Compensation for Surgical Practices:  
Are Investments a Good Idea?  

Exploratory Paper  

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Introduction

The purpose of this paper is to explore a variety of compensation programs for independent surgical practices (multiple surgical specialties) outside of the quality incentive payment program and patient care method while incorporating the organization mission, vision and values of the practice. This paper will also explore different types of group investments specifically for independent surgical groups to consider when strategizing for the future.

Background

Surgery is an ancient medical specialty that uses operative manual and instrumental techniques on a patient to investigate and/or treat a pathological condition such as disease or injury, or to help improve bodily function or appearance (Fingar, Stocks, Weiss & Steiner, 2014). A surgeon is a person who performs operations on patients. Persons described as surgeons are commonly physicians (Fingar, Stocks, Weiss & Steiner, 2014). The oldest know surgical texts date back to ancient Egypt about 3500 years ago. In ancient Greece, temples dedicated to the healer-god Asclepius, known as Asclepieia functioned as centers of medical advice, prognosis, and healing (Gawande, 2002). Hippocrates stated in the oath (c. 400BC) that general physicians must never practice surgery and that surgical procedures are to be conducted by specialists (Fingar, Stocks, Weiss & Steiner, 2014). Hippocrates created the distinction between physicians and surgeons.

Today, modern surgery continues to be specialized. Surgery is often performed in a hospital or ambulatory outpatient facility by surgeons. Surgeons understand and are trained to adhere to all patient care issues when a patient is in the operating room. Operating rooms are the most complete, self fulfilling and functional location for surgeons (Weiss, Elixhauser & Andrews, 2014). The surgical profession is one of responsibility and leadership. The surgeon is
responsible for the preoperative diagnosis of the patient, for performing the operation and for providing the patient with postoperative surgical and treatment. The surgeon is also looked upon as the leader of the surgical team (What is the job description for surgeons?, 2017).

There are seven major settings in which surgeons can put their education, training and skills to valuable use: private practice, academic medicine, institutional practice, hospitals, ambulatory surgery settings, government service programs and the uniformed services (What is the job description for surgeons?, 2017). This paper will focus on surgeons in a private practice. The surgeon’s private practice centers around patient care, provides for more professional independence, allows freedom to decide the organization of the practice, as well as the hours, the hospitals in which the surgeon practices and the type of patients that are attracted. Surgeons in a private practice tend to encourage long-term relationships with patients. They also require strong professional relationships with referring physicians. Surgeons in a private practice have the opportunity to perform ambulatory or office-based surgeries and have options for managed care contracts (What is the job description for surgeons?, 2017).

All surgeons are required to follow general principles of evaluation and management (E/M) documentation. If it is not documented, it has not been done (Evaluation and Management Services, 2016). Clear and concise medical record documentation is critical to providing patients with quality care and is required for accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and record pertinent facts, findings and observations about the patient’s health history. Medical record documentation helps physicians and other health care professionals evaluate and plan the patient’s immediate treatment and monitor the patient’s health care over time. Health care payers may require reasonable documentation to ensure that a service is consistent with the patient’s insurance coverage and to validate: the site of service, the medical necessity and appropriateness of the diagnostic and/or
therapeutic services provided and that the services furnished were accurately reported (Evaluation and Management Services, 2016). General principles of medical record documentation apply to all types of medical and surgical service in all settings. While E/M services vary in several ways, such as the nature and amount of physician work required, the general principles help ensure that medical record documentation for all E/M services is appropriate.

Surgeons in a private practice must create a strong referring physician relationship. It is critical to patients’ outcomes and long-term wellbeing (Grant, 2017). Cleveland Clinic believes that they can build better relationships with referring physicians, ultimately benefitting the patients that they send. They also grow referral volume by providing excellent service to referring physicians. In 2012, Cleveland Clinic created a foundation to achieve referring physician objectives by dedicating people, establishing processes and improving technology (Gelb, 2012). Establishing a referring physician strategy is important for surgical practices so that they are able to obtain insight and build stronger relationships. Understanding the needs of referring physicians while evaluating the referral decision-making process, including the surgical practice’s reputation and knowledge about the scope of the specialty, will help promote positive experiences, loyalty and increase volume of referrals from physicians within the target market (Gelb, 2012).

In 1871, in an address delivered to the graduating class of the Bellevue Hospital Medical College, Oliver Wendell Holmes said: “Your patient has no more right to all the truth than he has to all the medicine in your saddle-bags…he should get only just so much as is good for him.” This attitude as “benevolent paternalism” pervaded medical behavior for at least the next century, a sort of “father knows best” culture (Nisselle, 2015). Today, more patients want to make safe and appropriate health care decisions and choose his or her surgeon. Although the patient’s family physician may recommend a particular surgeon with whom he has built a strong
relationship the patient may wish to request a different surgeon. Surgeons are not “technicians” but “professionals” in the broadest definition of that word and does care about his or hers patients (Nisselle, 2015). Patients draw upon a wide range of factors when choosing surgical care. Surgeon reputation, competency, interpersonal skills, word of mouth, physician referrals and affiliated hospital are the most pertinent reasons for choosing a surgeon (Yahanda, Lafaro & Spoverato, 2016).

**Reimbursement**

A patient also needs to check with his or her insurance company to find out if he or she may choose a surgeon or if the insurance company has to select a surgeon for the patient (Having surgery? What you need to know, 2005). Currently, surgical practices are reimbursed based on the fee-for-service (FFS) or discounted fee-for-service which refers to the payment for each service rendered by a provider based on a discounted, negotiated fee. This discount is granted in exchange for referral. (Jacobsen & Robertson, 2016). There are various types of fee schedule foundations that are used in discounted fee-for-service reimbursement methodologies: Medicare physician fee schedules, Workers’ Compensation fee schedules, usual and customary rates, payer proprietary fee schedules and a combination. The Medicare Physician Fee Schedule (PFS) is based on the resource-based relative value system (RBRVS). Historically, commercial payers, Medicare and Medicaid have utilized fee-for-service as the primary reimbursement model to pay providers. Today, this is commonly referred to as pay for volume. Managed Care Organizations (MCOs) have been using a discounted fee-for-service reimbursement methodology for years. Practices, including surgical practices, monitor negotiated rates to ensure reimbursement is accurate. Strong surgical practices load and maintain contract allowables by payer into their practice management software. Overall, contract performance should be monitored and contracts should be negotiated on an annual basis to compensate for inflation and value. Surgical practices
choose to contract with various MCOs, so if the patient is a member of a non-contracting MCO then that patient will not be able to choose a surgeon outside of the patient’s network.

Fee-for-service arrangements are shaped by market forces as well as historical relationships and is currently the primary basis for most relationships in terms of managed care contracts (Jacobsen & Robertson, 2016). The fundamental drivers of fee-for-service arrangements are: the more you do, the more you make; the more highly reimbursed the code, the better to bill; allows for patient expansion through network participation; quality outcomes not necessarily a consideration; lack of accountability for total cost of care (Jacobsen & Robertson, 2016). In the typical fee-for-service reimbursement model, quality outcomes, cost efficiency and total cost of care are not central considerations. This methodology supplies the incentives to increase volume and maximize reimbursement by rendering the highest care level of service possible. High-performing practices establish resource tools to assist in monitoring and managing managed care agreements. It is important for surgical practices to continue to dedicate resources to evaluate fee-for-service contractual agreements while transitioning to alternative value based models.

A surgical practice must also look at the community demand for their services when planning for the future. The focus of increasing market share, assuring referrals and pre-empting competition has been the recruitment strategy for most practices (Lipthrott, 2009). Hiring unneeded surgeons and other physicians has created bloating in the health care system while raising the costs of health care. The focus should be on improving quality, which would draw more volume, rather than setting up a system of employed physicians in competition with independent physicians (Lipthrott, 2009). Community need would mean recruiting physicians: to serve rural areas or underserved groups, to reduce excessive wait times for appointments with certain types of physicians and to reduce the burden on existing physicians due to rapid
population growth or other factors (Lipthrott, 2009). Vanderbilt University Hospitals and Clinics completes a Community Health Needs Assessment every three years to meet their mission to advance health and wellness through patient care, education and research. They engage the communities that they serve through outreach, education intervention and prevention programs. Although Vanderbilt University’s Community Health Needs Assessment is broad they too focus on the community need and demand for surgical services (Community health needs assessment, 2013). Other entities such as Lake Ridge Surgery Center in Woodbridge, Virginia, conduct community assessments. They use the community assessment as their foundation for the implementation strategy to address the needs of their surgery patients. The community assessment provides Lake Ridge Surgery Center with an overview of the health related problems that may impact their decision making process in evaluating surgical needs of patients and how to meet the demand for physician offices (Community health needs assessment, 2017). It is important for surgical practices to complete a community need assessment for each of their surgical specialties which should include all outside entities that will impact the volume of market share such as: hospital employed surgeons, other independent surgical groups in the service area, managed care contracts, hospital programs that support a surgical specialty, socio-economic and health status of the service are population (Community health needs assessment, 2013).

**Legislation**

Legislation has impacted surgical practices. The Patient Protection and Affordable Care Act (ACA) and nicknamed Obamacare, is a United States federal statute enacted by the 111th United States Congress and signed into law by President Barack Obama on March 23, 2010. Under the ACA, hospitals and physicians would transform their practices financially, technologically and clinically to drive better outcomes, lower costs and improve their methods of distribution and accessibility. The ACA was designed to increase health insurance quality and affordability, lower the uninsured rate by expanding insurance coverage and reduce the costs of
health care. It introduced mechanisms including mandates, subsidies and insurance exchanges (Pear, 2012). The law and its implementation faced challenges in Congress and federal courts and from some state governments, conservative advocacy groups, labor unions and small business organizations. Together with the Health Care and Educations Reconciliation Act amendment, the ACA represents the United States health care system’s most significant regulatory overhaul and expansion of coverage since the passage of Medicare and Medicaid in 1965 (Oberlander, 2010). The Act allowed the creation of Accountable Care Organizations (ACOs) which are groups of doctors, hospitals and other providers that commit to give coordinated, high quality care to Medicare patients. ACOs were allowed to continue using fee for service billing approach. They receive bonus payments from the government for minimizing costs while achieving quality benchmarks that emphasize prevention and mitigation of chronic disease. If they fail to do so, they are subject to penalties (Gold, 2015). Unlike Health Maintenance Organizations (HMOs), ACO patients are not required to obtain all care from the ACO. Also, unlike HMOs, ACOs must achieve quality of care goals (Gold, 2015). Under the ACA the Medicare payment system switched from fee-for-service to bundled payments (Access, 2012). A single payment was to be paid to a hospital and a physician group for a defined episode of care rather than individual payments to individual providers. The ACA added health care costs for quality initiatives including incentives to reduce hospital infection, to adopt electronic medical records and to adopt bundled payments to coordinate care and prioritize quality over quantity (Chait, 2013). In 2016, the five major national insurers lost money and withdrew from the market: UnitedHealth withdrew from the Georgia and Arkansas exchanges; Humana exited other markets, Aetna cancelled planned expansion and withdrew from 11 of its 15 states and Blue Cross/Blue Shield Minnesota exited in 2017 (Mathews, 2016). The ACA has impacted physicians and surgeons. For example, if a surgical office has a significant amount of elderly Medicare patients they have had to change their payer mix by accepting exchange patients to get younger patients. However, surgeons have had to deal with higher out-of-pocket payments. High out-of-pocket payments
have the biggest impact on specialists with expensive services, such as orthopedic surgeons. It is also difficult for a practice to calculate how much the patient owes at any given time, because the deductible changes each time the patient pays for care, although some payers provide real-time information on members’ out-of-pocket levels. Surgical practices have had to enhance its collection process from patients by collecting deductibles up front, prior to providing care. The ACA is also forcing more solo surgical practices to join hospitals due to falling reimbursements, increased regulations and the cost of installing electronic health record (EHR) systems while being concerned that shifting referral patterns will exclude them (Page, 2013). One of the most significant impacts of the ACA on physician practices is that the ACA has built a new trend that is replacing straight fee-for-service payments with new payment methodologies based on outcomes, such as bundled payments and shared savings in ACOs. Although the federally recognized ACOs and the government’s Center for Medicare & Medicaid Innovation are taking their first cautious steps with new payment methodologies, many commercial payers are moving ahead at a fast rate. This movement for the new payment methodologies requires sophisticated IT systems, a great deal of data-reporting and shared networks. As the ACA has been implemented the Centers for Medicare & Medicaid Services (CMS) is reducing payments to practices that do not comply with various CMS initiatives (Page, 2013).

