Institutions Acquiring Physician Practices: Déjà Vu All Over Again?
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Physician-Hospital Integration: Models and Issues
Current Trends – Hospital Perspective

• Concern with health care reform and need for primary care
• Questions: future responsibilities for bundled payment; participation in ACOs
• Required specialty coverage for trauma/emergency departments
• Increasing competition and shrinking market share
• Physician defections to other organizations
Current Trends – Physician Perspective

• Concern: increasing expenses
• Downward pressure on reimbursement and income
• Diminishing returns
• Uncertainty as to Health Care Reform
• Physicians seeking:
  – Ancillary business opportunities
  – Compensation from hospitals
  – Joint venture or management service arrangements with hospitals
Responding to Trends

Learning from the Past

• 1990’s trend- hospitals acquired physician practices
• Physician concern - hospitals mismanaging practices & made operations *less* efficient

Moving Forward

• Exploring relationship(s) between hospitals and doctors
• Hospitals/Systems assessing broad range of affiliation options with physicians to advance shared missions and visions
Affiliation Options for Hospital-Physician Alignment

Independent Models
- Medical Staff Membership
- Physician Recruitment
- Space Leases
- MSO Services
- Medical Admin. Services Agreement (Medical Directorship)
- Professional Services Agreement (Hospitalist, On-call coverage)
- Co-Management Agreement

Integrated Models
- Less Integration
- Joint Venture
- Foundation/ Clinic Model
- Captive PC or Subsidiary Employment Model
- Full Integration

Less Integration Models
- Less Integration

Integrated Models
- Full Integration
## Legal and Regulatory Compliance Considerations and Risks

| **IRS 501c(3) Regulations** | - Prohibits potential private inurnment and/or benefit from tax-exempt funds  
- Scrutinizes FMV and self-interest relationships with “insiders” (e.g., physicians, etc.)  
- Further implications re: restricted uses of tax-exempt financing (e.g., bond) funds |
|-------------------------------|---------------------------------------------------------------------------------------------------|
| **Medicare & Medicaid (M/M) Anti-Kickback Law** | - Prohibits payments for M/M referrals  
- Civil and criminal penalties  
- Increased scrutiny/enforcement via “whistle-blower” suits |
| **Civil Monetary Penalties Statute** | - Prohibits financial incentives to reduce care to M/M patients  
- Limits “gainsharing” between physicians and hospitals  
- May affect incentive programs for Medical Directors and other compensated leaders |
| **Stark Regulations** | - Developed to reduce financial incentives based upon physician “self-referrals” to entities with which they have a financial relationship  
- Prohibits referrals of certain M/M “designated health services” including inpatient and outpatient hospital services |
| **Other Pertinent Regulations** | - Compliance with state insurance regulations re: Risk Share, IPA, MSO compliance  
- Compliance with other state laws and regulations (e.g., corporate practice of medicine)  
- Compliance with other federal laws and regulations (e.g., antitrust) |
Traditional Model: Medical Staff/ Voluntary Physicians

- Physicians apply for voluntary medical staff membership on hospital medical staff

- Relationship governed by Medical Staff bylaws

- Support provided with credentialing, CME, technology services, general marketing, physician referral services

- Physicians and hospital bill & collect separately
Space Leases

- Hospital rents space to physician, typically in a medical office building

- Space lease can also be in “Article 28” space
  - but then consider if space is bond financed, provider based regulations, and real estate taxes

- Must meet Stark exception and anti-kickback safe harbor for space leases
Physician Recruitment Arrangements

• Not an employment agreement; Not a personal services agreement
• Hospital can compensate recruited physician for relocating practice
• Can be no “unreasonable” restriction on recruited physician’s ability to practice in service area
• Benefits provided to recruited physician are a loan, which may be forgiven if physician remains in the hospital service area
• Recruited Physician can join another practice
Two possibilities:

• More traditional scenario: Hospital provides services to physicians’ office: staff, billing, IT, etc.

• Hospital retains physician’s office structure and contracts with physician’s office to provide services and physicians
  – Allows physician PC to remain in existence
  – Staffing (beware of unionization issues)
  – Space
Medical Director Relationships

• Can be as employee or as independent contractor
  – Stark employee exception
  – Stark personal services exception

• Employment: full time or part time
  – Easier to pay incentive compensation to bona fide employees

• Employee versus independent contractor distinction: IRS desire that all persons providing services be characterized as employees
  – Tax audits can re-characterize staff
  – Look at IRS factors: control, whether others providing similar services are employees, etc.

