Physician Alignment and Compensation Strategies for Small Hospitals

28th Annual Rural Health Leadership Conference – Phoenix

February 11, 2015
1. Why Align?
2. Planning for Alignment
3. Common Alignment Models
4. Value, Compensation and Compliance
5. Key Operational Considerations
6. Making a Decision
Trends and Realities

- Economics
  - Increasing, shared economic pressures from “Eroding” payer mix.
  - Increasing Operational/Infrastructure Expenses—further eroding “bottom line” margins.
- Physicians
  - The changing profile of “New” physicians and allied health providers.
  - The changing practice patterns of “Senior” physicians.
  - Increased competition for decreasing/mal-distributed physicians.
- Government
  - Increased legal/regulatory scrutiny and constraints.
  - Ongoing, increasing and uncertain pressures from “Health Reform.”
  - More realistic realities of “Reimbursement Reform” – ultimately driven by CMS.
- Payers
  - Continuing pressures from payers for P4P, “full networks” and clinical efficiencies.
- Operations
  - Intense demands of physician / practice management.
  - The limitations of compensation plans to drive desired behaviors.
  - Shared disappointments, regarding initial EMR and related IT integration initiatives, but increasing understanding of required shared effective IT platforms for mutual success.
- Consumers / Patients
  - Reduced loyalty and respect for all health care providers and payers.
The “Triple Aim” Philosophy Provides a New Paradigm: Value-Based Payment

“The Best Care, for the Whole Population, at the Lowest Cost”

**Metrics:**
- QUEST outcomes
- Select HEDIS metrics
- Health status
- Mortality rates

The term “Triple Aim” is a trademark of the Institute for Healthcare Improvement.

Metrics:
- Total medical PMPM
- Total Medical Trend
- Total Rx PMPM
- Admissions/1000
- Readmission rate
New Payment Models – Value-Based Purchasing

Value-based purchasing (VBP) offers a relatively low-complexity approach to increasing alignment of risk between healthcare providers and purchasers (i.e., opportunity to enhance value through shared financial risk).
Physicians

Demographic differences and objectives
- Older Physicians: practical, individualistic, dedicated, respectful but like to be in charge, personal sacrifice
- Younger Physicians: hopeful, teamwork, can do anything but like their time off, shared responsibility

Independence
- As of 2008, the number of physicians in employed positions exceeded the number of physicians in independent positions, according to MGMA

Compensation
- Continues to trend upward
  - Buoyed by support from hospitals
- Despite negative economic trends
- --- May reverse if HOPD billing goes away ---
Move Towards Alignment

MEDICAL STAFF: Independent physicians transitioning toward alignment
# Why Integrate?

## Common Motivations

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Physicians</th>
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</thead>
<tbody>
<tr>
<td>• Address community needs</td>
<td>• Economics</td>
</tr>
<tr>
<td>• Stabilize key medical staff specialties</td>
<td>• Maintain practice viability</td>
</tr>
<tr>
<td>• Create systems of care</td>
<td>• Attain income security</td>
</tr>
<tr>
<td>• Control and improve quality of care</td>
<td>• Resources</td>
</tr>
<tr>
<td>• Reduce costs</td>
<td>• Reduce / eliminate</td>
</tr>
<tr>
<td>• Respond to competitive threats</td>
<td>• operational challenges</td>
</tr>
<tr>
<td>• Position for Value-Based Reimbursement</td>
<td>• Gain contracting power</td>
</tr>
<tr>
<td></td>
<td>• Technology</td>
</tr>
<tr>
<td></td>
<td>• Be part of a system</td>
</tr>
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</table>

## Wrong Reasons

- Create new referral streams
- Just keep physicians happy...increase incomes
- Prevent referral leakage
- Everyone else is doing it
- The competition has it
1. Why Align?