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is another significant regulation that affects surgical and physician practices. In April 2015, President Barack Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015. This law repeals the sustainable growth rate (SGR) methodology for determining updates to the Medicare physician fee schedule. MACRA began in 2017, known as the transition year. The program’s main goals are to: improve health incomes, spend wisely, minimize burden of participation and be transparent (Center for Medicare & Medicaid Services, Quality Payment Program). The Quality Payment Program has two tracks: The Merit-based Incentive Payment
System (MIPS) and Advanced Alternative Payment Models (Advanced APMs). Not only does MACRA fund CHIP through fiscal year 2017, it could impact the fair market value of physician practices as a result of physician reimbursement changes through several components of MACRA. One of the biggest takeaways from MACRA is that it permanently repeals the SGR formula and stabilizes Medicare payments for physician services. Therefore, physicians will avoid the SGR cuts in the future, but the SGR is intended to support the transition from fee-for-service payments to value-based payments. The SGR repeal creates two options for providers; (1) enhanced fee for service or (2) accountable care. Option 1 is MIPS or the enhanced fee for service option and is to begin in 2019 as the only Medicare quality reporting program. Option 2 is APMs or the accountable care option and provides incentives and opportunities for physicians to develop and participate in new models of health care delivery and payment by participating in contracts with two-sided risk (Leggett, 2016). Physician payments for Medicare Physician Fee Schedule services have increased at an annual rate of .5 percent from July 2015 and are expected to continue at .5 percent through the end of 2019. From 2019 through 2026, the rate for both MIPS and APM will freeze at the accrued rate then increase annually again in 2026 and beyond. After 2026, MIPS annual payments will increase .25 percent per year, which will decrease from the .50 percent annual increase from 2015 to 2019, while APM annual payments will increase by .75 percent per year. These expected payment increases at gradual annual amounts have caused concern that the annual rates will not keep pace with inflation (Leggett, 2016). With the creation of the MIPS, Medicare’s multiple quality reporting programs have been replaced with the new single MIPS program which is slated to begin in 2019. MIPS will combine reporting for the Physician Quality Reporting System (PQRS), Electronic Health Records/Meaningful Use (MU) and Value-Based Payment Modifier (VBM) into one budget-neutral program with single payment based on an aggregate MIPS score. PQRS, MU and VBM no longer function as individual reporting programs and will end at the close of 2018 at which time MIPS will become the only Medicare quality reporting program. Performance and composite scores under MIPS will be
based upon four categories, including quality, resource use, meaningful use and clinical practice improvement activities. The focus is develop and increase the current quality measures and concepts in PQRS, MU and VBM. Because MIPS is a budget neutral program, penalties on low-performing physicians equal bonuses to high-performing physicians. Physicians with MIPS composite scores below the performance threshold will incur penalties on a sliding scale with maximum penalties up to 4 percent in 2019, 5 percent in 2020, 7 percent in 2021 and 9 percent in 2022 and beyond. Physicians with MIPS composite scores that exceed the performance threshold will earn bonuses on a sliding scale with the highest bonus at least as high as the highest penalty for that year. Because of MIPS, practices not reaching MIPS composite score targets will suffer reimbursement penalties, which will negatively impact practice and physician compensation values for poor performers. These MIPS penalties will result in decreased revenue, which could negatively affect the overall bottom line for practices. When considering the fair market value of physician surgical practices, it is imperative that practices contact their legal counsel who understand the components of MACRA and the impact to practices, especially related to reimbursement and payment model changes.

**Organizational governance**

A surgical practice must develop a long-term strategy with a strategic direction of the organization. The practice organizational governance involves the ability to facilitate the corporate legal structure, define policies and define the organization’s culture (Body of Knowledge: Medical Group Management Association (MGMA), 2009). The surgical practice must establish its mission, vision, values, goals and objectives with a governing body that supports the needs of the organization. The governing body such as a board of directors must do the following to be effective:

1. Uphold ethical standards and maintain adherence to corporate bylaws.
2. Effectively communicate the organization’s mission, vision and values to influence the strategic direction.

3. Provide leadership, innovative thinking and be able to change management direction if needed.

4. Understand how social, political and legal issues affect access, cost and quality of health care.

5. Assess the community health care needs.

6. Implement effective allocation system of revenues and expenses and understand components of an effective compensation systems.

7. Ensure linkage between the compensation plan and the organization’s mission, goals and culture.


The Physician Policy Manual and Code of Conduct are developed based on the organization’s culture, mission, vision and values as a shared commitment to legal, ethical and professional conduct (Jackson, 2016)). The organization’s policies are created as a structure to teach, support and monitor the integrity of the physicians while supporting the governing body and its leadership. The governing body promotes professional excellence by maintaining ethical standards of health care and business practices. Effective governance is essential to a successful surgical practice (Body of Knowledge: MGMA, 2009).

**Human resources**

Human resource management involves physician recruitment and retention which is critical for achieving and enhancing organizational performance. When a surgical practice’s governing body develops objectives, completes a Community Needs Assessment and determines
if there is a need to recruit then human resources is very important for a successful hiring process. The governing body identifies recruitment sources and techniques as well as defining the scope of the job and job descriptions (Body of Knowledge: MGMA, 2009). One common technique used for physician recruitment is benchmark data. According to The Association of Staff Physician Recruiters (ASPR) “Benchmarks are critical as we constantly strive for improved processes and results to meet the health care needs within our communities,” says Jennifer Metivier, MS, executive director of ASPR. Participation in Benchmarking Surveys provides an analysis of recruitment data as well as access to national trends in physician employment data and recruitment process statistics. This data includes physician compensation including starting salaries for new physicians, ranges of salaries based on geographical location and ranges of salaries based on physician experience in that specialty. The data gathered can be helpful for the governing body to determine compensation for a new physician joining the surgical practice.

**Compensation models**

It is critical for a surgical practice to have a fair compensation plan in place not only for new physicians, but for the entire practice. Physician compensation plans are defined as methodology for determining the amount of income that a physician will receive from the medical/surgical group practice or other entity. The compensation method can be via a guaranteed salary or a formula that is as simple or complex as the organization designs (Milburn & Mourar, 2014). Physician compensation must be linked to the financial realities of the organization and typically have the following objectives: recruit and retain physicians by offering the opportunity for a fair and competitive compensation; ensure financial viability by balancing collections and practice expenses, including physician compensation; and align physician incentive and rewards with health care organization’s mission, vision and values (Milburn & Mourar, 2014). Since income can provide a sense of self-worth and esteem to
individuals, compensation plans are closely linked to physician behavior. The right compensation and benefits package promotes productivity, improves quality, improves patient experience and contributes to the organization’s success. The wrong compensation and benefits package is disruptive and can fracture a medical group (Gans, 2013).

**Straight or guaranteed salary**

Straight or guaranteed salary is based on a set amount that the physician earns for an hourly or per-shift amount. The set amount is usually stated in an employment agreement or similar document when a physician first joins or begins working with the practice. There are several advantages of straight salary for compensation:

1. Administrative simplicity. It can be market based using compensation surveys.
2. Less stress on physician since compensation is a known amount and isn’t at risk for other factors. It is easy to budget.
3. Is not subject to frequent changes in demand or reimbursement.
4. Supports the concept of a team effort and team-based culture. It decreases the sense of competition.
5. It encourages collaborative efforts.
6. It does not encourage overutilization.
7. It is not impacted by participation in nonclinical activities.
8. It decreases individualistic attitude making it easier to implement changes (Milburn & Mourar, 2014).

The disadvantages of straight salary include:

1. It is not easily adjusted to changes in practice revenue.
2. It does not provide incentives or rewards to encourage desired behavior, including increasing productivity.
3. It is not linked to ongoing financial situation of practice and is not tied to use of resources or expenses (Milburn & Mourar, 2014).

Straight or guaranteed salaries are most appropriate for: hospitalists, radiologists and physicians in emergency rooms or urgent care centers who cannot control or have only minimal control of what happens during a shift, including patient demand or volume. Straight salaries are appropriate for new physicians who will have a period of being mentored followed by a period to build their share of a practice. Specialties that have less demand, but are recognized as a needed service within the community or organization, may fit in the straight salary category too.

There are a number of things to consider when setting up a straight salary compensation model in a surgical practice such as:

1. Ensuring that the amount of salary offered is within fair market value and physician expectations, but not enough to bankrupt the practice.
2. Salaries for new physicians should be based on data from recruiting firms and surveys such as the annual Medical Group Management Association Physician Placement and Starting Salary Survey.
3. Depending on the marketplace and the specialty, starting physicians should be offered a salary formula used for other physicians in the practice.

The major disadvantage of salary compensation is the lack of incentive to achieve and maintain productivity and thus an expected revenue stream for the practice.

Several options encourage productivity from physicians on salary.

1. One option is a base salary plus incentive.
2. Another option is to set minimal performance expectations to maintain employment (Milburn & Mourar, 2014).
Equal distribution of compensation pool

Another easy-to-administer compensation methodology is the equal distribution of the compensation pool. Advantages of the equal share methodology includes:

1. Administrative simplicity and easily adjusted to changes in practice revenue and expenses providing stronger link to the practice’s financial status.
2. Directly linked to a team effort and supports a team-based culture; lack of competition encourages collaborative efforts.
3. Not impacted by participation in nonclinical activities.
4. Decreases the individualistic attitude making it easier to implement changes (Milburn & Mourar, 2014).

The disadvantages to equal share methodology include:

1. Does not provide individual incentives or rewards to encourage desired behavior.
2. Less individual accountability since compensation is not directly tied to physician’s individual effort or use of resources or expenses.
3. More compensation is at risk than with a guaranteed salary.
4. Possibility for resentment if belief develops that one physician (or more) is not “pulling” his or her weight.
5. Is subject to changes in demand or reimbursement causing more month-to-month fluctuations than with salaries (Milburn & Mourar, 2014).

It is more appropriate for single-specialty practices or specialties within a practice that are similar in reimbursement and resource demand. Practices that want to minimize internal competition for patients will use the compensation pool methodology more; and practices with physicians of compatible work ethic, productivity and resource utilization use this type of pool. It is also appropriate for practices whose culture promotes teamwork. There are a number of things to consider with equal share methodology including: individual physicians’ direct expenses can
be allocated or they can be expected to pay for malpractice insurance, continuing education, benefits and so forth out of their compensation; and developing performance expectations (Milburn & Mourar, 2014).

**Salary or equal share plus incentives**

Another type of compensation model is to increase the complexity and add incentives: Salary or Equal Share plus incentives. This model will address the lack of incentive to increase productivity and the weak link to personal accountability for costs. A physician may be able to receive an incentive on achieving certain goals, following practice behavioral expectations or contributing to the practice’s financial success. Limiting the number and/or complexity of incentives can keep the plan relatively simple to manage. However, the more involved incentives with a higher percentage of compensation at risk, this option can be a more complex option to manage (Milburn & Mourar, 2014).

Compensation formulas can use different types of incentives such as: equal share plus incentive methodology or base salary plus incentive methodology. Both of these types of methodologies support a team environment and the security of a known compensation. Additional advantages include:

1. Can be more closely linked to the practice’s financial success.
2. Increases a sense of personal accountability.
3. Influences behavior to align with organizational goals and culture.
4. Increased flexibility to adjust to changes in revenue.

There are disadvantages to equal share plus incentive or base salary plus incentive models which include:

1. Base salary not easily adjusted to changes in actual practice revenue.
2. Equal distribution can still generate resentment between physicians.
3. Limited accountability for revenue and expenses.

4. Difficulty in selecting appropriate percentage or amount of compensation for incentives that will motivate and what factors to include in payment calculations.

5. More complex to administer than straight salary or equal share compensation (Milburn & Mourar, 2014).

As complexity increases, more variables and factors are included in compensation formulas. Compensation by a predetermined amount (salary or stipend) becomes a smaller portion of the total compensation or disappears altogether. Instead, compensation is based on variable factors that are more closely tied to physicians’ behavior and use of resources. These plans can be more difficult to develop and administer but have enough advantages that they are a popular choice for surgical practices (Milburn & Mourar, 2014).

**Productivity-based compensation methodologies**

Productivity-based compensation methodologies have gained in popularity to encourage physicians to increase their productivity and therefore, the practice revenue. This has been a good strategy to combat the low rate of reimbursement increases compared with the cost increases. Many surgical practices have shifted to productivity-weighted plans to meet organization goals and improve the practice finances. There are many details and factors to consider that add complexity to the basic physician productivity formula. However, the general concept of productivity-based methodology has advantages such as:

1. Increases physician accountability.

2. Encourages and rewards a physician’s effort to increase productivity and revenue.

3. Improves patient access because of incentives to see more patients and provide more services.
4. Compensation is based on an individual physician’s level of activity, decreasing complaints of others “not pulling their own weight” (Milburn & Mourar, 2014).

