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Hospital/Cardiologist Integration: Employment is Not the Only Way!

Exploratory

If a cardiologist in January of 2008 was asked, “if he/she wanted to be employed by a hospital or ever thought of it,” the likely response would have been “NO!!!!” Cardiologists are inherently independent and the thought of answering to a hospital administrator causes significant heartburn. Fast forward two years and the entire landscape changed. Financial pressures, healthcare reform, quality initiatives, and fear have all caused a new look into the future. That future looks like the only way to success is through an integration strategy with a hospital. The latest surveys indicate as many as 80% of cardiologists are looking into some form of integration.¹

Purpose

The employment model of integration might be the “easy” model but may not be the long term panacea that the cardiologist persona fits best. There are strong indicators that governance issues, IT dilemmas, and overall dissatisfaction, may make this a less than desirable model for the future. The purpose of this paper is to explore the reasons for and the possible outcomes of the implementation of different models of cardiology/hospital integration. Cardiologists seeking stabilization and security may not be aware of possible alternatives for this negotiation. The goal of this paper is to provide an overview of possible models which can be chosen by physicians in order to facilitate consensus during the negotiation process. An ideal model should form a lasting partnership between negotiators by combining an integrated product and knowledge that, “one size fits all” is not applicable.

Background Information on Current Trends in Integration

Current Literature

Questions in regards to physician hospital integration are plentiful. Many may actually be entrenched in current integration negotiations, while other negotiations may have been completed. However, most administrators are just beginning to think about what this might mean to the practice. This paper will provide potential opportunities for leaders to assess
multiple strategies, because, if there is a single solution for cardiologists and hospitals to integrate, it has not yet been revealed.

The journey begins by knowing the desired end result and what has happened in the past that could potentially be repeated, both good and bad. This is a time intense long relationship and it is no journey for the faint of heart. There will be times of slow, seemingly no movement sprinkled with spurts of intense activity. The best qualities of the negotiator will surface, as well as the worst throughout this process. Understanding historical trends can contribute to the understanding of the current healthcare marketplace, including physician attitudes and hospitals. The most important reason for a history lesson is so history does not repeat itself. Following the historical perspective, current methods of integration will be discussed as well as the impacts of regulatory and legal requirements on each methodology. By the end of the paper, it is hoped that enough food for thought has been created to provide the strength to start the journey. The research methodology used in this paper is a combination of literature search, surveys by others, and interviews of experts along with personal knowledge gained from experience.

Historical Perspective

1870-1930

The hospital industry started in the late 1800’s and developed primarily in the larger cities on the Eastern seaboard of the United States. Technological and medical breakthroughs coupled with increased populations and economic growth spawned the idea that the hospital was built for the physician to have a place to tend to a sick patient. It was the best of all worlds for the physician. The physician did not have to manage staff or worry about the business of taking care of their patient. Physician salaries soared while many hospitals lost money. Even in the early 1900’s physician autonomy was the standard. Physician hierarchy and organizations were completely separate from hospitals and physicians practiced in solo practices. Physicians received fees for services provided, not salaries, and the hospital was seen as a right by the physician to use as an extension of private practice, with payment for hospital services to the physician. Hospital expenses continued to climb and there was no collegiality between hospitals and physicians in this early model. 2

1930-1965

An era of great change starting with the Great Depression of the 1930’s came over healthcare. Income and hence survival was threatened during this time for everyone. It was this era that first looked to private enterprise to provide insurance to care for people who didn’t have financial resources. The first payers, Blue Cross and Blue Shield appeared as a separated hospital and physician enterprise. Blue Cross was founded in 1929 by Justin Ford Kimball, Vice President of Baylor University healthcare facilities in Dallas, Texas. The first plan guaranteed teachers twenty-one days of hospital care per year for just $6 per year. The American Medical
Association was first against this and then decided to support it when it became apparent that hospitals might have some effect in government. Technology became easier to obtain by hospitals and because insurance was covering lab and X-ray. A surge in utilization was first recorded during this time. Physicians indirectly benefited from these hospital insurances because now patients had money to pay for physician’s care, since patients no longer had to pay for high hospital bills. Blue Shield, the physician component, was founded in 1939 in the Pacific Northwest. Lumber and mining camp workers paid monthly fees to a physician bureau in exchange for care when needed. The overall concept is still present today as physician and hospital reimbursements currently remain separate.