2. Planning for Alignment

3. Common Alignment Models

4. Value, Compensation and Compliance

5. Key Operational Considerations

6. Making a Decision
## Planning for Alignment

### Establish Integration Goals (hospital and physician perspectives)

- Degree of Integration
- Business / Financial / Physician Income
- Governance / Autonomy / Succession
- Quality and Service Offerings
- Operations and Technology
- Culture
- Compliance

### Look Short, Mid and Long-Term

- Establish your time frame
- Phase in efforts toward goals
  - Short Term – assure that practice operations are supported
  - Mid-Term – promote trust and change culture
  - Long-Term – Transform care delivery

### Develop Key Performance Expectations and Metrics

- Quality
- Efficiencies
- Productivity
- Market
- Financial / Pro Forma / Dashboards
- Operations
- Technology
- Contracting
# Basic Necessities

<table>
<thead>
<tr>
<th>Establish a Team</th>
<th>Develop a Plan</th>
<th>Educate Administrative and Medical Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hospital Management / Board</td>
<td>• Goals</td>
<td>• Business Purpose / Objectives</td>
</tr>
<tr>
<td>• Physician Leadership</td>
<td>• Implementation</td>
<td>• Integration Options</td>
</tr>
<tr>
<td>• Advisors</td>
<td>• Operations / Business</td>
<td>• Operational Implications</td>
</tr>
<tr>
<td></td>
<td>• Marketing</td>
<td>• Leadership</td>
</tr>
<tr>
<td></td>
<td>• Legal and Compliance</td>
<td>• Economics</td>
</tr>
</tbody>
</table>
Evaluate Market Opportunity

- Demographics
- Population
- Technology / Services
- Market / Payers
- Financials – Detailed/Sustainable
- Sensitivity Analysis
  - Change in PCP Base
  - Change in Specialty Base
  - Shift in Market Share
  - Competitors (Traditional and New)
  - Reimbursement
# The Future May Look Different

## External Assessment

<table>
<thead>
<tr>
<th>External Assessment</th>
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<tbody>
<tr>
<td>Government Involvement / Health Reform</td>
</tr>
<tr>
<td>Payer Involvement / Mix</td>
</tr>
<tr>
<td>Competitor Actions (includes other physicians)</td>
</tr>
<tr>
<td>Legal Implications</td>
</tr>
<tr>
<td>Market Influence on Compensation and Valuation</td>
</tr>
<tr>
<td>Relationship with Community Physicians</td>
</tr>
<tr>
<td>System Employment of Referring Physicians</td>
</tr>
<tr>
<td>Community and Patients</td>
</tr>
<tr>
<td>Market Factors</td>
</tr>
</tbody>
</table>
1. Why Align?
2. Planning for Alignment
3. Common Alignment Models
4. Value, Compensation and Compliance
5. Key Operational Considerations
6. Making a Decision
• Limited, but Varied Alignment Approaches
  • Most integrated health systems utilize a combination of the following nine (9) physician/hospital alignment approaches.

• Accelerated Integration Initiatives
  • Core Initiatives to: (1) reduce the “enterprise cost structures”; (2) enhance documented quality and service; (3) improve overall business and clinical efficiencies.
  • Significant reliance upon fully integrated (e.g., employed, foundation/PSA) and exclusive professional services agreements.
  • Extensive focus upon co-management and clinical integration initiatives to further involve the independent physicians.
  • Multiple, ongoing efforts to further empower physicians within a wide-range of physician leadership positions/structures.
  • Significant and expanded investments in related operational/support structures, including “physician-practice” IT/EMR/PM systems, etc.
Spectrum of Integration

**Traditional**
- Medical staff leadership
- IT initiatives

**Physician Recruitment**
- Community needs assessment
- Ease burden on independent physicians

**Medical Director and Personal Service Agreements**
- Increased performance accountability
- Expanded responsibility for clinical integration

**MGMT Services Organization**
- Expand role to support other affiliation tactics

**Specialty Institute / Center of Excellence**
- Used for subspecialty integration
- Can serve as transitional model

**Joint Managed Care Initiatives**
- Renewed use of risk-sharing models
- Clinically Integrated Networks

**Joint Ventures**
- Help address capital and operational risks

**Co-MGMT Agreement**
- Engage physicians in clinical / service line improvement
- Alternative to other payment arrangements

**Employment Foundations and PSAs**
- Increasing preference for physicians

**LEVEL OF INTEGRATION**
Primary High Alignment Options

Co-Management
- Most applicable for inpatient services, but being expanded to other areas: oncology, GI, Orthopedics, OB/Gyn, etc.

Professional Service Agreement
- Not fully aligned, but interdependent
- Reasonable model when employment is not an option.