There are disadvantages of a productivity-based plan such as:

1. It is more complex to administer.

2. More of compensation is at risk to the physician.

3. Potentially leading to overutilization.

4. Potential exists for physicians to game the system through upcoding or encouraging patients to return more frequently than medically necessary (for surgeons it could also be encouraging more surgeries than medically necessary).

5. The plan increases competition among providers in the group which also may adversely impact the desire to hire additional physicians.

6. Changes in revenue or reimbursement from one period to the next can increase the volatility of physician compensation.

7. Nonclinical activities are not encouraged because of the potential impact on productivity.

8. There is no direct link to quality, outcomes or patient satisfaction (Milburn & Mourar, 2014).

Although the number of disadvantages is greater than advantages, productivity-based compensation plans are popular amount physician practices because the fee-for-service environment provides an incentive to boost productivity in order to increase revenue and therefore compensation. A study of MGMA data by David N. Gans, MGMA-ACMPE vice president of Innovation and Research, about physician compensation and collections showed the link: “In each of the medical specialties examined, the median collections per physician were highest for the doctors who were paid by productivity-focused compensation systems. The increase in collections varied from 14 to 28 percent for physicians on productivity based plans versus salary based formulas (Gans, 2010). Productivity-based compensation can also be used in
physician groups that are reimbursed based on the number of patient visits or patient procedures with the use of encounters or patients as a productivity measure. Practices that have less emphasis on team culture and more on individualism and personal accountability can do well under this methodology. The basic plan rewards physicians for their efficiency or high productivity but doesn’t reward behavior that can support practice or team activities (Milburn & Mourar, 2014).

There are several productivity measures to choose from when looking at a compensation plan: charges, collections, work relative value units (wRVUs), patient encounters and the number of patients. Each of these measures has advantages and disadvantages, so each practice will need to consider each measure thoroughly. There are also other considerations when a practice utilizes productivity-based compensation plans including: productivity-based allocation; hybrid or multiple-component systems and value-based incentives. These are much more complex compensation plans that practices may choose to implement.

With the introduction of value-based or pay-for-performance reimbursement systems, surgical practices need to investigate a portion of physician compensation on the quality, outcomes or patient satisfaction factors that payers are using for determining reimbursement. A portion of compensation can be dependent on physicians’ scores or ratings on these factors while the remaining portion is determined by more traditional methods, including salary, equal share or productivity (Milburn & Mourar, 2014). The external challenges facing surgical practices is the shifting reimbursement models from Medicare and other payers. The reimbursement systems are moving from reimbursing on a fee-for-service basis to include incentives for quality, outcomes, improved patient experience and reduced costs. The shift is summarized as: Paying for value, not volume. Medical practices are starting to include value-based factors in compensation formulas. Value-based reimbursement requires a shift of emphasis to ensuring that appropriate care is provided while volume is maintained. These reimbursement models require an organizations infrastructure to provide and track care in new ways but also a cultural shift to
include emphasis on the new factors. Compensation plans can help with the cultural shift in providing the right incentives to adapt to the changing systems (Milburn & Mourar, 2014).

**Outside income**

Outside income is another source of income for a surgical practice. Outside income is defined as supplemental nonclinical income that is not derived by patient services (Kim, 2010). The outside nonclinical income can be for the various services such as: on-call services, medical director services, administrative services, honorariums for speaking or publishing, principal investigator for clinical trials and providing expert testimony. How the practice handles compensation for these services will depend on the physicians’ employment agreements, how much time is involved and the culture of the practice.

**On-call services**

It is widely understood that physician on-call pay is given to practitioners to compensate for time they spend waiting on work. A form of pay often used for on-call service is a stipend (Mobley, Sheff & Zlonick, 2006). There are different types of approaches to paying a surgeon or group of surgeons a stipend such as: daily stipends, weekly stipends, monthly stipends and annual stipends. “The number of organizations paying for call in some form or another appears to be increasing as new physicians enter the workforce,” said Jeffrey B. Milburn, MBA, CMPE, MGMA Health Care Consulting Group. “Call compensation may address multiple variables, and methodologies can range from being a fairly simple hourly rate or annual stipend to a more complex arrangement addressing time and additional subsidies for uninsured patients, retention of professional fees and restricted or unrestricted call coverage.” Physicians in surgical practices reported $1,000 in median on-call compensation per day (MGMA Survey Report, 2013). When structuring on-call pay arrangements there are a number of regulatory issues that must be considered, including the Stark Law and the Anti-kickback Statute. Each of these requires that
physician compensation arrangements fall within Fair Market Value (FMV) (Mobley, 2013). If the arrangement occurs between physicians and a not-for-profit organization, the organization must also ensure that the compensation provided for call coverage falls within the FMV in accordance with the Internal Revenue Service (IRS) exempt laws. As physicians take on more administrative and nonclinical duties, compensation levels and stipends for those duties continue to change, according to the Medical Group Management Association’s Medical Directorship and On-Call Compensation Survey: 2012 Report Based on 2011 Data.

**Medical directorships**

Surgical specialty medical directors responsible for documentation and care planning, quality monitoring and/or physician relations reported a median stipend of $36,000 per year. Roughly 50 percent of the respondents to MGMA’s Medical Directorship and On-Call Compensation Survey: 2012 Report said that these medical directors spent less than six hours per week on nonclinical directorship activities. There are additional medical director roles at insurance or pharmacy companies that are normally filled by physicians who are not providing direct patient care, but could be supplemental income for a surgical practice if it meets the mission, values and compensation structure of the group.

**Administrative**

Administrative stipends for surgeons include, but are not limited to the participation in: hospital committees, leadership roles at hospitals or ambulatory surgery centers, members of a board of directors at a health care entity, leadership position at the affiliated medical school, teaching certification courses, conducting rural presentation and participating as a guest speaker or surgical expertise for legal malpractice cases. Stipends for nonclinical duties can be incorporated into the compensation plan for the group as a separate piece of the compensation methodology if nonclinical income meets the mission, values and goals of the surgical practice.
If a surgical practice’s compensation structure currently allows nonclinical income to be incorporated in the plan it could be a viable strategy for the practice if the community and hospital systems need the private surgical practice’s expertise. Outside income should be thoroughly considered for additional income as part of the compensation plan as practices prepare for value-based reimbursement. Value or performance-based contracting maintains existing FFS methods but ties payment increases or other incentives to providers’ performance on specific measures of quality and efficiency. The purpose of Value-Based Payment Models (VBP) is to provide incentives or payment based on quality measures with the assumption that improved measures or metrics include: patient satisfaction, chronic disease management, evidence-based care process completion, outcomes and reduction in costs or at least a slowdown in rise of costs (Milburn & Mourar, 2014). Although VBPs and other new reimbursement models are expected to increase over time as a means of reducing overall health care costs while ensuring that patient health is improved by the services provided, a surgical practice should consider modifying the compensation methodology to include quality. It is difficult to incorporate the incentives in a physician compensation plan while still in a largely FFS environment that emphasizes volume. Practices find themselves in a conflicting world for a while (Milburn & Mourar, 2014). Physician compensation incentives must follow the shift in culture and processes that must occur to succeed under VBP.

While surgical practices are evaluating their current compensation methodology to prepare for VBP, it is important to address additional compensation for the physicians and the practice. The underlying strategy is to increase practice profitability without increasing the labors of the physicians. When the physicians are working longer hours or seeing more patients per hour, it is not leveraging profitability. There are arguments that profits should not be the focus of medicine; however, without profits, there would be no salaries and there would be no physician-employers other than the government (Borglum, 2011). To take economic risk requires the opportunity of economic reward and there are many opportunities for surgical practices to use
leverage- both conservatively and aggressively to improve the financial success. Private equity investment in the health care industry has grown considerably in recent years (Becker, 2014). Health care is often defined, for investment purposes, to include several broad categories and dozens of niches such as: provider-based companies that actually serve patients such as: urgent care, ambulatory surgery centers, lab services, diagnostic and mammography services, pain management, medical devices, revenue cycle management companies, health information technology and electronic health records. In addition, organizations that sell into or provide services to providers such a real estate can be a profitable investment for a surgical practice too (Becker, 2014).

**Investments**

**Real Estate**

Surgical practices that invest in real estate for their own use may choose to buy or build a free-standing building that they occupy alone or with additional space for rent paying tenants. A surgical practice may choose a condominium in a medical office building and may become limited partners or have joint ventures (Manley, 2014). Physicians may also invest in real estate they do not occupy. A surgical practice investment in real estate offers the potential benefits: pride of ownership, a feeling of greater security, possible tax benefits in the form of depreciation, cash flow from tenants and increased asset value (Manley, 2014). However, these benefits are not assured and there is the potential for economic loss and friction in a surgical practice that may diminish the collegiality and even the viability of the practice group. There are issues that need to be addressed by a practice before committing to buying real estate.

1. **Capital intensive.** Compared with leasing the space needed for the practice, buying real estate is more capital-intensive. When purchasing property the buyer must fund the capital needs. This means that the capital that could be used for equipment, software and other enhancements to the practice competes with real estate needs.
2. Real estate is not liquid and has high transactions costs. When the practice is ready to sell there may not be acceptable buyers.

3. Market risk. A practice purchasing real estate will be exposed to changes in the real estate market that affect the value of the investment.

4. Management intensive. When a practice invests in real estate there are management responsibilities such as: maintenance, upgrades, compliance with changing building codes, security, seasonal maintenance of lawn, snow and ice removal, etc.

5. Conflicts of interest. Some practices only have a few partners who own the real estate that the practice occupies which can create conflicts of interest and may subject the practice to friction. If the partners who own the practice want to increase the practice’s rent to reflect current market conditions, other partners may object. The practice will also need to decide how to handle new partners and determine if he or she is required to invest in the real estate as a new partner.

6. Exit strategy. For most real estate investments, success is determined when the property is sold or refinanced. Recently, physician properties have become harder to sell. Fewer physicians entering the market wish to practice on their own or in small groups, so the demand for these spaces is much less (Manley, 2014).

**Urgent Care**

A leading provider-based investment and one of the fastest-growing segments of American health care is urgent care, a common category of walk-in clinics that provides convenient patient care seven days a week for low- to mid-acuity illness or injury. The urgent care model developed in the 1970s as an annex of physicians’ practices that offered extended hours and targeted acute but non-emergent care (Cockrell, 2013). Services can include a medical history, physical examination and treatment services similar to those provided in a physician practice. In addition, some urgent care centers also provide advanced imaging, in-house...
laboratory services and point-of-care dispensing of certain pharmaceuticals. At present, it is estimated that there are anywhere between 9,000 and 20,000 urgent care providers in the United States (Cockrell, 2013). Urgent care staffing depends on the scope, philosophy and resources of the urgent care provider. Most urgent care centers use a physician-based model with family and emergency physicians.

Urgent care has mushroomed into an estimated $14.5 billion business for various investors within health care and outside of health care (Creswell, 2014). Investing in urgent care is popular across the nation, as private equity investment firms invest billions in urgent care. Since 2008, these investors have spent $2.3 billion into urgent care clinics (Creswell, 2014). Commercial insurance companies, regional health systems and local hospitals are also buying urgent care practices. The business model for urgent care is simple: Treat as many patients as possible. Urgent care is a low-margin, high-volume proposition with an average charge of $155 per patient per visit (Creswell, 2014). Urgent care clinics also have a crucial business advantage over traditional hospital emergency rooms in that they can cherry-pick patients. Most of these centers do not accept Medicaid and turn away the uninsured unless they pay upfront. However, as urgent care centers expand their reach, regulators in some states are scrutinizing their activities. While some states require the clinics to be licensed, most do not and the vast majority of states do not specifically regulate urgent care. It is unclear whether such urgent care centers offer better or worse care than other providers, but some physicians who do not participate question if the patients are trading quality for convenience. There is a race to build large chains with powerful, national brands- a McDonald’s or Gap of health care. Millions of newly insured Americans are seeking care, but others are frustrated with the long waits at the Emergency Rooms (ERs) or conforming to a regular physician’s office hours. In 2012, physicians or physician groups owned 35.4% of urgent care centers (Page, 2014). Surgical practices need to consider the following factors if they are interested in investing in urgent care:
1. Urgent care centers have patients that tend to be younger, healthier and less expensive and need immediate minor care. Surgical practices cannot provide this type of service. The surgical practice governing body would need to define management roles of the urgent care clinic or decide to hire a professional management firm who has experience in running an urgent care center.