The Great Depression threatened everyone and hospitals were sorely neglected during the War Years. Following the conclusion of World War II, priority was given to improving and professionalizing the management of hospitals by the three founding organizations of healthcare management: the American Hospital Organization, founded in 1899, the American College of Hospital Administrators, founded in 1933, and the Joint Commission on Accreditation for Health Services Administration, founded in 1945. The Prall Report of 1948 defined the extensive problems that existed between hospital administration and physicians, and recommended special education programs for hospital administrators to attend to better manage the conflicts with physician relations. It probably comes as no surprise that the same conflicts between hospital administration and physicians was highlighted in a 1963 report and again in 1978. There was a continued growing concentration of the physician practice in the hospital with a strong lack of clarity of the roles of the medical staff and their responsibility. There was constant distrust, antagonism, resentment, and hatred in physician-hospital relationships.

The level of hospital authority changed in 1957 when the case of Bing vs. Thunig found that the hospital has the liability to the community to maintain responsible behavior by the physicians and was further supported by Darling vs. Charleston Community Hospital in 1965 when it was found that it was the hospital who had direct authority to supervise the care rendered to its patients. This was the beginning of quality assurance committees and looking at outcomes.

1965-1990

A date remembered in healthcare circles is 1965, the start of Medicare and Medicaid. The single most important event designed to widen access to healthcare until the current Healthcare Reform Act under President Obama. There was of course in the beginning a lot of skepticism as these government programs were considered a possible beginning of socialized medicine. Physicians were still paid fee for service and were guaranteed clinical autonomy under these changes.

In 1973 the HMO Act allowed experimentation with financial risk bearing both by hospitals and physicians. At the same time some hospitals became investor owned, allowing for the potential
profits these risk sharing plans were to spawn. It was at this time when increased regulation was starting to surface. In the early 1980’s there was significant market competition and hospitals started to develop very lucrative joint ventures with physicians, as a means to increase overall market share. The landscape started to change in 1983 when the Medicare diagnosis related group (DRG) was introduced to hospitals. This was a system to classify hospital visits into groups of diagnosis and reimburse at pre-set levels. Hospitals for the first time were forced to analyze and manage resources and the medical staff played a large role in the utilization of these resources. The 1982 case of Arizona vs. Maricopa County Medical Society set the stage that independent physicians could not compare and set prices, leading the way for the merging together of physicians, as well as the managed care movement of the mid 1990’s. By 1995 one third of all insured were under a managed care policy and capitation was born. This capitation movement was another prompter for hospitals to employ physicians, hoping to decrease utilization practices of physicians. Today, physician productivity is a key matrix in provider compensation, unlike the capitation model of that era. 5

Independent Physician Associations (IPA’s) were formed and integration of physicians and hospitals exploded. The IPA was usually organized and managed by large Physician Practice Management Companies (PPM’s) and was designed to bring the single physician and single specialty into a more lucrative and merged association. The term horizontal integration was the buzzword and indicated physician employment, either by hospitals or Physician Practice Management companies. Physician practices were purchased for inflated sums with upfront payments in mega amounts. Today, physician practices are being purchased for fair market value with no upfront payments. In the late 1990’s the physician Resource-Based Relative Value Scale (RBRVS) was developed and the now current system for paying physicians began. Relative Value Units (RVU), based on RBRVS payments to physicians now have fifty percent of the buying power they had in 1995. 6

Hospitals expanded outpatient services and went into direct competition with the physician. During the 90’s there was a significant increase in hospital mergers and acquisitions, with a focus on systems instead of individual hospitals. The driving force was that not-for-profit systems were expanding and adding hospitals, the for profit health systems were growing, and the hospitals were trying to increase market share to protect insurance contracts. The failure both of the PPM companies and physician employment was blamed on a lack of aligned incentives and another hit to physician-hospital relationships ensued. 7