Employment
- Highest level of integration
- Trade-off between autonomy and income security for physicians
- Hospital assumes more financial risk
- Physicians now fully accountable to hospital
Co-Management

- Department Council
- Operations
- Medical Director
- General Oversight

- National Registries
- State Quality Reports
- Pre/Post-Procedural Care
- Core measures
- HEDIS Measures
- Value-Based Purchasing

- Develop Service Line Financials
- Monitor and Recommend Tactics
- Budget Variances
- Service Offerings
- Outreach Development

- Studies read within 24 hours
- Readmissions
- On-time Start Times
- Overall Satisfaction
- EMR – Hospital/Practice
- Room Utilization

Admin

Quality

Financial

Operational
Alignment: Independent physicians with Medical Staff Privileges and Hospital form co-management entity to provide improvement efforts to specialty service line at hospital.

Financial: Hospital compensates physicians or co-management entity for dedicated administrative / leadership services plus incentives for achievement of improvement goals.

Co-Management Relationship
- $117,000 Fixed payment for administrative services
- Up to $117,000 at-risk payment for performance incentive

Physicians have Individual Physician Service Agreements with Co-Management Entity

Hospital

Group A

Specialty Co-Mgmt. Entity

Group B

Co-Management Participation
- Up to $25,000

Dr. XYZ

Employment Relationship

DOLLAR AMOUNTS FOR ILLUSTRATION ONLY.
### Administrative Services

- **Physicians perform specified management tasks**
  - Protocol development, education and training, meetings, outreach, management activities and support, initiate and implement quality improvements, etc.
- **Meet specified time commitments, usually on top of regular clinical schedule**
- **Compensation normally tied to recorded activities (time or fixed payment)**
- **Two surgeons would share co-directorships**

### Performance Achievement

- **Program achieves pre-set improvement objectives**
  - Objectives may encompass quality, efficiency, financial, satisfaction or other objectives
  - Goals are set in collaboration with physicians and connected to measures for which physicians have direct influence
  - Incentive compensation paid for achievement (or progress) toward goals (variable payment)
# Co-Management Overview

<table>
<thead>
<tr>
<th>Overview</th>
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<tbody>
<tr>
<td>• A contractual arrangement between Hospital and certain members of the Medical Staff to appropriately recognize and reward them for management and improvement of the quality, operations, financial performance and administration of defined scope of services within a hospital spine service line.</td>
</tr>
<tr>
<td>• Arrangement may exist between hospital and a single group or with physicians from multiple groups.</td>
</tr>
<tr>
<td>• Arrangements with physicians from multiple groups requires creation of a Co-Management entity.</td>
</tr>
<tr>
<td>• Physicians remain independent of the hospital (in most circumstances).</td>
</tr>
<tr>
<td>• Employed MD would participate in co-management activities with administrative and incentive compensation determined separately.</td>
</tr>
<tr>
<td>• Compensation for co-management services may not be tied to the value or volume of referrals.</td>
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<table>
<thead>
<tr>
<th>Conditions</th>
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<tbody>
<tr>
<td>• Hospital identifies need to engage physicians, especially across multiple groups, in order to address deficiencies within a service line.</td>
</tr>
<tr>
<td>• Hospital requires level of physician leadership above and beyond traditional medical director engagement.</td>
</tr>
<tr>
<td>• Neither hospital or physicians desire a direct employment relationship, but recognize need to be more closely aligned.</td>
</tr>
<tr>
<td>• Hospital seeks more aligned relationship than just paying for call.</td>
</tr>
<tr>
<td>• Other local or political conditions may exist which makes the CMA an attractive option.</td>
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</table>

<table>
<thead>
<tr>
<th>Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Arrangement does not affect billing of hospital or physician services, though should be intended to better position hospital for value-based reimbursement.</td>
</tr>
<tr>
<td>• Hospital pays physicians for agreed upon administrative / leadership services – typically, based on hours at an FMV hourly rate.</td>
</tr>
<tr>
<td>• Hospital pays physicians an incentive payment for achievement of predetermined program objectives.</td>
</tr>
<tr>
<td>• Overall value of the co-management agreement must be FMV. Amount is determined based on intensity of services provided, scope and size of program, and market comparison.</td>
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</table>
Co-Management Overview (cont.)