2. A feasibility study will be needed to determine the demand for urgent care in the area.

3. As surgeons, the urgent care center will be competing with referring physicians, so it is important that the surgical practice evaluates how investing in an urgent care center will impact their volume if they upset their referrals.

4. The surgical practice would need to seek expertise and obtain financial data if this investment is cost effective for the practice. Start-up costs for an urgent care center are at least $1 million per center and can go much higher (Page, 2014). Experts advise leasing a high-cost retail space and building it out at an anticipated cost of $850,000 or more. New equipment will be need as well as advertising to help increase volume.

The significant advantages for a surgical practice to invest in an urgent care center include:

1. Understanding health care.
2. Being able to “cherry pick” patients with insurance.
3. Less government regulations.

Disadvantages for a surgical practice to invest in an urgent care center include:

1. Start-up costs expensive.
2. Although surgeons understand health care it is a different area of health care.
3. Competing with referring physicians.
4. Costs associated with hiring a management company to manage center.
5. If volume in the center is low then costs go up and profits go down.

As the urgent care model continues to evolve and strategic buyers continue to vertically integrate with urgent care facilities as a cost containment mechanism, there is likely to be an upswing in urgent care regulation. Some of the government considerations that have been discussed for regulating urgent care have been requirements for registration, accreditation, licensure and certificate of need and a variety of other restrictions (Cockrell, 2013). It is more important now than ever for strategic and financial buyers such as surgical groups who are contemplating investment in the urgent care market to work with experienced health care regulatory counsel. In addition, as VBP models move into the health care market, reimbursement for urgent care centers may become less appealing to invest in.

**Ambulatory Surgery Center**

Surgical practices who want to remain independent may invest in an Ambulatory Surgery Center (ASC). Investing in an ASC can provide surgical practices financial return necessary to remain independent. Surgery is increasingly being conducted in ASCs that specialize in elective, same-day or outpatient surgical procedures. Since the early 1980s Congress has authorized Medicare to cover the facility costs of certain procedures in ASCs to encourage the shift of surgical procedures from inpatient to less costly ambulatory settings. Between 2003 and 2011, the number of Medicare-certified ASCs grew from 3,779 to 5,344 (A data book: Health care spending, 2011). In 2010, approximately 90 percent of ASCs were owned by physicians alone or through a joint venture (Report to the congress: Medicare payment, 2010). Although ASCs have not experienced large growth recently, they are still profitable. With approximately 5,500 ASCs in the country, they continue to deliver solid profits (Becker, Adamopoulos & Ellison, 2014). According to Mike Lipomi, President and CEO of Surgical Management Professionals, there is still a tremendous profit margin in surgery centers; even though it is less than it has been in the
past it is still much larger than the vast majority of all investment opportunities and limited risk for physicians who generate the business. Surgeons who invest in an ASC where they regularly bring cases are able to make additional revenue based on the success of the center. There are several benefits for surgical practices investing in an ASC:

1. Surgeons can remain economically independent. Experts say that it is important to invest in something the practice has knowledge or expertise. Surgeons know surgery.

2. Loans are still available for ASC investments. ASCs have proven safe and effective investments which lenders are more willing to fund those types of projects.

3. Surgeons have control over their surgical environment. Surgeons who have ownership in the ASC can participate in the decision making about surgical supplies and equipment along with daily activities that impact the quality of their outcomes and patient satisfaction.

4. Investment positions specialists as low cost providers. Surgery centers receive a lower reimbursement than hospitals and many have an infection rate lower than the local hospital. This also makes ASCs attractive to accountable care organizations (ACOs).

5. Surgeons can do more cases in ASCs because of the efficiency. The staff members at ASCs are much more efficient than at hospitals because they are focused on working with surgeons to perform the same procedures every day. This is especially true if the surgery center is single-specialty such as an orthopedics-focused ASC or general surgery focused ASC.

6. Administrators are easy to access in ASCs. The surgery center environment is very different from the hospital environment, especially when it comes to accessing leadership at the top.
7. Surgery centers are flexible for innovative technology and ideas. Since surgery centers are often physician-led and administrators are easily accessible, they can be on the forefront of new ideas and technology in the field. Administrators will look for more innovative models since they are looking at new ways to generate revenue.

8. Surgeons learn more about business. Surgeons who invest in ASCs become more aware of the economic and financial aspect of running the business which they can use in their practice.

9. Enables partnerships with other physicians and new physician recruitment. Investment in a surgery center can bring physician groups together within the community, whether they are competing groups or from different specialties. This partnership will generate alternative option to hospital use and employment. A physician group’s investment in a surgery center can also attract new physicians who may want to remain independent. The investment is an additional revenue stream that can help with recruiting partners to their practices. “Without the ASCs, it’s very difficult to maintain independence from health systems that are buying up practices left and right” (Dyrda, 2012).

There are some implications whether the financial considerations associated with physician ownership of ASCs could lead to more surgeries or procedures than are medically necessary. However, a study by the health economics and policy analysis firm KNG Health Consulting shows no evidence that ASCs drive up the demand for medical care (Benefits of physician ownership, n.d.). In fact, the study showed that except for colonoscopies (while current levels of screening in this country still lag behind those recommended to achieve effective rates of cancer screening), no growth in the total number of procedures being performed was observed.
as the number of ASCs increased. A surgical practice considering investing in an ASC needs to consider the following legal issues/disadvantages before investing:

1. The Anti-Kickback Statute and the ASC Safe Harbors. The key regulatory statute implicated by ASCs is the federal Anti-Kickback Statute which prohibits the offer or exchange of any form of remuneration with the intent to induce referrals of patients. This prohibition applies to ASC investments by physicians. The Anti-Kickback Statute is a criminal statute and it applies to all people who make or influence referrals for services reimbursed by federal health care programs (some states also have self-referral laws that apply regardless of payer). The Anti-Kickback Statute is intent-based. To violate the statute, one must “knowingly and willfully” violate one of the prohibitions. Further, if any one purpose of the arrangement is to induce referrals then the statute is violated. The primary mechanisms for enforcement are direct actions brought by the Office of the Inspector General of the U.S. Department of Health & Human Services (OIG) and qui tam lawsuits brought by whistleblowers (McGraw Walsh, 2013). Congress and the Center for Medicare & Medicaid Services recognize that the Anti-Kickback Statute is intentionally very broad and could inadvertently prohibit legitimate business arrangements which have very little or no risk of fraud and abuse. Therefore, Congress and CMS have promulgated certain safe harbors to the Anti-Kickback Statute. Arrangements that satisfy all of the elements of a safe harbor are immune from both criminal prosecution and administrative enforcement (McGraw Walsh, 2013). It is very common for surgery centers to attempt to structure their ownership in compliance with one of the four ASC Safe Harbors to the Anti-Kickback Statute. The applicable ownership safe harbor is dependent on the type of venture. For example, the ASC Safe Harbor for Multispecialty ASCs require the following:
a. Terms on which investment interest is offered to investor are not related to volume or value of referrals or business generated by the investor;
b. The entity or other investor must not loan funds or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest;
c. The amount of payment to an investor in return for the investment must be directly proportional to the amount of the capital investment of that investor;
d. All ancillary services for Medicare beneficiaries performed at the ASC must be directly and integrally related to primary procedures performed at the ASC and none may be separately billed to Medicare;
e. The ASC and each investor must treat Medicare patients in a nondiscriminatory manner;
f. Patients must be fully informed of the physician investor’s investment interest in the ASC;
g. At least 1/3 of each physician investor’s medical practice income from all sources for the previous fiscal year or previous 12 month period must be derived from the physician investor’s performance of ASC procedures;
h. At least 1/3 of the ASC procedures performed by each physician investor for the previous fiscal year or previous 12 month period must be performed at the ASC.

ASC Safe Harbor compliance is often operationalized in the governing documents of the entity and is part of the robust compliance plan intended to avoid many of the arrangements that are prohibited by the Anti-Kickback Statute (McGraw Walsh, 2013).
2. Anesthesia Arrangements. In June 2012, OIG issued Advisory Opinion 12-06 which specifically addressed concerns with anesthesia arrangements in connection with ASCs. OIG concluded that each of the two anesthesia arrangements proposed risk of fraud and abuse.

   a. The first arrangement involved payment by the anesthesia group of a per-patient fee to the ASC in return for “management services” from the ASC. The second arrangement the anesthesia group provided anesthesia services to a subsidiary of the ASC which in turn billed third-party payers for those same anesthesia services. Both of the arrangements allowed owners of the ASC to profit from the provision of professional fees payable for anesthesia services, which would otherwise have been paid to and retained by the independent anesthesia group.

Neither of these arrangements will satisfy the safe harbor to the Anti-Kickback Statute. Each anesthesia arrangement should be approached with a complete understanding of the risk levels inherent in each structure.

3. Physician-Owned Distributors. The OIG has issued several negative statements about physician-owned distributor (POD) companies over the years. It originally issued highly critical guidance on October 6, 2006, and then again on March 26, 2013, the OIG issued a Special Fraud Alert (McGraw Walsh, 2013). There was particular concern that PODs profit from selling implantable medical devices for use on patients in physician-owned hospitals and ASCs. In the Special Fraud Alert, OIG stated that it is “particularly concerned” about financial incentives in this context. OIG stated that the physician has the ability to strongly influence the choice implant used and called these types of PODs “inherently suspect” under the Anti-Kickback Statute. The Special Fraud Alert lists a number of suspect characteristics that are warning signs for problematic PODs:
a. The size of the investment offered to each physician varies with the expected or actual volume or value of devices used by the physician.

b. Distributions are not made in proportion to ownership interest or physician-owners pay different prices for their ownership interests because of the expected or actual volume or value of devices used by the physicians.

c. Physician-owners condition their referrals to ASCs on their purchase of the POD’s devices through coercion or promises.

d. Physician-owners are required, pressured or actively encouraged to refer, recommend or arrange for the purchase of the devices sold by the POD or are threatened with, or experience negative repercussions for failing to use the POD’s device for their patients.

e. The POD retains the right to repurchase a physician-owner’s interest for the physician’s failure or inability to refer, recommend or arrange for the purchase of the POD’s devices.

f. The POD is a shell entity that does not conduct appropriate product evaluations, maintain or manage sufficient inventory in its own facility or employ or otherwise contract with personnel necessary for operations.

g. The POD does not maintain continued oversight of all distribution functions.

h. When an ASC requires physicians to disclose conflicts of interest, the POD’s physician-owners either fail to inform the ASC or actively conceal through misrepresentations such as their ownership interest in the POD.

OIG stated that even if an arrangement does not display any of the above characteristics, it still may be unlawful. The OIG expressed heightened concerns where the physician-owners of the
POD are few in number and physician-owners alter their practice or referral patterns shortly before or after investing in the POD. Both of these arrangements could have potential criminal liability (McGraw Walsh, 2013).

Consultants for ASCs continue to be optimistic regarding physicians investing in surgery centers and believe that they are crucial to the future of success of cost-efficient health care (Linder, 2014). Consultants believe that ASCs provide an outstanding opportunity for physicians in terms of a great place to perform surgery and a great place to treat their patients as well as remaining a viable financial investment. A key driver in evaluating the ASC market and investment potential is to look at the underlying foundation and the role of ASCs in the future of health care. As payers look more to quality outcomes, patient satisfaction as well as price to determine the most appropriate site of service, ASCs are well positioned to be part of that solution. In addition, between 2003 and 2008, combined Medicare spending and beneficiary cost sharing on ASC surgical procedures continued to grow despite no positive updates to ASC payment rates from 2004 through 2009 (Report to Congress, 2011). CMS implemented a revised ASC payment system effective January 1, 2008. Under the revised ASC payment system, the standard ASC ratesetting methodology bases payment for most services on the list of ASC covered surgical procedures on the outpatient prospective payment system (OPPS) relative payment weight multiplied by an ASC conversion factor. Despite the revised payment system, total Medicare spending for ASC services increased to $3.1 billion in 2008 compared to $2.2 billion in 2003 (Report to Congress, 2011).

When surgical practices are evaluating ASCs as a possible investment, it is important to consider how the Patient Protection and the Affordable Care Act will affect the ASC payment program. ACA required the Secretary of Health and Human Services to develop a plan to implement a value-based payment program for payments under the Medicare program for ASCs. The Report to Congress describes the current efforts to improve quality and payment efficiency in ASCs. In addition, it considered the steps required to design and implement an ASC VBP
program for payments under the Medicare program. CMS view VBP as an important step forward in revamping how Medicare pays for health care services by moving the program towards better value, outcomes and innovations instead of volume. Therefore, CMS will link payments for surgical procedures to quality of care rendered in ASCs. In addition, VBP could allow patients, physicians and decision makers to compare quality and value across health care delivery setting offering similar services.