In the early 2000’s hospitals again pursued physician employment but this time without practice buyouts, less generous compensation packages, shorter term guarantees and better incentives for alignment. Hospitals were feeling good. Access to credit increased, the stock market was good, new services were a daily occurrence and most people were insured. The single specialty of cardiology was still successful and fiercely independent. Cardiologists did not jump to the PPM’s or to the hospitals during this era. Physicians diversified from just seeing patients to having free standing imaging centers and cath labs, as well as a strong emphasis in diagnostic
testing. In many cases over half of practice revenues were a result of extending of their practice beyond routine office and hospital visits. Cardiologists expanded their areas of expertise to Board Certifications in Nuclear and CT Imaging. Things looked favorable until 2007 when the perfect storm started to rage. The first wave was a decision by the Centers for Medicare & Medicaid Services (CMS) to reduce payments to freestanding ambulatory surgical centers to sixty-five percent of the fees paid to hospital outpatient departments. The second was a decrease of echocardiogram reimbursement and nuclear, resulting in millions of dollars in lost revenue for a midsize practice. Add a decreasing economy with more uninsured and out of work and a rising cost structure and the perfect storm ensued. Cardiologists began to look for a way of survival, as debt positions deteriorated and revenues continued declining.

The aging population will continue to drive utilization of services. Revenue for cardiologists appears to be under constant governmental and regulatory scrutiny and it appears clear that an integration strategy is going to be necessary for both hospitals and cardiologists to be successful in the planned integrated delivery systems of the future.

Models Currently in Use

There are five current models of integration. These are 1) employment, 2) professional services agreement (PSA), 3) business enterprise model (enterprise), 4) medical directorship agreements, and 5) cardiovascular service line/clinical co-management agreements. The greatest level of integration is the employment model with incremental changes to the least integrated being the cardiovascular service line/clinical co-management agreement.

Discussion of Findings

Strategic Reasons for Physician/Hospital Alignment Strategy

Hospital Incentives

Why do hospitals want integration? The level of hospital admissions has been very volatile and health systems have had to seek new strategies and alternatives that will allow hospitals to remain competitive. To be successful in the future hospitals and medical groups and doctors will have to work together collaboratively. The most effective healthcare systems that have participated in growth have a strategy of pursuing new alignment strategies, whether it is employment or partnering via a mechanism of professional service agreements. Hospitals are hoping to have an edge in managed care contracting and in trying to get ahead of healthcare policy changes and regulatory reform. Hospitals need to continue to improve balance sheets by strengthening buying power, efficiencies, adding new physicians and programs, while streamlining activities. There are huge incentives for information and data sharing both by governmental bonus structures and by cost effectiveness.
Physician Incentives

Why are cardiologists considering integration? Compensation is declining with no change in sight, increased costs of doing business, increased sophistication of practice management requirements, increased patient expectations, increased governmental requirements and scrutiny. Cardiologists see that reimbursement trends will continue to favor the hospital, especially if the Accountable Care Organization (ACO) model takes over. Quality of care is not just a physician issue but a hospital one as well and more influence over the hospital activities will aid in improving quality measures. Cardiologists have dabbled over the last few years with joint ventures, medical directorships that had an element of cardiovascular service line control, and pay for call. Cardiologists have been considered entrepreneurs by physician peers. Success in these ventures has varied widely and has still not replaced the revenue lost from the ancillary cuts.

So what can a cardiologist do to maximize security? Integration can provide financial stability, improved lifestyle, better infrastructure support, succession planning, marketing, and reimbursement. Integration is about valuation, compensation, and governance. All of this does not go without its challenges as history reveals. There are great differences in cultures and varying viewpoints in clinical management and clinical performance standards. The loss of control as discussed earlier as well as autonomy and the basis of trust are challenging. There is only so much reimbursement available and the physician will have to feel valued and incentivized to perform at the maximum potential.

Financial pressures, regulatory constraints, practice culture changes, and hospital fears have set the stage for the new physician-hospital integration models from the physician standpoint. The next section will discuss the legal and valuation requirements applicable to all of the models. Compensation, governance, independence, security, and competition will be discussed with each individual model, as well as any nuances of legal and valuation that may apply.

Regulatory Constraints and Sources of Risk

Legal, regulatory, and tax exempt considerations

All integration models must use a strong legal base as the starting point. Knowledge that integration strategies will fall under the public and governmental watch make this an absolute requirement.

Stark

The Stark Law prohibits referrals from the physician to any entity with which they have a financial relationship. There are several exceptions to this law, all requiring Fair Market Value (FMV) and no result of referrals. It is for this reason that under arrangement activities are no
longer approved and designated health services can no longer be leased by hospitals when owned exclusively by physicians.  