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Hospital:</th>
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<tbody>
<tr>
<td></td>
<td>• Closer alignment with key physicians to influence quality and care delivery. Demonstrates willingness to involve physicians in certain hospital operations and secures a committed relationship from physicians.</td>
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<tr>
<td></td>
<td>• Should result in elevated performance outcomes of the department.</td>
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<td></td>
<td>• Can help stabilize key members or specialty of the Medical Staff.</td>
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<td></td>
<td>• Can serve as a transitional model before direct employment or PSA.</td>
</tr>
<tr>
<td></td>
<td>• May help ease some medical staff political concerns.</td>
</tr>
<tr>
<td></td>
<td>Physicians:</td>
</tr>
<tr>
<td></td>
<td>• Better alignment with hospital to influence hospital-based practice environment.</td>
</tr>
<tr>
<td></td>
<td>• Creates new income opportunity for physicians.</td>
</tr>
<tr>
<td></td>
<td>• Physicians have no financial risks, but requires greater individual efforts.</td>
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<tr>
<td></td>
<td>• All physicians may not be able to participate.</td>
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</table>

<table>
<thead>
<tr>
<th>Disadvantages</th>
<th>Does not create the level of integration of PSA or full employment.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Hospital must have infrastructure to measure and manage performance objectives.</td>
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<td></td>
<td>New expense to the hospital which may not have an immediate return.</td>
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<tr>
<td></td>
<td>Terms of arrangement will require periodic renegotiation.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Compliance Issues</th>
<th>Range of legal and regulatory issues apply including Stark, AKS.</th>
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<tr>
<td></td>
<td>Compensation and financial terms must be commercially reasonable and fair market value.</td>
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</table>

<table>
<thead>
<tr>
<th>Applicability for Hospital</th>
<th>May be preferable model for Hospital to facilitate participation by physicians in multiple groups.</th>
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<tbody>
<tr>
<td></td>
<td>Can help serve as a bridge between the competing groups to work with the hospital.</td>
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<tr>
<td></td>
<td>May be more politically acceptable than an employment offer.</td>
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<tr>
<td></td>
<td>Example: Co-Management can be as narrow as spine-only, or could be developed for all of orthopedics.</td>
</tr>
</tbody>
</table>
### Co-Medical Director Duties
- Medical Directorship
- Department Meeting Leadership
- Management Liaison and Input
- Outreach
- Quality Metric Development and Monitoring
- Protocol Development
- Systems of Care Development
- Operational Efficiency
- Patient Safety
- Supply Optimization
- Cost Management
- Staff Training

### Performance Metrics
- Average Length of Stay
- Percentage of Patients Spent Days in ICU
- Percentage of Patients with 30-Day Readmissions
- Mortality Index
- Post-surgery Functional Improvement
- Post-Surgery Pain Assessment
- PQRS
- Cost per Case
- OR Turnaround
- Patient Satisfaction

**Examples for Discussion and Program Development**

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**Alignment:** Select physicians from either group form New PC; Other physicians remain in their current groups and maintain Medical Staff Privileges

**Financial:** New PC physicians receive guaranteed / incentive income and benefits from hospital in exchange for all professional fees; Hospital may acquire or lease clinic infrastructure (staff, overhead, etc.);

- Physicians own all assets and employ staff
- All payer contracting performed by group
- Group retains all PC/TC fees

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**Med Staff Relationship**

**Group before PSA**

**Group after PSA**

- Physicians remain independent
- Assets and staff acquired by hospital (lease option)
- Physicians reassign all billing to Hospital
- PSA pays physicians FMV compensation

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**HOSPITAL**
## PSA Overview

