospital system over time (as opposed to a hospital that began employing physicians).
  - Can be either single-specialty (such as a Center of Excellence) or multi-specialty.
  - Physicians are not only employees of the CIM, but they are generally at the helm of these organizations.
  - Physicians may be corporate members as well as employees.
  - Examples: Deaconess-Billings Clinic, Billings, MT; Genesis Heart Institute, Davenport, IA; Swedish Cancer & Heart Institutes, Seattle, WA; Piedmont Heart Institute, Atlanta.
Will Alternative Employment Models Bring About Systemic Change or Are They Just Another Fad?

• Physician employment is no guarantee of integration
• Physicians must be empowered to improve clinical performance
• Pay-for-performance models will force hospitals to get serious about performance management
• Early adopters have experienced success
• Greater collaboration yields improved economics, culture and compliance

Will Alternative Employment Models Bring About Systemic Change or Are They Just Another Fad?

• Clinical integration requires a commitment of resources and behavioral change that many are not ready to make:
  • Clinical protocols and benchmarks
  • Restructured governance and staffing
  • Data monitoring and reporting
  • An accountable legal framework
  • Technology, especially electronic records
  • Latitude in payer contracting
  • Performance improvement tools
  • Performance based compensation

Will Alternative Employment Models Bring About Systemic Change or Are They Just Another Fad?

• Assessing organizational readiness
  • Engagement of independent physicians
  • Ability to offer employment to physicians
  • IT support to help manage the new model
  • Reasons for clinical underperformance need to be addressed first
  • Understanding of physicians of their role in improving care and stabilizing the financial condition of the hospital
  • Ability to make a strong case for alternative employment models
  • The level of medical staff tension, e.g., politics
Will Alternative Employment Models Bring About Systemic Change or Are They Just Another Fad?

• Unlike JVs, alternative employment arrangements can form the basis of a clinically integrated system.

• Characteristics of a system that will thrive in the new payment environment:
  • Selective physician membership
  • Delivery of evidence-based care
  • Infrastructure for collaboration and coordination
  • Performance transparency
  • Payment transparency
  • Meaningful performance improvement incentives

Will Alternative Employment Models Bring About Systemic Change or Are They Just Another Fad?

• Will alternative employment models be the foundation for what the Health Reform Legislation calls “accountable health organizations”?
• Stay tuned: this is likely to be a huge topic of discussion in the coming year.

Will Alternative Employment Models Bring About Systemic Change or Are they Just Another Fad?

• Final Comments:
  • Physician leadership is essential
  • Shared commitment to the needs of patients and innovation
  • Study why policy makers in Washington admire the large non-profit clinic models of the Midwest
  • No matter what happens, the trend toward larger medical organizations is inevitable
  • Query: what will happen to the voluntary hospital medical staff if alternative models become the norm?
  • Hospitals and physicians can be spectators or participants in the changes that are underway