Tax-Exemption Status

Assuming the hospital integration discussion is with a tax-exempt organization, all of the payments made from the hospital to the physician group must be at fair market value (FMV). This avoids issues of excess private benefit and private inurement. In addition, the payments must all be commercially reasonable. These requirements substantiate the need of a knowledgeable valuation firm. If a hospital has used tax-exempt bonds to finance any space that may be used by the physician group, the parties must insure the arrangement does not result in private use and benefit of the space. Revenue Procedure 97-13 is an IRS safe harbor that outlines the maximum duration and maximum level of variable fees within the contract.  

Anti-Kickback

No payment from the hospital may be an inducement for the referral of patients. This again will rely on FMV and no intention of physician referrals. 

Provider-Based Billing (PBB)

Provider-based billing, also referred to as hospital outpatient is the billing process used for services that are provided in a hospital outpatient location. In the integrated model these are usually the diagnostic testing services. These services are reimbursed at the ambulatory payment classification (APC) rate. The advantage of PBB is an opportunity for increased reimbursement for services furnished, access to hospital resources, and high level integration. In order for ancillaries to be considered provider based, a sufficient amount of hospital control is required and the venture must further the charitable purposes of the organization. The provision of these services must be as an outpatient department of the hospital and all financial arrangements must be at FMV and arm’s length. There must be limited length terms of the contracts and there should be the ability to terminate for cause over objectives of the interested parties. 

In order to qualify for provider based billing, the facility must be held out to the public as a part of the hospital that is serving as the main facility. When a patient enters the facility, it must be clear that they are entering the main facility and billed accordingly. Signage, branding, written notification of financial liability, and forms must indicate the hospital status.

The facility will be operated under the license of the hospital and will have to meet all governmental regulations and regulatory requirements. This will include Joint Commission (JCAHO) accreditation and state requirements. If provider based billing is in place, instead of global billing as the practice has done in the past, the technical component of the test is billed as
a hospital outpatient department and the physician reading, even though performed in the office, will have a place of service for the reading as hospital outpatient (location 22).

Clinical services are treated as any other hospital department. Employees will have to meet the same standards as the hospital, including competencies, badging, credentials, etc. Financial operations of the department are integrated within the main hospital and sharing of income and expenses is required.

Although voluntary on the part of CMS, attestation may be required by the hospital. An attestation is a determination by CMS that the facility meets the requirements of provider based billing. If an attestation is not obtained and CMS upon later review finds the facility to be out of compliance, all monies paid for services received at the facility will have to be repaid to CMS. An example of an attestation can be found on the CMS website.\textsuperscript{12}

Valuation

Valuation is a government requirement for any healthcare facility with government-sponsored reimbursement and is one of the first steps in the process.\textsuperscript{13} This will provide a substantial component of the groundwork for the negotiations. Although this is an early step in the process it is very important that the basic terms of the agreement are clear. What model is being used? What services will be provided under the agreement? How are physicians going to be reimbursed? Who is at risk in this negotiation? Throughout the process there will be checkups by the valuation company to determine that requirements for Fair Market Value (FMV) have not been violated and one final approval prior to signing of the agreement.

Once the basics of the integration model are agreed to, key terms and the basics of the valuation process must be understood. There will be valuations of each area of agreement: billing, co-management, medical directorships, WRVU, and expenses in order to obtain an overall FMV allowed amount.

Any valuation dollar assigned to an integration agreement must be based on the following premises:

- **Commercial reasonableness:** is a term that is used in discussions of designated health services and Stark. This simply put means the financial agreement makes sense even with no promise of increased volumes to the hospital.

- **Fair Market Value (FMV)** as defined by Stark is that the value is at arm’s length and is consistent with the general market place.