| **Overview** | • Traditionally, hospital will acquire the assets of a group (including staff), but not employ the physicians.  
• Physicians PC consists only of physicians.  
• Hospital assumes operational responsibilities and expenses. Hospital retains all professional fee revenue.  
• Physicians provide professional services under hospital contracts.  
• Hospital provides physicians FMV compensation which may include guarantees, incentives, benefits, etc. |
|---|---|
| **Option** | • Physicians retain all ownership of assets and hospital covers all reasonable expenses on a pass-through basis.  
• Physicians may retain ownership of certain ancillaries and technical collections. Professional collections accrue to the hospital. Alternatively, hospital could lease ancillaries from the physicians and retain all collections. |
| **Conditions** | • Physicians desire security, but not prepared to give up all autonomy, or desire control over governance and compensation.  
• Hospital seeks closer alignment with particular group to better influence quality, care delivery efficiencies, and contracting.  
• Hospital needs to stabilize group or specialty within medical staff, but not prepared to offer employment.  
• Other local or political conditions may exist which makes the PSA an attractive option. |
| **Financial** | • Physician Assets: May or may not be purchased by hospital.  
• Revenue: All practice revenues accrue to the hospital.  
• Expenses: All necessary and reasonable expenses borne by the hospital, either as a direct expense or pass-through (if physicians retain ownership of assets). Physicians may incur some legal or accounting expenses.  
• Payer Contracting: Professional services fall under hospital contracts. Hospital may elect to convert practice to outpatient department and bill services as HOPD. |
### Advantages

**Hospital:**
- Closer alignment with key physicians to influence quality and care delivery. Secures a committed relationship.
- Common branding.
- Strengthened contracting position.
- Can serve as a transitional model before direct employment.
- May help ease some medical staff political concerns.

**Physicians:**
- Income and professional security, predictability.
- Better alignment with hospital to address environmental uncertainties.
- Hospital assumes all revenue and expense risks.
- Retain governance control over key decisions and distribution of compensation (flexibility).

### Disadvantages

- Does not create the level of integration of full employment.
- Hospital must share control, which requires higher complexity management.
- Terms of arrangement will require periodic renegotiation.

### Compliance Issues

- Range of legal and regulatory issues apply including Stark, AKS.
- Compensation and financial terms must be commercially reasonable and fair market value.

### Applicability for Hospital

- May be preferable to permit physicians some flexibility in compensation methods and benefits.
- May be more politically acceptable to other physicians in the community.
### Minimum Guarantee plus Incentives
- Guarantee can be devised in relation to individual physicians (specialties)
- Incentives usually tied to productivity, but can also include quality, etc.

### Productivity Incentives
- Usually based on WRVUs, but could be connected to professional collections
- Some PSA may provide a “draw” with aggregate compensation reconciled to actual productivity

### Administrative Services
- Should be incorporated into the PSA (recommended for transparency)
- Can be connected to:
  - Medical Directorship
  - Practice Management
  - Leadership Participation
- Mid-level supervision and call can also be considered

### Benefits, Retirement, etc.
- Separate fixed amount per physician paid annually

### Administration of Compensation
- Monthly fixed payment from hospital to New PC.
- Quarterly or semi-annual reconciliation for incentive payments.
**Direct Employment**

**Alignment:** Select physicians become employees;

**Financial:** Employed physicians receive income and benefits from hospital; Hospital retains all professional fees from employed physicians;

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**Group before Employment**

**Medical Staff Relationship**

**Hospital**

- Physicians become individual employees of hospital or of subsidiary
- Hospital acquires assets

**Employment Relationships**
# Employment Overview

| **Overview** | A direct employment arrangement between Hospital and individual physicians.  
Employment arrangements may encompass a variety of duties (clinical, administrative, etc.) |
|--------------|------------------------------------------------------------------------------------------------|
| **Conditions** | Hospital identifies need to fill a gap in physician staffing.  
Independent physicians unwilling or not capable of fulfilling gap in staffing.  
Economics of independent practice are too uncertain / negative, and physicians seek employment from the hospital. |
| **Financial** | Hospital retains billing / collections for all physician professional services.  
Hospital pays physicians for clinical and administrative services.  
Hospital may incorporate incentive payment for to promote achievement of employment goals (productivity, quality, etc.)  
Overall value of employment compensation must be FMV. FMV is determined based on market factors, physician qualifications, performance expectations, etc. |
### Advantages

**Hospital:**
- Highest alignment with key physicians to influence quality and care delivery. Should result in elevated performance outcomes of the service line.
- Stabilizes key specialty.

**Physicians:**
- Greatest opportunity to directly influence hospital-based practice environment.
- Creates income security for physicians.
- Alleviates operational and business risks.

### Disadvantages

- Hospital must develop infrastructure to manage physician practices.
- Significant financial obligations for the hospital.
- May create tension with other physicians in the community.
- Physicians give up independent practice / business autonomy. Physicians can lose entrepreneurial drive.
- May limit compensation opportunities for physicians (ancillary revenue, compensation models, etc.)