**Laboratories**

When surgical practices are considering their investment options it is prudent to consider ancillary services such as laboratory services. There are two main types of labs that process the majority of medical specimens: hospital laboratories which are attached to a hospital or private laboratories which receive samples from general practitioners, insurance companies, clinical research sites and other health clinic for analysis (Medical laboratory, n.d.). Over the last few years, the OIG has increased scrutiny on lab businesses due to expansion in this area. For example the growth rate of lab business billed to Medicare is three times that of other businesses. The lab business, both on a large scale and small scale, remains a huge area for investment, coinciding with a focus on preventive care and coordinated efforts to treat patients with chronic disease. There are approximately 8,000 medical and diagnostic laboratories generating $55 billion in annual revenues. The industry is highly fragmented and competitive with thousands of independent labs, physician office labs and hospital based labs (Sommer, 2011). Demand is linked to the number of people receiving medical treatment. The profitability of individual companies depends on efficient operations and good marketing. There are large economies of scale in the operation of medical labs, which can receive samples from a wide geographical area. Small medical labs can compete effectively by providing specialized analyses or by serving geographical regions with few medical facilities. Across the nation, medical laboratory accreditation compliance is getting tougher.
There have been regulations for physician-owned laboratories since 1989 prompted by concern over escalating costs of the Medicare program. Congress ordered the OIG to conduct a study of the financial relationships physicians had with laboratories, medical supply companies and diagnostic equipment. The study analyzed whether a physician’s financial interests influenced the recommendations made to his or her patients and whether those recommendations increased costs. The results of the study indicated that physicians with a financial interest in laboratory testing facilities ordered more laboratory tests—up to forth-five percent more (Zisk, 2012). Section 1877 of the Social Security Act also known as the physician self-referral law and commonly referred to as the “Stark Law” prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment or compensation), unless an exception applies. It establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse (Physician self-referral law, n.d.). When enacted in 1989, Section 1877 of the Social Security Act applied only to physician referrals for clinical laboratory services. In 1993 and 1994, Congress expanded the prohibition to additional DHS and applied certain aspects of the physician self-referral laws to the Medicaid program. Following the enactment of Stark I, the law enacted to “Stark II” which extended the ban on self-referrals to payments for Medicaid patients in addition to Medicare patients and not only ban self-referrals for laboratory services, but also ten DHSs (Zisk, 2012).

Most experts predict that the long term trends are favorable for the diagnostic laboratory investment (Sommer, 2011). However, the practice would need to engage in a consulting firm to review options of investing in an existing laboratory or starting up a new laboratory, evaluate logistics of the laboratory and whether to invest locally, whether to invest as a group physician practice as a stand-alone or as a joint venture, etc. It is also important for a surgical practice to
weigh out the advantages and disadvantages for investing in diagnostic laboratories. Some of the advantages are:

1. Laboratories are predicted to see increases in volume (due to both population growth and the baby boomers are getting older).
2. Increase in innovative testing for esoteric/genomic (cancer genetics).
3. Increase in clinical drug testing for chronic pain management and addiction treatment.

Some of the disadvantages for a surgical practice to invest in a diagnostic laboratory:

1. Scrutinized government regulations for physician-owned labs (POLs).
2. Increase in government audits of POLs.
3. Cannot refer any of the practice’s patients if the physicians own the laboratory.
4. If the practice invests in a new laboratory there will be start-up costs.

According to experts, the lab business remains a huge area for investment. For example, Levine Leichtman Capital Partners has invested $110 million in Genova Diagnostics Inc., a specialty clinical laboratory with a testing approach tailored to personalized treatment and prevention of chronic disease (Becker, Adamopoulos & Ellison, 2014). Investing in laboratories may be a viable option for surgical practices to consider.

Diagnostic services such as radiology are another ancillary service that a surgical practice may consider investing in. In 1895 X-rays were discovered by German physicist Wilhelm Rontgen. X-ray is an electromagnetic wave of high energy and very short wavelengths which is able to pass through many materials opaque to light. Rontgen discovered their medical use when he made a picture of his wife’s hand on a photographic plate formed due to X-rays (X-ray, n.d.). Since Rontgen’s discovery that X-rays can identify bone structures, X-rays have been used for medical imaging. Up to 2010, there were 5 billion medical imaging examinations conducted
worldwide. Radiation exposure from medical imaging in 2006 made up about 50% of total ionizing radiation exposure in the United States (Medical radiation exposure of the U.S. population, 2009). A major change in radiology practice in the United States occurred in the 1970s with the advent of computed tomographic (CT) scanners. At that time, this equipment had a price tag of more than a half million dollars, which was substantially more costly than any imaging equipment that had been manufactured in the preceding 70 years of American radiology practice (Berlin & Berlin, 2005). By the 1980s, the price of CT scanners had risen to more than $1 million and at the same time magnetic resonance imaging (MRI), ranged from $1.5- $2 million had begun appearing in the marketplace. MRI is a medical imaging technique used in radiology to form pictures of the anatomy and the physiological processes of the body in both health and disease. MRI scanners use strong magnetic fields, radio waves and field gradients to generate images of the organs in the body. Another type of imaging machine is a positron emission tomography (PET) machine which is a nuclear medicine functional imaging technique used to observe metabolic processes in the body (Positron emission tomography, n.d.). PET scanning is widely used in clinical oncology. The CT, MRI and PET scanners have been the most radiological imaging services owned by physicians. Digital mammography is also part of the radiology imaging services that are included in imaging centers.

Digital mammography is similar to conventional mammography in that x-rays are used to produce in-depth images of the breast, yet digital mammography takes an electronic image of the breast and stores it directly in a computer allowing the recorded data to be enhanced, magnified or manipulated for further evaluation. Enhancing the image provides faster results and greatly reduces the need for retakes due to the image being over or under exposed. From 2000 to 2008, digital mammography has been replacing film mammography without solid evidence that digital mammograms save more lives (Perry, 2011). The Center for Public Integrity reports that digital mammography is one of the number of tests that attribute to the increase in Medicare costs while do little to make Americans healthier (Perry, 2011). Medicare claims for digital mammography
soared from 426,000 in 2003 to almost 6 million in 2008. In 2000, the average cost of a digital mammography machine was $350,000, but for a 3-D digital system in 2016 is approximately $430,000. Between 2000 and 2003, there was an 8.5% decrease in the number of mammography facilities operating in the United States, dropping from 9,400 to 8,600 (Wolf, 2009). Historically, reimbursement for mammography has been low. Between 1997 and 2000, Medicare reimbursement increased by only 1.5%. In 2002, CMS increased the reimbursement from $69.23 to $81.81 for screening mammography, but did not cover the cost of mammography (Wolf, 2009). Today, CMS is acknowledging that mammography involves more work than they used to, so there is a small increase in reimbursement for 2017. However, historical the reimbursement for mammography has been decreasing.

Between 2002 and 2007, radiologist-owned Medicare PET scans increased by 259%, whereas nonradiologist-owned or nonradiologist-leased scans grew by 737%. Five specialty groups accounted for 95% of all nonradiologist PET volume in 2007; internal medicine subspecialties, medical oncology, cardiology radiation oncology and primary care. In 2002, all Medicare PET examinations performed on units owned or leased by physicians, the share for nonradiologists was 13%; their share rose to 24% in 2007 (Agarwal, Levin, Parker & Vijay, 2010). According to the Center for Studying Health System Change, one in six physicians in 2008 reported their practice owned imaging equipment. The study also showed out of 2,750 physicians, 17.4% owned/leased advanced imaging and 22.7% owned/leased equipment for X-rays (Michael, 2010).

Due to the significant increase in advanced imaging services, physician self-referrals became a target for scrutiny. In 2004, nearly 33 % of providers in California who submitted bills for MRI scans and 22 % of those who submitted bills for PET scans were classified as “self-referral.” Among them, 61% of those who billed for MRI and 64 % of those who billed for CT did not own the imaging equipment. Rather, they were involved in lease or payment-per-scan referral arrangements that might violate federal and state laws (Mitchell, 2007). This data
suggested that these physicians exploited exceptions in the Stark II law to continue to self-refer patients for imaging.

Under federal law, it is illegal for a physician to refer Medicare or Medicaid patients for designated health services in which the physician has a financial interest. Nearly half of states have similar prohibitions that apply to privately insured. There are additional referral arrangements for advanced diagnostic imaging procedures. Such arrangements, which generate additional income for referring physicians, often require them to make minimal or no financial investment. The typical referral arrangement is structured as either a lease agreement or payment per scan performed. Under a so-called lease or time-sharing arrangement the referring physicians rent an imaging center (with equipment and employees) part time for a specific day of the week or for part of that day. The referring physician sends the patient to the facility on the designated day and then submits a global bill to the insurer for the scan. To comply with Stark rules, such part-time arrangements must be with a facility in the same building as the physician’s primary practice office. In addition, other Medicare rules require the physician or a member of his or her group practice to supervise the test. The level of supervision required, either direct, general or persona, depends on the type of test involved (Mitchell, 2007). Alternatively, the referring physician may send his or her patients to a designated imaging provider and pay this provider a set fee for each scan performed. In this situation, the referring physician submits a global bill to the insurer for each scan referred. The legality of both types of arrangements, however, is questionable under both the Anti- Kickback Statute and the federal self-referral law. Physicians have also avoided the prohibition on self-referral by incorporating advanced imaging machines in their offices which is permissible under the in-office ancillary exception (Mitchell, 2007).

There has been a trend in declining reimbursement for the past decade for imaging services. During the early to mid 2000’s many physicians saw the development of MRI and other freestanding diagnostic imaging centers as a perfect opportunity to recoup some of their practice net income lost to rising overhead and shrinking professional fee reimbursements. However, the
imaging center boom has gone bust and many physician-owned imaging centers are finding it difficult just to keep the lights on (Rodriguez, 2008). Physician investors should consider a variety of options for turning their investments around and even if the investment cannot be salvaged, should carefully develop a strategy to cut their losses to the extent possible. In the last several years, diagnostic equipment manufacturers, brokers and lenders, recognizing a demand in the physician market were eager to sell equipment and make loans to start-up imaging centers, often based on overly-promising projections of referrals and quick investment returns (Rodriguez, 2008). In addition, with the pressure from hospitals and the perception that physician ownership must necessarily mean overutilization of services, many commercial insurance payers have begun imposing significantly heightened credentialing standards on freestanding imaging providers. In many cases, the standards required a freestanding imaging center to have five or more modalities before it will be considered as a participating provider. The Deficit Reduction Act has also enforced reduction in Medicare reimbursement for diagnostic imaging services as much as 30%. Combined with decreased Medicare reimbursement, burgeoning debt and only highly-leveraged rapidly-depreciating assets, many physician-owned imaging centers have folded (Rodriguez, 2008).

However, despite the declining reimbursement, and previous losses, experts state that diagnostic imaging will continue to attract investors (Jackson, 2016). The biggest motivating factor to invest in imaging is innovation. Many radiologist groups and imaging centers are interested in pursuing the latest technologies, but may not have the funds to do so. Therefore, these practices and imaging centers are open to outside investors, including surgical practices. Surgical practices need to consider the following implications if they are entertaining the possible investment of an imaging center:

1. Fully understand the imaging center’s economic outlook (whether a new center or an existing center).

2. Have a full grasp of the imaging center’s payer mix, referral sources and competition.
3. Understand the federal Stark statute and how it affects physician ownership of a designated health service.

4. Cost of investment and will it include the top of the line equipment.

5. How will upgrades to equipment be budgeted and how will that affect investment.

6. Understand the full requirements and cost of certifications, licenses, specialized staffing and supplies for an imaging center.

7. Consider an exit strategy.

When considering the exit strategy, it is important when dealing with a languishing imaging center, time is of the essence (Rodriguez, 2008). The longer the business is left to stagnate and decline, the more difficult it will be to either salvage it or liquidate it for reasonable value.

Although physician-owned imaging centers have had an upswing-downswing economic growth trend from 2002-2013, for the last four years the economic growth has climbed and is forecasted to continue to climb. While still profitable, the imaging industry has considered imaging to be a cost center due to the high overhead of equipment, upgrades, supplies, staffing, certificates of need and leases. Therefore, it is important for a surgical practices to evaluate all implications as they review imaging as an investment option.