- **Strategic value** is the value to the hospital. Hospitals are interested in integrating with key practices that can help expand healthcare networks. Depending on many circumstances this strategic value might be very high.
Keeping all of the above in mind, the practice valuator will use a combination of income, cost, and market approaches. The income approach assesses what income the asset (practice) would be expected to produce. This will be calculated by average expected reimbursement per CPT code and expected RVU levels combined. The cost approach looks at what it would cost to replicate the assets being purchased.\(^\text{14}\)

The market approach is more about valuing intangible assets or non-physical assets, like practice name and recognition. Certifications and recognitions achieved also are included in this approach.\(^\text{15}\)

This combination of approaches produces a global amount that cannot be surpassed and confirms whether what has been discussed is commercially reasonable. It is important for the valuation firm to share that number with the parties to determine if the negotiations for economic considerations will meet the desired end. This opinion must be delivered by an independent third party and there are very distinct methods that are governed so that FMV for services is met. Just because someone has negotiated $60 per Work RVU does not mean that is applicable to all practices in the area. The previous nature of practice revenues may not indicate that as the appropriate RVU level for the practice. It is important to have all documentation complete prior to this process. The following will be necessary to provide for the preceding twelve to thirty-six months for all valuations.

1. Income and Balance Statements for the previous 3 years: expenses need to be listed by procedure. Vendors, supplies, and an estimate of cost per year and per test are necessary.
2. CPT breakdowns by physician, by carrier, by year: should include average payments by carrier
3. Percentage of charges to each carrier, write-offs and payments
4. Any unusual arrangements (outside contracts) or carve-outs
5. Any certifications held by the practice
6. Equipment and furnishings: the date of purchase, any lease agreements, any service agreements, original price of equipment will need to be included. Having all of this information in spreadsheet format makes it easier and decreases the potential for mistakes. An assessment of FMV by the vendor of record will serve as a comparison for the results of the valuation. If space is being rented, lease agreements should be included as well both for legal and valuation purposes.
7. Total work RVU’s by physician, credentials of each physician, and total hours worked by each physician.
8. Any known or expected community need
The selection of a valuation firm is critical. The hospital will probably have a preferred company they have worked with in the past, but it is important to make sure the firm has a very clear understanding of physician employment and PSA models as well as the additional agreements that may become part of the aggregate compensation. The valuation must be performed by a non biased third party. This is the time to shop for knowledge, not price. Because of the volatility of the physician market most valuation firms will only guarantee their FMV numbers for 1-2 years. At that time all will be reassessed and may require adjustments to dollars paid. Clean, clear, and accurate data for the valuation firm to make the appropriate decisions is a must. Physicians cannot be paid more than is collected, physicians have to perform the work to get paid, and full time benefits cannot be paid for part-time doctors. Most of the valuation process is common sense. The more organized and complete the preparation, the better and faster the valuation should proceed. Maintenance of copies of all documents is important for conference calls and questions that may arise.

Models of Integration

Employment

The most common model of integration, as stated by a recent MedAxiom survey is the Employment Model. Seventy six percent of responders to the survey, who had integrated, selected this model of integration. An employment model is when the assets of the practice are sold and the physicians and staff are employed by the hospital. The practice will close in all aspects. As recently as a few years ago, most cardiologists would never have considered leasing or selling physician services or a physician practice to a hospital or health system. Now, tightening of economic conditions and fatigue from keeping up with new regulations and business issues has facilitated the re-emergence of practice sales to hospitals.

Legal

The principal advantage to employment is from a legal and regulatory standpoint. When a physician is employed by a hospital, payments made to the physician will generally meet safe harbors to the Fraud and Abuse Statute and to the Stark Act. A safe harbor applies to a payment and business practice that might otherwise fall outside of the rulings of Stark and Fraud and Abuse, but have been found to be beneficial to the community and are thereby protected from prosecution. All of the other models will meet these requirements as well, however there will be more scrutiny placed upon the final contract.

Financial Implication/Valuation

There is no difference in the methodology for valuation.
Governance

The corporate framework of hospital employment may not be suited for every physician. Employed physicians experience major differences than in private practice, in that no longer is the physician working to pay the office expenses and the internal motivation may be underscored. It was for this reason physician employment in the past often failed. Today’s employment model requires productivity targets and incentives. These are built directly into the contract and enhance the sharing of risk between the physician and hospital. Management and control can be the most challenging part of the employment model. Physicians will feel the need to have more control than is possible in a large organization and hospital structure. At the end of the day, if there is discord or disagreement, the employer (the hospital) will have the final say. This may in itself produce significant discord and discontent with the physician.

Security

Employment offers a feeling of security for the physician in this increasingly complex environment. In general hospitals have more capital reserves to draw from when new technologies or electronic health records (EHR) are needed. While physicians could and have purchased these technologies in the past, many banks now require personal guarantees, something many physicians are not willing to do. Hospitals have more staff resources available in the areas of human resources, compliance, and office functions. Supply costs may be less due to group buying power allowing physicians to utilize higher quality supplies than before. The hospital has more resources for marketing, business development, and recruiting than the private cardiologist.