### Compliance Issues

- Range of legal and regulatory issues apply including Stark, AKS.
- Compensation and financial terms must be commercially reasonable and fair market value.

### Applicability for Hospital

- Provides Hospital greatest control over delivery of services.
- Does not preclude other specialty arrangements (i.e. co-management, etc.)
Employment isn’t always Alignment

Opportunities to Clarify Leadership, Structure & Coordinated Strategy for Clinical Integration & Care Management

1. Partnered Admin & Physician Leadership & Accountability
   - Exec. Roles
   - Med. Admin.
   - System Council
   - SL Committee
   - Other

2. Coordinated Integration & Affiliation Relationships
   - Fully Integrated
   - Foundation
   - Co-Management
   - Exclusive PSA
   - Other Support

3. Payor Contracting Functions & Models
   - Network Dev.
   - Risk & Non-Risk
   - PHO & IPA
   - Direct
   - Carve-Outs
   - Other

4. Coordinated Infrastructure Support
   - “Care Mgmt”
   - MSO
   - QA/UM
   - Finance
   - EMR/IT
   - Other

Requires new, transformational approaches to physician alignment, compensation and performance management relationships.
Organized Medical Staff(s)
(per respective hospital bylaws and accreditation requirements)

- Inclusive of elected and/or appointed physician officers and representatives.
- Inclusive of subspecialty Clinical Depts./Sections
  - May include ex officio seats on other System/Hospital Boards and Councils
- Inclusive of Independent Physician Groups
- Inclusive of Integrated (e.g., System/Hospital employed or exclusive physicians/practices.)
Clinically Integrated Networks

A Clinically Integrated Network (CIN) is collaboration among independent/private practice and employed physicians and a hospital or health system, to develop a clinical integration program, which is an active and ongoing program of clinical initiatives to improve the quality and delivery of health care services, leading to greater efficiency in care delivery and cost savings.

> While FTC has chosen not to formally define CIN, recent advisory opinions have referenced:

• “(Clinical) Integration can be evidenced by (a physician) network implementing an active and on-going 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. This program may include:
  
  – Establishing mechanisms to monitor and control utilization of healthcare services that are designed to control costs and ensure quality
  
  – Selectively choosing network physicians who are likely to further these efficiency objectives; and,
  
  – The significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.”
Clinically Integrated Networks (con’t.)

» The most effective CINs:

• Establish infrastructure (Governance, IT, Open-sharing of Communications / Information)

• Every physician is NOT invited to participate – only those with highest quality and willingness to adhere to common quality, cost-effectiveness, and safety measures

• Difference between employed and independent physicians is minimized (although independent physicians raise anti-trust concerns)

• Avoid conflicts of interest

• Achieve market recognition

• Requires every physician to participate in every contract

• Shares incentive funds

• Engage in joint contracting / payor discussions as subordinate function
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What are physician practices worth?

Valuation

Cost / Asset Approach
- Tangible Assets – FFE, real estate
- Intangible Assets – Records, established workforce

Income Approach
- Going concern value – DCF
- Limited applicability – minimal profitability

Market
- Insufficient comparability / data

Hospitals no longer pay for “Goodwill”; generally not considered FMV
• When they say it’s not about the money...
  • Design
    • Promote agreed upon objectives
    • Flexible and transparent
    • Incorporate reliable metrics
    • Fiscally prudent
  • Compliance
    • Stark, AKS and IRS
    • Fair Market Value
    • Commercially Reasonable
As physician practice structures change, so do their compensation approaches.