Pain Management

There has been a significant increase in investment interest in the pain management sector for the last several years. Pain management is a branch of medicine employing an interdisciplinary approach for easing the suffering and improving the quality of life of those living with chronic pain (Hardy, 1997). Pain management practitioners come from all fields of medicine. In addition to medical practitioners, a pain management team may often benefit from the input of pharmacists, physiotherapists, clinical psychologists and occupational therapists. Together the multidisciplinary team can create a package of care suitable to the patient. There are different sorts of pain management that addresses different sorts of pain. For alleviating long-
lasting pain, chronic pain medication is used in pain management. Depending on the severity of pain determines the type of medication needed.

The increase in physician-owned pain management centers (PMCs) is driven by the core pain business and revenues from ancillary services such as lab testing and ambulatory surgery centers- divided by pain management physicians (Becker, Adamopoulos & Ellison, 2014).

According to the Institute of Medicine, more than 100 million Americans suffer from some sort of chronic and/or acute pain. When one third of the population is affected, the health care industry notices the demand. This led to an early and understandable reputation as “pill factories,” sometimes dispensing care with fraudulent consequences. Since physician-owned and physician-led anesthesia practices have moved into the field, PMCs are being re-shaped into sophisticated, well-managed operations. PMCs have popped up everywhere, often with limited quality, cost and inventory controls. Anesthesia practices take what they have learned in the surgical operating room about quality and moved it into the clinic level, leading to better outcomes for everyone (Becker, Adamopoulos & Ellison 2014). Health care in the United States has a growing trend of more surgeries, an aging population and an evolving understanding of the relationship between prescription medications, mental health and pain. Research supports that the market should embrace both a wider net for the patients deemed eligible and appropriate for pain management as well as a broader scope of services for treating them (Hoffman, 2014). Well capitalized pain management businesses that offer a more coordinated approach to care delivery can make a meaningful difference clinically and reduce care costs and become profitable for effective outpatient care (Hoffman, 2014). The growing needs of pain management patients and physician practices to maintain patient satisfaction and quality levels while avoiding readmissions, are all reinforcing the trend toward care models focused on coordinated care across the care continuum.

There are various state laws that regulate PMCs, and the same federal laws that apply to ASCs apply to pain management centers (Anti- Kickback Statute as well as Stark referral laws).
State oversight in PMC laws can include legal provisions establishing state inspection authority. In some states, inspections of PMCs are mandated at regular intervals to determine compliance with license/administrative regulations. State legislation finds that pain is a significant health problem and that the diagnosis and treatment of pain is complex and can involve several therapeutic modalities. The treatment of pain may require the use of controlled substances in appropriate circumstances. In order to promote the public health, safety and welfare, each state has a duty to restrict the inappropriate use of controlled substances while supporting a physician’s or other health care provider’s ability to provide appropriate pain treatment consistent with patient needs and sound clinical judgement (Kansas Pain Patient’s Quality of Care Act, 2006). For example; in 2016, Tennessee General Assembly passed Public Chapter 1033 related to office inspections and the licensure of pain management clinics. The intent of the law is to reduce the proliferation of “pill mills” that supply the prescription drug abuse epidemic in Tennessee (New law tightens regulations for pain clinics, 2016). In addition, Washington State has tried to get in control of their steep rise in prescription-drug overdose deaths which has prompted a number of physicians and clinics to stop taking new chronic-paid patients on opiates and in some cases to cut off current pain patients (Ostrom, 2017). At the same time, states are mandating that the medical director is certified in pain management so that the PMCs will be under credentialed physicians who understand and are able to manage PMCs. Regulations for PMCs continue to climb as the prescription-drug overdose trends and PMCs grow.

In 2014, CMS’ cuts for pain reimbursement were drastic. CMS stated that the cuts in pain reimbursement were due to overutilization which caused a target for scrutiny in the 2014 and the 2015 OIG Work Plan. The 2015 OIG Work Plan released a statement that audits and data from anesthesia providers for pain management will continue to be reviewed by investigators from OIG (Stegar, 2014). In addition, all pain management claims will be reviewed for supporting documentation.
A surgical practice that is considering investing in a PMC will need to consider the following:

1. Determine if it is a PMC or is it pain management within an ASC? Those are two very important decisions with different implications.
   a) If it is a PMC then a surgical practice will need to consider the advantages and disadvantages of anesthesiologists as the providers who provide the services. In addition, the Medical Director is required by most states to be credentialed in pain management, so it will most likely be an anesthesiologist.
   b) As a PMC, the surgical practice will need to understand all of the laws including Stark as it relates to referring to its physician-owned PMC.
   c) As a PMC, the surgical practice will need to have analyses on cost of investment, expenses of equipment, overhead including staffing and management.

2. If the surgical practice is considering investing in an ASC and including pain management as part of the ASC then the surgical practice will need to follow the ASC rules and implications as previously mentioned.

Despite the current regulations and lower reimbursements for pain management services, experts say that any ASC with adequate pain management procedure volume that is enough to keep providers and staff productive and equipment busy will be profitable (Gamble, 2014). Therefore, it may be more feasible to consider the second alternative if a surgical practice is interested in investing in pain management.

Medical Devices

Another area of interest for surgical practices to invest is in medical devices. A medical device is any instrument, apparatus, appliance, software or material whether used alone or in combination, including the software intended by its manufacturer to be used specifically for diagnostic and/or therapeutic purposes and necessary for its proper application which is intended
by the manufacture to be used for human beings (Medical device, n.d.). Medical devices vary according to their intended use and indications. Medical devices such as pacemakers, insulin pumps, operating room monitors, defibrillators and surgical instruments, including deep-brain stimulators, can incorporate the ability to transmit vital health information from a patient’s body to medical professionals (Robertson, 2011). Medical device and equipment companies pulled in more money than any other kind of company in the first quarter of 2007 in the San Francisco Bay Area (Stein & Devaney, 2007). Medical device investments hit their highest point from 2002-2007 and continued to rise. Part of the reason for the growth was due to the shift from investing in high tech to health care. Attributed growth also stemmed from a solid progress and achievement with Food and Drug Administration (FDA) approval (Stein & Devaney, 2007).

In 2011, the Senate Finance Committee sent a request to the OIG to investigate the growth of physician owned distribution companies (PODs) to distribute medical devices. The Senate Finance Committee’s inquiry is in response to the proliferation of PODs and the possible violation of fraud and abuse laws (Volkov, 2011). A POD is an arrangement under which physicians invest and own an entity used to distribute medical devices to physicians and hospitals for use in surgery. In 2007, the Department of Health and Human Services (HHS) OIG expressed concern that there was strong potential for improper inducements between and among physician investors, the entities, device vendors and device purchasers. The OIG believed that these ventures should be closely scrutinized (Volkov, 2011). Due to the significant increase in the number of PODs, especially from 2009-2011, the Senate Finance Committee requested the OIG to examine the issues, provide additional guidance on compliance with the existing laws and report back to Congress. In fiscal year 2011, physician-owned distributorships supplied devices used in nearly 1 in 5 spinal-fusion surgeries billed to Medicare, according to the HHS OIG. Medicare spent $3.9 billion for spinal surgeries in fiscal 2012 (Sutherly, 2015).

In March of 2013, a Special Fraud Alert was published to address physician-owned entities that derive revenue from selling or arranging for the sale of implantable medical devices
ordered by their physician-owners for use in procedures the physician-owners performed on their own patients at hospitals or ASCs. The Special Fraud Alert focused on the specific attributes and practices of PODs that were believed to produce substantial fraud and abuse risk and pose dangers to patient safety. The purpose of the Anti-Kickback Statute is to protect patients from inappropriate medical referrals or recommendations by health care professionals who may be unduly influenced by financial incentives (Special fraud alert: Physician-owned entities, 2013). The OIG is aware that some PODs develop or manufacture their own devices and does not discourage innovation; however, claims, particularly unsubstantiated claims, by physician-owners regarding the superiority of devices designed or manufactured by their PODs do not disprove unlawful intent. The risk of fraud and abuse is particularly high in circumstances when such physician-owners are the sole (or nearly sole) users of the devices sold or manufactured by their PODs. Also, because the Anti-Kickback Statute ascribes criminal liability to parties on both sides of an impermissible “kickback” transaction, hospitals and ASCs that enter into arrangements with PODs also may be at risk under the same statute (Special fraud alert: Physician-owned entities, 2013). The OIG views PODs as inherently suspect under the Anti-Kickback Statute.

Investments in medical devices grew by 4.9 percent through 2016, driven by consistent innovation in technologies and the demands of the aging population (Becker, 2014). However, the medical device industry continues to face hardships from reduced and bundled reimbursement payments, cost containment initiatives by providers, the Affordable Care Act’s medical device tax (2.3 percent) and the burdensome FDA regulatory process. However, certain sectors of the medical device industry, such as orthopedics, have continued to see healthy growth and investment interest.

Due to the current OIG view of PODs and the regulations for PODs, a surgical practice would need to engage in strong legal counsel with expertise in physician-owned medical device arrangements before considering this as a potential investment. However, if a surgical practice
considered investing in the medical device arena without utilizing the device for their own patients, then it may be a more realistic investment.

**Revenue Cycle Management**

Another area that a surgical practice may wish to consider investing in is revenue cycle management (RCM). The revenue cycle management purpose is to optimize the patient financial experience along the entire continuum of care within the practice. RCMs run the gamut from full-service providers to companies providing software as a service (Becker, 2014). RCMs have provided attractive investment opportunities for strategic and financial buyers alike, not just for health care (Becker, 2104). If RCMs provide billing services only then it would provide various patient financial services including negotiating insurance contracts, precertification of services, coding claims, filing insurance claims, following up with claims that have or have not been paid, sending out patient statements, calling insurance companies, speaking with patients and collection calls to patients. It is basically, completing all of the billing process for each patient. There are a few options for a surgical practice to consider if using a RCM:

1. Does the surgical practice want to start its own RCM?
   a. If surgical practice establishes a RCM, will it have additional medical practices as clients?
   b. Consider location, building and specialized management company to manage the RCM.

2. Would the surgical practice invest in an existing RCM?

3. Would the investment in the RCM be billing only or a full service RCM?
   a. If full service, will the surgical practice still need practice system software?

4. Should the surgical practice consider not investing in the RCM but utilizing its services only?
a. If the surgical practice chooses not to invest in the RCM, but utilizes full services of the RCM, will this save the surgical practice money?

5. The surgical practice will need to complete a return on investment (ROI) for various vendors to compare costs.

6. The surgical practice will need expert comparison of analysis for investing in a RCM vs. utilizing a RCM for all billing services.

On a larger scale there are national revenue cycle management companies that provide end-to-end revenue cycle solutions, including patient access, enrollment and eligibility, clinical documentation improvement, health information management and accounts receivable management services. These larger RCMs deliver value to hospitals, health system and medical practice clients through better business outcomes, including optimized revenue cycle operations and improved clinical and financial performance (University of Louisville Hospital selects Conifer Health, 2017). The larger RCMs allow hospitals, health systems, including ACOs and medical practices to achieve safe, high-quality, cost-effective care that will continue to grow and enables patients to more easily engage with and navigate a care and payment path that benefits them and the care delivery organization as a whole (University of Louisville Hospital selects Conifer Health, 2017). The RCMs provide extensive capabilities and understand the market challenges so that they are able to optimize the end-to-end solutions to keep with advances in an ever-changing competitive health care environment. On July 11, 2017, research and markets have announced the addition of the “Global Healthcare Revenue Cycle Management Software Market 2017-2021” report. The report covers the complete scenario of the global Healthcare Revenue Cycle Management Software market. During the research, it was found that the driving force behind this market is the consumer’s demand for Healthcare Revenue Cycle Management Software products (Denis, 2017). This market is attracting high demands from the regions North America, Europe, Asia, Pacific, Middle East, Africa and Latin America. Health care service
providers deploy automated systems to address the RCM processes and to fill the payment gap that arises from the processes of medical billing and collections. The information technology applications, such as hospital information system and electronic health records (EHR), have outdated technology platforms that lack advanced functionalities needed to address RCM issues. Hospital and health systems prefer to outsource the RCM services due to the issues pertaining to revenue cycle processes and workflows (Denis, 2017).

Although larger, global RCMs attract larger entities such as hospitals and health systems, it is a viable resource that may be of interest to surgical practices. The interest level for surgical practices to consider depends on the findings of the financial analysis. Investing in a RCM may be less appealing for a surgical practice; however, utilizing the RCM for full billing services should be considered.