Unraveling an employment agreement is the most difficult of all of the models. Since the previous corporation dissolved, the entire process must be initiated as if starting a practice from scratch. This can be expensive and daunting. In addition if there are non-compete clauses in place from the contract, there might be issues there as well.

Competition

What is allowed from a competitive nature will be dictated by the hospital. Since physicians are employed they are under the jurisdiction of the hospital.

The Professional Services Agreement Model (PSA)

The PSA model is considered less integrated than employment or the business lease model, as it is essentially a lease model. In a PSA, the hospital negotiates a FMV rate for the professional services of a physician group, usually measured in FTE numbers (full time equivalents). It is possible in the PSA to only contract for a few physicians in the group. It is also possible to lease assets and staff and the payment for these are passed through from the hospital to the practice,
with an added percentage for supervision and oversight. The PSA model will usually include medical directorships, service line management, and co-management agreements. In a PSA, physicians may sell or lease ancillaries to the hospital and have the hospital bill the technical fees in a provider based billing model.

Legal

The PSA model will require extensive legal assessments to be sure that no violation of Stark or Fraud and Abuse Statutes are violated. Because the physician is not employed in the PSA model, the safe harbors do not exist and therefore all components of legal requirements are essential.

Financial Implications/Valuation

Compensation as a reason for integration is usually the area most focused on during the negotiations. No matter what the selected model is, salaries paid by hospitals will generally pay physicians more than they are currently making. If a physician integrates in any of these models, take home pay may increase by as much as 10-40%.

The hospital will generally pay physicians for professional services based on the FMV of the work performed. A standard measure of work is the Medicare Work Relative Value Units (wRVU’s). Most methodologies pay a fixed dollar amount per RVU and depending on the valuation the value could range from $41-$66. The middle range appears to be clustered between $46 and $55. This will either count by physician or as an aggregate, based on the desires of the practice. Payment in this manner allows the practice to keep the current pay culture. In negotiations it is important to remember the non-clinical activities as well.

Practice expenses in this model are paid as pass through amounts by the hospital based on an agreed upon a starting budget and re-evaluated yearly.

Ancillary services can be retained, sold, or leased at FMV. Monies from the ancillary technical fees are considered in the overall global payment amount but cannot be a direct part of compensation as that would be a volume related payment.

If the sale of assets is included in the transaction, a FMV assessment of the assets will be made. Historically this has been 1-1.3 times revenue, however recent valuations are closer to .8-1x revenue and some have gone as low as .5-.7 times revenue.

Governance

Governance is probably the most important part of the integration and affects the cardiologist’s life on a daily basis. Unfortunately it is given the least amount of time. The governance could include a continuance of the status quo. A more advanced model would include clinical co-management agreements with quality and outcomes measures, vendor contracting, and medical directorships. Often these agreements are required in order to get the physician
compensation within the desired salary range. Physicians are paid not only for time spent in these add on agreements but also for consulting expertise. Whatever is decided, it is imperative that it is very clear who has the authority over clinical and business decisions. Which decisions will be made together, and which decisions will be made unilaterally are critical for success. Ideally this area finds collaboration and is set to align incentives in a positive way for each party.

In cardiology, the ancillary services will generally be governed by the hospital, a requirement for provider based billing. Management can be accomplished without employment of staff but must be developed carefully. It would be hoped that the best of both worlds could come together in a better whole by using the PSA model. Questions to be asked and obtain in writing during the negotiations include:

1. What requirements will there be of employees (badging, drug testing, orientations, employee files)?
2. How do current salaries compare with hospital salaries? Will the hospital set a cap on salaries?
3. What will signage expectations be?
4. Whose protocols will be used? How will this affect accreditations?
5. What forms will the hospital require at check in?
6. Who will carry the nuclear license? Who will be Radiation Safety Officers (RSO)?

Independence

The physicians in a PSA should feel the most independence. In this setting the hospital has no say in regards to clinical activities of the physician; however the independence of the physician practice is another story. If the ancillaries are a part of the hospital, their rules, forms, etc. apply and depending on what the contracts state, there may be some or minimal supervision of the clinical staff. Whether it is PSA or employment, there will be some differences in the overall independence of the physician.