While independent practices have oriented around Individual models, integrated practices tend to be migrating toward Hybrid Models.
# Other Compensation Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Pros</th>
<th>Cons</th>
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<tbody>
<tr>
<td>Pure Productivity (WRVUs, collections, etc.)</td>
<td>- Highly incentivizes physicians to work hard</td>
<td>- Can create unintended consequences and unsupportive competition among physicians</td>
</tr>
<tr>
<td></td>
<td>- Only pay for what you get</td>
<td>- Generally, not conscious of cost</td>
</tr>
<tr>
<td></td>
<td>- Common to independent physician practices</td>
<td>- Not aligned with new reimbursement models</td>
</tr>
<tr>
<td>Straight Salary</td>
<td>- Easy to administer</td>
<td>- No individual performance accountability</td>
</tr>
<tr>
<td></td>
<td>- Income predictability</td>
<td>- Can be dissatisfying to hard working physicians</td>
</tr>
<tr>
<td></td>
<td>- May work better under new reimbursement models</td>
<td>- Difficult to change physician mindset</td>
</tr>
<tr>
<td></td>
<td>- Can promote teamwork</td>
<td></td>
</tr>
<tr>
<td>Equal Share</td>
<td>- Can be tied to financial performance</td>
<td>- Limited to individual specialties</td>
</tr>
<tr>
<td></td>
<td>- May work better under new reimbursement models</td>
<td>- Requires like-performing physicians</td>
</tr>
<tr>
<td></td>
<td>- Can promote teamwork</td>
<td>- Can be dissatisfying to physicians</td>
</tr>
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Notable Key Trends include:

1. Increased pressures on base/floor levels of compensation, with expanded accountability for “minimum work standards”;
2. Reduced reliance upon volume/productivity alone;
3. Deliberate movement toward “capped” total incentives;
4. Enhanced reliance upon quality/service, and efficiencies.

**Pros:** Adaptable to multiple specialties; can be adjusted over time; and accommodates multiple goals

**Cons:** More difficult to administer / more management; more complex to understand; and goals may need to be regularly adjusted
What is a physician worth?

### Required by Medicare and IRS Rules

<table>
<thead>
<tr>
<th>Primary Reliance on a Market Approach</th>
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<tbody>
<tr>
<td>• Different Methodologies</td>
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<tr>
<td>• Published Data...surveys</td>
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<tr>
<td>• Individual Performance (productivity analysis)</td>
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<tr>
<td>• Market Comparables</td>
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<tr>
<td>• Adjustments based on:</td>
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<tr>
<td>• Market Dynamics</td>
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<tr>
<td>• Physician Qualifications</td>
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<tr>
<td>• Additional Duties / Conditions</td>
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</tbody>
</table>
• **Additional Regulatory Standard**
  
  • In simple terms...
    • Absent referrals from the physicians, would the arrangement make business to the hospital?
    • Does the physician compensation exclude the value and/or volume of referrals?
      • Measured objectively and subjectively.

• **Toumey and Halifax Enforcements resulting from Stark Violations**
  • CR was a critical factor
    • $240 mm penalty and $80 mm settlement
    • State AG investigating board members

• **An arrangement may be FMV, but not commercially reasonable**
1. Why Align?
2. Planning for Alignment
3. Common Alignment Models
4. Value, Compensation and Compliance
5. Key Operational Considerations
6. Making a Decision
Key Operational Considerations

**Practice Management Capacity**
- Management / Operations
- Contracting
- Revenue Cycle
- Staffing
- Expense Management
- Technology
- Facilities

**Physician Behavior**
- Changing Attitudes and Practice Styles
- Performance / Effort
- Patient Satisfaction
- Coding and Documentation
- Engagement / Citizenship
- Governance Participation

**Financial**
- Acceptable Level of Loss
  - Ancillaries shift to hospital
  - New expenses are incurred
Themes

1. Why Align?
2. Planning for Alignment
3. Common Alignment Models
4. Value, Compensation and Compliance
5. Key Operational Considerations
6. Making a Decision
Decision Points

Setting the Strategy
- Assess the Opportunity
- Define the Objectives

Selecting the Model(s)
- Different specialties / groups may warrant different approaches
- Assessing Physicians

Building the Capacity
- Don’t underestimate the cost and burden of physician management
- Ensure the right systems are in place

Plan and Implement
- Budget
- Timeline
- Accountability

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Thoughts to Consider

What is Strategy? (according to Michael Porter\(^1\))

› Strategy is the creation of a unique and valuable position
› Strategy requires you to make trade offs in competing; to choose what not to do
› Strategy involves creating “fit” among activities

What questions do you ask?

› What are your customers’ unmet wants and needs? How does your strategy address them?
› How will your markets be different in the future than they are today? What can you do to position yourself for the future?
› What is the business case for your investments? How will you measure and track performance to ensure impact?