**Health Information Technology and Electronic Health Records**

There has been a tremendous growth in different types of health information technology (HIT) opportunities nationwide. Health care reform initiatives, including Health Information Technology for Economic and Clinical Health (HITECH) Act and the ACA, have led many health systems and physician practices to invest heavily in information technology (IT), which has made HIT an increasingly popular investment area (Becker, 2014). HIT’s share of health care private equity arrangements rose from 10 percent in 2011 to 15 percent during the first three quarters of 2013 (Becker, 2014). In the first half of 2014, there were 30 companies focused on expanding the care continuum and 47 companies providing patient empowerment solutions (Becker, 2014).

The HITECH Act of 2009 means hardware, software, integrated technologies or related licenses, intellectual property, upgrades or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access or exchange of health information (Greenspun, Coughlin & Stanley, 2013). Technologies
may include: electronic health records, personal health records (PHRs), e-prescribing, HIT, analytics/decision support, patient support tools and mobile health technologies. The push to increase adoption through regulatory requirements in the HITECH Act has raised physicians’ levels of awareness about EHRs. Health care reform related programs requiring clinical integration have accelerated adoption. This has occurred as physicians accept more risk for cost-savings and patient outcomes. However, implementation and operational integration cost are major concerns to many physicians (Greenspun, Coughlin & Stanley, 2013).

Since 2007, technology costs at physician-owned multispecialty practices have nearly doubled. The largest increase in technology costs occurred and most likely corresponds with physician practices’ implementation of HITECH and other requirements to use certified electronic health records (MGMA Cost and revenue survey, 2016). The increase in IT expenditures increased by more than 70 percent between 2007 and 2011 for single specialty practices. Orthopedic surgery reported a 78.1 percent increase in IT general operating expenses during that same time period (MGMA Cost and revenue survey, 2016). Physician-owned, multispecialty practices spent 34 percent more on technology in 2014 and an increase of 11.8 percent in technology related operating costs; with an average of spending nearly $21,000 per full-time physician (MGMA Cost and revenue survey, 2015). The increase is due in large part to the federal meaningful use program and the impact of mandated EHRs on individual practices. According to Halee Fischer-Wright, M.D., CEO of MGMA, “The way patients ask for and receive care is changing. The increased use of technology can improve the quality of patient care by improving records management, optimizing work flow and meeting HIPAA compliancy regulations.” In addition, physician-owned practices spent $32,000 per physician to implement, upgrade and maintain HIT during 2015. The cost includes equipment, staff, maintenance and related expenses. The $32,000 per physician cost in 2015 is about 40 percent higher than the $19,500 per physician that physician-owned multi-specialty practices spent in 2009 (MGMA Cost and revenue survey, 2016).
As the EHR market has matured, a once crowded field of vendors has narrowed significantly. At the end of 2013, there were 10 vendors who accounted for about 90 percent of the EHR market. With health insurance companies concerned with cutting down costs and improving the health outcome of patient populations, some payers are now mining data collected from EHRs to try to intervene and steer consumers to a healthier lifestyle (Becker, 2014). As the industry increasingly turns to data and analytics to address health care costs and reimbursement, private equity investments in IT have centered on EHR systems (Becker, 2014). Another continued area of increasing investment is the mobile health sector. According to the Food and Drug Administration, there are 500 million smartphone users worldwide who will use mobile health applications (Becker, 2014). By July 1, 2013, nearly $850 million had been invested in 90 different mobile health companies. Some of these companies focused on emerging areas of investment including remote patient monitoring, wellness and personal health tools and tracking. In 2013, Athenahealth, Inc., a cloud-based EHR provider purchased Epocrates, Inc., the leading developer of mobile health point-of-care applications for $293 million (Becker, 2014). This sector will continue to grow as providers use EHR systems, data analytics and mobile health.

Due to all the government regulations and intent behind improving patient care, physicians feel investments in electronic health records failed to offer substantial returns due to impractical technology (Davis, 2015). More physician groups are making the case that stringent regulations and suboptimal technology have left physicians spending too much time completing their electronic health records. It is not that physicians are against HIT since most have adopted technology “at a blistering pace,” American Medical Association (AMA) President, Steven J. Stack M.D. stated, “but unrealistic and uncoordinated requirements are overburdening physicians’ time and affecting the quality of patient care.” The AMA published a list titled “How EHRs tied up physician time in 2015” which explained the following:

1. EHR technology continues to underwhelm. Physicians felt EHR investments failed to offer substantial returns due to impractical technology.
2. Meaningful use is outliving its usefulness. The federal program heavily concerns the physicians, as the Stage 3 rules were pushed forward despite many objections.

3. Physicians are talking back and being heard. In 2015 there were many campaigns to provide physicians with the ability to speak up about concerns, including EHR town halls hosted by AMA, online feedback forms and meetings with health IT developers. Congress and the Senate have weighed in, calling for Stage 3 delays (Davis, 2015).

The Association of American Physicians and Surgeons (AAPS) surveys found that 80 percent of 571 physicians surveyed felt EHRs impede patient care and almost half say patient safety is at risk. The AAPS also put out a strongly worded complaint that charging the EHRs could “crash” the United States health care system. “EHRs are supposed to be a cure all for inefficiency and medical errors,” said AAPS Executive Director, Jane M. Orient, M.D. “But the costly, clunky systems the government demands are worsening the problems and even driving some software experts back to paper.” Other physicians find EHRs often lead to errors and is a major distraction from face-to-face patient care and interaction, thereby increasing the chance of missing important information, and in the end, increasing the probability of clinical and treatment errors, according to the AAPS survey.

Moving forward, experts predict EHRs will be a critical tool to support changes necessitated by the massive transformation of the United States health care system under the ACA. Expenditures, systematic hiccups and failures are inevitable as the insertion of these new policies and EHR systems will, no doubt, have a somewhat disruptive effect on health systems (Newhook, 2014). Instituting and revising EHR systems wisely will be key in saving costs in the future. It will be up to health care administrators to stay on top of failures and successes, adapting to challenges and reapplying successful tactics. In 2016, nearly 78 percent or 8 in 10 physicians use certified EHRs (DeSalvo & Washington, 2016).

The federal government will continue to mandate EHRs for continued care by all medical practices including surgical practices. Surgical practices who have adopted EHR systems are
already invested into EHR and IT. The question for surgical practices to consider for investing in EHR systems is:

1. Are we satisfied with our current EHR system? Does it provide the functionality that we need as specialists? Is our current vendor up to date with certification?
2. If not, what is the cost to switch vendors?
3. If switching vendors, do you switch the practice system software and the EHR?

Once the above questions have been answered by the surgical practice and governing board, it is crucial to get competitive bids including return on investments (ROIs) for the vendors being considered.

A surgical practice may look at “investing in” EHR two ways: purchasing EHR software from a vendor or investing money into a software company and receiving returns from the profitability of that company. One of the most significant investments for physician practices, health systems and hospitals is their investment into their EHR system and IT systems. Since this is a significant investment for practices to conduct business, it would be more important to utilize the vendor to its advantage so that the software is functional, efficient, reliable, up-to-date and certified. The surgical practice needs to evaluate the software so that it meets all the federal requirements criteria while providing functionality for caring for surgical patients, instead of receiving additional compensation through an EHR or IT investment, a surgical practice needs to look at ways to save costs.

**Skepticism and group conflict**

Group conflict or hostilities between different groups is a feature common to all forms of human social organization (Freud, n.d.). Group conflict can be separated into two sub-categories: inter-group (distinct groups of individuals are at odds with one another) and intra-group conflict (select individuals that are part of the same group clash with one another). Although both categories of conflict have the ability to spiral upward in severity, the group level conflict is
considered to be more powerful than conflict present at the individual level, a phenomenon known as the discontinuity effect (Forsyth, 2009). The discontinuity effect of inter-group conflict, suggests that groups are even more competitive and aggressive than individuals (Smith & Mackie, 2007). Task conflict arises when intra-group members disagree on issues that are relevant to meeting shared goals. However, people who disagree with the group do so at the own peril, even when their position is reasonable. There are also disagreements over the methods or procedures the group should follow to complete its tasks. This process conflict occurs when strategies, policies and procedures clash. In essence, during this procedural conflict, group members disagree on how to disagree and forms distrust or skepticism of strategic planning. Psychologists have not been able to evade the constraints of group conflict themselves: “Envy, rivalry, power conflicts, the formation of small groups within a group, resulting in discord with companies “being caught up in the factionalism of the struggle between the ins and the outs” (Girard, 1977).

What causes group conflict? Specifically, what causes group conflict in a surgical practice? The individuals in a group all have needs, many of which will be set in each of their minds as they enter or join a group which are the things each person wants to get out of the group situation. Causes for group conflict include:

1. If an individual feels that his or her needs are being compromised, dismissed or ignored. Essentially, each individual wants her or his needs to be fulfilled to be validated as a member of the group.

2. In a surgical practice or group, all members will have come from different cultures, training and perhaps different surgical specialties if it is a multi-specialty surgical practice. Therefore, the background of group members can affect how they react to others and in some cases, may feel threatened.
3. Different goals among physicians in the group. Physicians have different agendas based on personal objectives or those that are imposed by others. Conflict will occur whenever objectives are not communicated clearly.

4. Different beliefs and ideas among physicians in the group. In a group, each member will have their own technique and philosophy with regard to the project the group is engaged with as well as differing ideas. Physicians may take attacks on sensitive issues personally and may find it difficult to separate themselves from their beliefs and ideas.

5. Conflicts can also arise when personalities clash. Physicians often dislike in others the traits they dislike or refuse to acknowledge in themselves (Ramos, n.d.).

6. Fear can be a major trigger for conflicts within groups. Fear arises when physicians become concerned about the future (Fuller, n.d.).

If there is group conflict, it is important that a surgical practice resolves this conflict before moving forward with strategic planning. If there is physician conflict within the group, there will be skepticism regarding the operations of the group, staffing, processes, compensation outside investments for individuals and outside investments for the group. The existence of conflict in a surgical practice may have both positive and negative results on those who are involved and the general situation. The outcome depends on how conflict was handled and dealt with by the physicians involved. When conflict is efficiently managed, it can diffuse more serious conflicts (Why do conflicts arise?, 2009). Conflict also stimulates a search for new information and tightens or increases unity and performance in a group. On the other hand, the existence of conflict may cause a delay in formulating decisions or resolution especially if it is not managed well (Why do conflicts arise?, 2009). Conflict ultimately causes hindrance for strategic planning.
Organizational governance and alignment of strategic planning

One of the most significant issues for surgical practices today, is the issue of governance. As previously mentioned, effective governance is essential to a successful medical or surgical practice. A surgical practice needs to ensure effective governance and leadership through polices, long-term strategies and the strategic direction of the organization (Body of Knowledge: MGMA, 2009). There are 8 categories for organizational governance according to the Body of Knowledge for Medical Practice Management:

1. Facilitate the establishment and monitoring of the appropriate corporate legal structure for the organization.
2. Facilitate organizational governance structure and maintain proper corporate record-keeping of strategic decisions.
3. Lead the integration of corporate mission statement into all aspects of the organization’s culture.
4. Lead development of the organization’s strategic plan and its implementation.
5. Establish, communicate, implement and monitor production and compensation standards for physician and midlevel professional staff.
6. Implement and/or support organization leadership management of clinical staff conduct and performance expectations or programs.
7. Foster the growth and development of physician leaders as knowledgeable, participative stakeholders.
8. Encourage and lead participation in advocacy endeavors at local, state and national levels.

If a surgical practice follows the eight steps above and implements full organizational governance, then the causes of group conflict and skepticism will be proactively addressed by effectively communicating the organization’s mission, vision and values to influence the strategic direction of the practice. The physician policies, leadership, communication and involvement
with stakeholder physicians will also help alleviate intra-group conflicts and strategic planning will fostered.

**Conflicts of Interest**

The governing board has completed its obligation to the surgical practice by developing organizational governance. The next step is to consider the possible conflicts of interest if the surgical practice wishes to expand its revenue by investing in the entities previously discussed. An interest may be defined as a commitment, goal or value held by an individual or an institution. Conflicts of interest (COI) arise when the professional responsibilities of individuals or organizations are or have the potential to be compromised by other, external obligations. The failure of fiduciary responsibility is the key concept in defining conflicts of interest situations (Conflicts of interest overview, n.d.). Today, COI are recognized in various fields, but in medicine such compromises are especially threatening as they can undercut the health and well-being of patients. Physicians and physician practices may compromise their professional responsibilities by pursuing private financial gain (Conflicts of interest overview, n.d.). Physicians should put patients’ interests first, regardless of financial considerations. The potential for conflict of interest is, therefore, inherent in industry-medicine relationships. Collaborations must be carefully regulated and in some cases, prohibited to patients’ well-being, promote scientific integrity and ensure public trust.