Security

As woven throughout this paper, the threat of the economy and continued governmental chipping away of cardiology revenue will strip the security of the physician. By aligning with a stronger partner, the hospital system, this security is greatly enhanced to weather the storm.

Competition

Competition is a multi-level question. If a physician group is guaranteed a set reimbursement regardless of the amount of work performed, the likelihood to pursue and continue any
competitive activities is minimized. This however, is not a wise consideration as the contract always has the ability to be terminated and losing market share foothold does not benefit anyone. In addition, the more lucrative the contract for the hospital, based on the physician assisting in increasing both personal and hospital market share, the more likely contract negotiations for round two will go better.

Competition on the side of the hospital is one of the key reasons for hospitals to integrate. By integrating with a strong market share group, the hospital increases its potential for capturing market share instead of sharing with competing hospitals.

**Business Enterprise Model (Enterprise)**

In the Business Enterprise Model, physicians are employed, while the staff and assets are leased. The Enterprise model requires the practice stays intact and does allow for an easier return to the previous practice if that becomes necessary. The Enterprise model might allow slightly higher physician compensation than the PSA, especially when working with the not-for-profit systems and for more interdependence and aligned goals. The hospitals are relying on this relationship, as with the others, that this close alignment will encourage physicians to identify and implement revenue improvements and cost savings in order to equalize the payments for the physicians.  

**Legal**

The legal advantages of employment are maintained in the Business Enterprise Model.

**Financial Implications/Valuation**

Valuation for the Enterprise model will be split between the employment of the physicians’ component and the leasing of employees and expenses. As in the PSA model, if provider based billing is planned for ancillary services, the equipment would be sold with a resultant valuation of assets.

**Governance**

The Enterprise model mixes the Employment and PSA model in regards to governance. The physicians maintain control over their practice and the practice must stay intact. This model does allow the physician to feel more control than in the Employment model due to shared governance.

**Security**

In an Enterprise model the physician may experience the greatest feelings of security. Employment of the physicians allows more of an integrated level of security; while the
maintenance of the practice allows the physician to have a place to return to if the model is not successful long term.

**Competition**

What is allowed from a competitive nature will be dictated by the hospital. Since physicians are employed they are under the jurisdiction of the hospital. If the hospital has dictated what and where a physician can work, previous referral sources may not be available if and when the physician decides to return to private practice. This will affect the revenue availability in a negative way.

**Medical Directorship Agreements Model**

Medical Directorship Agreements are generally based on agreed to time and meetings that an individual physician will attend. Time is tracked by time-sheet and is paid at FMV. This model is one of the two least integrated models and has a long track record with hospitals and physicians. A Medical Directorship Agreement will often be combined with a PSA to increase the reimbursement available.

**Legal**

While seemingly simple, it is still important to follow legal guidelines of Stark and Fraud and Abuse. Paying for time spent at FMV is critical.

**Financial Implication/Valuation**

This valuation is simpler in that it is just for FMV for hours of the physician spent.

**Governance**

There is no true governance to this component except that physicians will not be paid unless they perform the work.

**Security**

Medical Directorships are an added form of income and if the physician does not perform as to expectations, the relationship is easily terminated with a resultant loss of the additional income.

**Cardiovascular Service Line/Clinical Co-Management Model**

Service Line Agreements or Co-Management Agreements are more integrated with concurrent goals. There are generally agreed to quality measures which are tracked and the physicians
paid based on achievement of the goals. This set of agreements may also include management of service lines within the hospital and is very flexible as to what it includes. Co-Management and Service Line Agreements can also be added to the PSA model for additional income.

**Legal**

In the legal safe harbor for Co-Management Agreements, any quality measure must be a “reach” for the achievement of the measure and the goal must have clinical significance to patient care. The goals and payments must be very defined and significant actions on the part of the hospital and physicians will be required to attain these goals.

**Financial Implication/Valuation**

Valuation of Service Line and Co-management Agreements are considered a variable amount, as the dollar amount paid is not guaranteed. Pay for call might fall under this agreement as well. The OIG Advisory Opinion No. 07-10 allows for certain physicians to be paid for caring for patients who present to the Emergency Room. The physician must be on active staff of the hospital and must provide services when called according to an organized call schedule. Hospitals don’t often want to get into this complicated issue; however more and more agreements are being reached between hospitals and cardiologists to provide this service.23

**Governance**

Governance in this model is very collaborative as both parties remain independent and are moving toward a common goal. There may be some frustration on the physician part when changes to the hospital process affect overall goals and there must be a high level of communication and collaboration for this model to work.

**Security**

In the Co-Management model, security is about the job done and quality measures reached. If all parties are working together, the sustainability of this model has long term potential.

**What to do Once the Decision has been made**

The professionals who will be needed in the journey of integration, will be a consultant who is well versed in integration projects. There are several, and names are available through national organizations. The consultant will assess what level of risk the physicians are interested in, from legal, financial, governance, etc. This is a first step to distinguish what models might be best suited to the current practice. The consultant will provide a term sheet to the hospitals with what is expected and desired. Once the hospital has expressed the desire and ability to continue, the real work begins. Be prepared for the term sheet to change during the
negotiation and the physician must know where the “line in the sand” is for the practice. The practice will probably be asked to sign an exclusive negotiating agreement to stay in effect during the negotiations.

One of the best approaches might be to create an Executive Physician team to assist in the negotiations. The role of this team is not to actually negotiate but guide the negotiators to an agreed to end point. During this process weekly meetings for updates and new directions will be necessary.

It is strongly encouraged that all of the important issues be placed on the table before too many hours are spent. This might include the following topics;

1. What model is everyone willing to accept?
2. How long is the contract overall? Five years is common but might need to be modified depending on bond requirements by the hospitals.
3. How long, if at all will the work RVU’s be guaranteed? Two years is common but it may be less or more.
4. Who is going to do the billing?
5. What is the expectation in regards to EMR?
6. Who will “control” what aspects of the relationship?
7. Who will be the “negotiating” team on the hospital side and how much decision power do they have?

The next steps will be valuation as discussed, followed by actual documents. During the valuation time and in preparation for documents, if not done so before, it is time to hire a healthcare attorney who specializes in this area. This is not the place for the practice corporate attorney; although the practice attorney will need to be apprised of the transactions to make sure Corporate Bylaws allow such a transaction.

The entire process may take from twelve to eighteen months and at a probable expense of $100,000 to $200,000 depending on the complexity. The Practice Administrator will be heavily involved, as consultants will probably not be able to keep up with the day to day requirements this negotiation will produce.

Once the negotiations are near completion it is then imperative to start organizational meetings that include leaders from both sides. Decisions have to be made about how to inform referring primary care partners as well as patients and the community. The details are many.
Overview of Performance Measures

Overall performance and achieving ACO status will depend on physician-hospital integration with clinical and financial alignment. Physician decisions and actions impact 70-80% of the hospitals cost structure and if physicians are included to identify problems, prioritize them, and analyze causes, they are less resistant to clinical change processes. Sharing in governance and decision-making will help the integrated system thrive.

Transparency is critical to the success of any model of integration. Resource allocation decisions must be based on objective data with active input from physicians and hospitals and all parties must be held accountable to objective performance measures.

The ongoing relationship will be assessed on the interdependence of the parties, both financially and culturally. Trust will be assessed, although it is understood this may take the most time to develop. Any integrated structure is inherently risky and making it work will be a constant challenge.

Conclusion

This paper has demonstrated that there are several models currently present that with care can provide autonomy and security for the cardiologist considering integration with a hospital. It is clear that one size does not fit all and that each individual must assess what level of comfort is provided by each model. Seeking professional advice from consultants, lawyers, and accountants will assist in the selection of the best model. It will be important to continue to watch and evaluate the success and longevity of practices using different models as the integration movement continues.
Endnotes

1 MedAxiom “Hospital/Physician Integration Survey” July 2011.


3 Ibid., 22

4 Ibid., 23

5 Ibid., 26

6 Ibid., 28

7 Ibid., 30

8 David Melloh, Partner and Chair of Health Law Group interview by author. June 2011.

9 Ibid

10 Ibid

11 Ibid

12 Coker Consulting Group PowerPoint Presentation, “Hospital/Medical Group Alignment Transactions” May 2011


14 Ibid

15 Ibid

16 Ibid


21 David Melloh, Partner and Chair of Health Law Group Interview by author. June 2011