The Patient Protection and Affordable Care Act, passed during President Obama’s presidency, is designated to protect Americans in a variety of ways, including by more stringently regulating physicians’ ownership of the tools and services they recommend to their patients and by augmenting the disclosure requirements imposed on physicians when they do have a financial interest in the services they recommend (Patient Protection and Affordable Care Act, 2010). Under statutory and ethical rules, physicians must disclose their ownership interests in diagnostic tools such as X-ray machines and scanning equipment, but now under the ACA, physicians must
put that disclosure in writing and provide a list of alternative providers their patients may see instead.

According to the American Medical Association’s 1957 “Principles of Medical Ethics,” there was a time when patients were protected from the financial self-interest of their physicians who were expected to derive professional income only from patient services. However, in 1975, the United States Supreme Court held that the federal antitrust laws applied to all of the “learned professions,” and following that decision, restrictions on advertising, investment and fee-setting were invalidated, making physicians free to invest in the business of medicine (Wilk v. American Medical Association, 1990). A physician’s expectation of financial gain when a patient chooses treatment options that the physician owns creates a classic conflict of interest in a physician-patient relationship (Rodwin, 2007). Studies have shown that despite their commitment to provide the best possible care to their patients, physicians who own diagnostic and treatment tools and services recommend such tools and services to their patients more often than physicians who have no ownership interest (Rodwin, 2007).

There have been debates as to whether the discloser rules actually do allow patients to make “informed decisions” about their care (Zisk, 2012). Significantly, studies suggest that disclosure of physicians’ financial ties and invitations to go elsewhere do not encourage patients to either question their physicians’ ability to provide quality care or seek alternative care nor does it change the patients’ decision they make about their care. In fact, patients rarely abandon physicians, reject physician recommendations or demand second opinions (Schneider, 1998). Quite the contrary, the physician-patient relationship often facilitates an atmosphere where the patient is reluctant to initiate conflict or question the physician’s judgment because the patient must rely on the physician’s professional medical judgment (Zisk, 2012). Therefore, the patient is uncomfortable rejecting the physician’s advice and they feel it is harder to protect themselves by challenging their physician’s advice.
Since the United States Supreme Court has upheld the constitutionality of those ACA provisions that strengthen the disclosure requirements, it is time for legal and physician practices to rethink how to best protect the interests of patients receiving the best possible health care. Research suggests that patients feel compelled to help their physicians reach their financial goals once they are aware of their physicians’ interests, even though these patients lose trust in their physicians’ advice (Zisk, 2012).

**Decision Process**

When a surgical practice is evaluating whether outside investments is a good idea for its practice, it is critical for the governing board to engage in legal and accounting experts while creating a strategic plan that reflects the practice’s mission, value and goals. Successful surgical practices may vary in structural size, market or history, but have defined characteristics:

1. Unified identity with centralized physician-led governance model.
2. Shared vision and formulized cultural expectations.
3. Transparency for strategic decisions.
4. Compensation plan tailored to advance group objectives.

If a surgical practice implements the five characteristics above, it will be successful in engaging physicians and building trust in the decision-making process. Decision-making is regarded as the cognitive process resulting in the selection of a belief or a course of action among several alternative possibilities. Every decision-making process produces a final choice, which may or may not prompt action. Decision-making is the process of identifying and choosing alternatives based on the values and preferences of the decision-maker (Kahneman, 2000). Characteristics of decision-making include:

1. Objectives must first be established.
2. Objectives must be classified and placed in order of importance.
3. Alternative actions must be developed.
4. The alternative must be evaluated against all the objectives.
5. The decision actions are taken and additional actions are taken to prevent any adverse consequences from becoming problems.
6. There are steps that are generally followed that result in a decision model that can be used to determine an optimal plan.

Group decision-making techniques should try to avoid “winners” and “losers.” Consensus requires that the majority approve a given course of action, but that the minority agree to go along with the course of action (Monahan, 2000). Voting-based methods for a group would require support from more than 50 percent of the members of the group, but may be defined within the bylaws of the practice. The surgical practice should have the decision-making objectives in place through the governing board so that all stakeholders understand the process and will be supportive of the decision.

A surgical practice should also understand what an “investment” is when making the decision to invest or not. An investment is the action or process of investing money for profit or a thing worth buying because it may be profitable or useful in the future. An investment is also an act of devoting time, effort or energy to a particular undertaking with the expectation of a worthwhile result (Investment, n.d.). In finance, the benefit from investment is called return. The return may consist of capital gain or investment income, including dividends, interest, rental income etc., or a combination of the two. The projected economic return is appropriately discounted value of the future returns (Investment, n.d.). Investors generally expect higher returns from riskier investments and may bear a risk of loss of some or all of their capital invested (Investment, n.d.). The next step in decision making is for the surgical practice to address the following questions:

1. Should the surgical practice invest in outside entities?
2. If the practice agrees to invest in outside entities, which entities?
3. Should it be a group investment or an individual investment?

4. How will the outside investment be financed?

If a surgical practice makes a decision to move forward with investing in an outside entity as a group it will need to choose the appropriate investment for its group. As previously mentioned, there are stringent regulations affecting many of the investment options discussed in this paper, so the surgical practice and its board of directors will need to review the legal risks and how those will affect the practice. The research provided in this paper shows an overwhelming possibility for surgical practices to invest in ASCs, if all of the surgeons in the practice utilize the ASC without utilizing a competitor’s ASC. The ASCs have reasonable regulations that would not limit a surgical practice to referring patients to an ambulatory surgery setting when appropriate. In addition, finance companies are more eager to loan a surgical practice business loans for an ASC endeavor since they have a history of profitability for low risk loans. The surgical practice will need to understand the financial risks that will affect the practice, particularly since it is a group investment.

A financial risk is any of various types of risk associated with financing, including financial transactions that include company loans in risk of default (Financial risk, 2011). Often it is understood to include only downside risk, meaning the potential for financial loss and uncertainty about its extent (McNeil, 2005). Financial risk is the possibility that shareholders will lose money when they invest in an entity that has debt, if the company’s cash flow proves inadequate to meet its financial obligations. When a company uses debt financing, its creditors are repaid before its shareholders if the company becomes insolvent (Financial risk, 2011). The financial risk is one of the biggest concerns with practices when considering investments.

If a surgical practice makes a decision that outside investments are advantageous, but are too risky for the practice as a group then the governing board may allow the individual physicians to invest on their own. The governing board will need to consider implementing guidelines that constitute an acceptable investment for their individual partners as this should not be a conflict of
interest among physician partners, the practice, competitors, referring physicians or patients. The physician partner investing is still a member of the group practice which reflects the group.

If a surgical practice makes a decision not to invest in outside entities because this concept does not meet the mission, values or goals of the practice and the practice considers these endeavors too risky, both financially and legally, then the practice needs a different strategic plan moving forward.

Community support

A surgical practice has an obligation to the community that it is in to provide corporate citizenship. It is a social responsibility of a surgical practice to meet legal, ethical and economic responsibilities and produce high standards of quality care for the community while maintaining profitability. The demand for socially responsible corporations continues to grow, encouraging investors, consumers and employees to use their individual power to negatively affect companies that do not share their values (Financial risk, 2011). It is common for physician practices to support education, health and wellness, cultural events and community outreach.

When a surgical practice is considering an investment to expand its practice, they need to consider if there is a market need for the endeavor and will it be supported. For example, if a surgical practice would like to invest and build an ASC, but the community already has multiple ASCs in close proximity including an outpatient center at the community hospital, will this have a positive perception of the community? If a surgical practice builds an ASC or an imaging center for example, will the community support this competition? A market analysis will identify if there is a need, but the surgical practice will still need to address the issue of competition with the hospital (s).

There are many services performed in hospitals that can safely and conveniently be performed in ASCs and physicians have become owners of entities directly competing with hospitals for patients. Economic pressures have created an adversarial climate in some areas
between physicians and hospitals (Berenson, Ginsburg & May, 2006). By 2005, hospitals took a new form of approach to brand, market and provide services called a “service-line strategy.” Although closely affiliated specialist physicians, including surgeons, are central to hospital-based service-line products, there has been competition directly with hospitals by developing or expanding physician-owned specialty facilities of various kinds (Berenson, Ginsburg & May, 2006). ASCs and imaging centers often involving physician-ownership have gained growing community acceptance of non-hospital-based care. (Berenson, Ginsburg & May, 2006).

**Patient Care**

The word patient originally meant “one who suffers.” A patient is any recipient of health care services. The patient is most often ill or injured and in need of treatment by a physician or other health care provider (Patient, n.d.). It is now widely agreed that putting patients at the center of health care, by trying to provide a consistent, informative and respectful service to patients, will improve both outcomes and patient satisfaction. When patients are not at the center of health care, when institutional procedures and targets eclipse local concerns, then patient neglect is possible (Reader, 2013). There are many reasons why health services should listen more to patients. Patients spend more time in health care services than any regulators or quality controllers. A critical role in practice management is the effective and efficient processes surrounding the patient. There are a number of organizations that support quality patient care for success:

1. **Medical Group Management Association – Patient Care Systems** states that physicians must ensure that patients receive the best possible care, focus on patient safety and strive for efficient operations (Body of Knowledge: MGMA, 2009).
2. **American College of Surgeons** was founded in 1912 and promotes quality care for the surgical patient by requiring high standards for surgical education and practice.
3. American Medical Association was founded in 1847 which promotes the art and science of medicine and the betterment of public health.

4. American Board of Colon and Rectal Surgery was established to promote the health and welfare of the American people through the development and maintenance of high standards for certification in the specialty of colon and rectal surgery.

5. American Board of Thoracic Surgery was established for the primary purpose and most essential function is to protect the public by establishing and maintaining high standards in thoracic surgery.

6. The American Board of Orthopaedic Surgery exists to serve the best interest of the public and the medical profession by establishing educational standards for orthopaedic residents and by evaluating the initial and continuing qualifications and competence of orthopaedic surgeons.

7. American Hospital Association represents and serves all types of hospitals, health care networks and their patients and communities.

Organizations, communities, physician engagement and strategic planning must support quality patient care for successful physician investments. In 400 B.C., the Hippocratic Oath was developed for each physician as they swear, by a number of healing gods, to uphold specific ethical standards (Hippocratic oath, n.d.). A surgical practice exploring investments must not jeopardize quality patient care.

Conclusion

Administering a surgical practice includes developing and maintaining compensation programs for the physicians within the practice. One of the external challenges facing surgical practices is the shifting of reimbursement models from fee-for-service to include incentives for quality, outcomes, improved patient experience and reduced costs. The shift can be summarized
as paying for value, not volume which will affect how patient care is delivered and how it is reimbursed. Legislation is driving the transition from volume to value-based health care through the ACA and MACRA. The ACA’s primary objectives are centered at increasing the affordability and rate of health insurance coverage for Americans while reducing overall costs and improving quality of care. MACRA, signed into law in April of 2015, makes significant changes to how Medicare reimburses for services. Starting in 2019, providers participating will enter into one of the pathways for MACRA which is the MIPS pathway, APM pathway or partially qualified APM. The pathway followed will have financial impact on Medicare payments. This means that providers will take more financial risk. There is an unprecedented amount of risk that lies ahead for physician practices.

Due to the shift and riskier reimbursement model, independent surgical practices will need to plan strategically when evaluating options for additional compensation programs such as investments. Many physician practices, including surgical practices, will join the hospital systems to help alleviate the burden of increased costs and overhead. It is prudent for these independent surgical practices to consider expanding compensation to include investments such as: real estate, urgent care, ASCs, laboratories, diagnostic services, pain management, medical devices, revenue cycle management, health information technology and electronic health records. Each potential investment needs to be evaluated in detail by the governing board while engaging stakeholders to determine if an investment meets their mission, vision and values.

The evaluations of investments in this paper concluded that a surgical practice may have the best success with investing in an ASC as a group investment. This conclusion may not be feasible for all types of surgical practices, but for most. The regulations for referring to an ASC are less stringent, business loans are easier to receive and generally profits are higher. As a group investment, stakeholders are more willing to work together to make the investment successful and as surgeons, an ASC is what they know.
Although this paper focuses on surgical practices, it also allows physicians and practice administrators from all types of physician practices including Accountable Care Organizations to consider investments or compensation programs.
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