• But can contract instead with a physician’s PC to provide physician’s services
Professional Service Agreements

• Agreement between hospital and physician group to provide professional services in a specialty area

• Can be exclusive (e.g., anesthesia, radiology) or non-exclusive (e.g., rehab)

• May be for on-call coverage in a specialty area
  - ensure that hospital can meet its EMTALA obligations in the ER
Clinical Co-Management Agreements

• Provides compensation to physicians for co-management of a hospital clinical service line or department
• Physicians form LLC for co-management services (not direct patient care)
• Hospital contracts with physician LLC for co-management services
• Each party appoints members of an advisory or executive committee to oversee performance goals and standards
Compensation

• Fixed compensation-
  – Administrative and/or medical director services
  – May be based on hourly rates (fair market value; rate set in advance)

• Incentive compensation –
  – Typically based on achievement of performance standards & goals set forth in the contract.
  – Should also be based on FMV, formula set in advance.
Examples of Performance Criteria

• Procedures/OR cases starting on time
• Improved patient/physician satisfaction
• Reductions in post-procedure infections/complications
• Incentives should not be volume or referral based

Need outside experts:
- To review hospital operations and develop performance benchmark
- Valuation expert for FMV compensation
Professional Services Agreements/Physician Enterprise Model (PEM)

• Independent contractor relationship between a physician or physician group and a hospital or health system:
  – Physician/group agrees to provide defined professional and related services on behalf of the hospital/health system
  – Hospital/health system pays a fair market value professional services fee to the physician/group
  – All clinical services performed by physician group are billed by the hospital/health system
  – Hospital/health system responsible for all costs associated with operating the practice (space, staff, equipment, etc.)
Elements of the PSA/Physician Enterprise Model

• Integrated model- physicians (and potentially staff) remain employed by practice and perform services on behalf of hospital/health system as independent contractors

• Single contract through PSA between practice and hospital/health system

• Hospital/health system pays a single service fee to the practice for all services of physicians (and any staff), space, equipment, medical records

• Physicians (and potentially staff) receive employment compensation and benefits from the practice
What Makes PEM So Attractive?

• To patients, little has changed

• Physicians still have good reason to manage the practice as they did before hospital employment

• Promotes greater sharing of data

• Often, hospital can get higher rates for the same services

• Limited downside risk
Captive PC Arrangements

• Establishes separate professional corporation
  – Separate physician billing; no mingling of bills
  – Sole shareholder is a physician employed by (or closely affiliated with) the hospital
  – Health benefits provided through the PC or the hospital
  – Pension plan often specifically for PCs
Captive PC Arrangements

- Physicians may be W-2 employees of the PC alone; or if the physician provides services to both the hospital and the PC, the physician may be employed by one and leased to the other
- Many practice acquisitions are through captive PCs
- Captive PCs may seek tax-exemption as “supporting organizations” of the hospital
Physician Employment

• Traditional model – gives most control & flexibility to hospital
• Stark employee exception & anti-kickback employee safe harbor
  – Identifiable services provided
  – Consistent with fair market value
  – Does not reflect volume or value of referrals
  – Contract would be commercially reasonable if no referrals existed
Employment: Pro and Con

- **Pro**: complete integration; control; full alignment of strategic, financial, operational and community benefit objectives; “safe harbors” for bona fide employment relationships

- **Con**: hospital infrastructure may not be suited for effective management of physician practices; cultural acclimation issues; depending on structure, reimbursement complexities
Practice Acquisition

- Very common
- Value of practices has dropped
- Common model: acquisition of practice & employment of physician (by hospital or captive PC)
- No safe harbor for the acquisition by a hospital
- Total arrangement (acquisition costs plus subsequent compensation) may be subject to scrutiny to determine whether there are “disguised” payments for referrals
Key Employment Contract Considerations

- Pre-employment requirements (exclusion list, etc.)
- Physician reps and warranties (including COI disclosures)
- Enumeration of duties
- Performance standards
- Payer participation
- Board certification and other professional qualifications
- Medical staff bylaws requirements
- Compliance program requirements
- Schedule; time requirements; outside activities
- Restrictive covenants; confidentiality
- Protection of intellectual property
- Dispute resolution
- Term
- Termination provisions and procedures
- Benefits, including “tail” insurance issues
The Way We Were ... 2008

- Minnesota consolidated healthcare market
- In addition to physicians, 10 years of history writing hospitals
- Health IT subsidiary with 10 years of experience
A Change at the Top - The Board Leads the Way

• Strategic planning takes off-
  Geographic expansion
  Product line extension
• Becoming a Data-Driven Company
  Data Warehouse
  Data Analytics/Benchmarking
• Non-organic growth envisioned
  Mergers & Acquisitions
  Affiliations
Institutions Acquiring Physicians

- Potential Liability Issues
- What does this mean for Underwriting?
- Risk Mitigation Opportunities
- What does the future hold?
The make up of layers is dependant on location, severity, exposure, historical losses etc.

Teaching Hospital in High Exposure
- Catastrophe Layer - $150,000,000
- Transitional Layer – $10,000,000
- Inherent Exposures Layer- $15,000,000

Teaching Hospital in Medium
- Catastrophe Layer - $20,000,000
- Transitional Layer – $5,000,000
- Inherent Exposures Layer- $2,000,000

Community Hospital in Medium/Low
- Catastrophe Layer - $10,000,000
- Transitional Layer – $5,000,000
- Inherent Exposures Layer- $250,000

Critical Access Hospital in Low
- Catastrophe Layer - $2,000,000
- Transitional Layer – $1,000,000
- Inherent Exposures Layer- $25,000

Some of the smaller entities have Aggregates applied to their SIR
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### MACRO RETENTION ANALYSIS

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The Impact of severity will be greatest on the ‘Smaller’ providers that currently have the lowest ‘Inherent Liability Layers’

They were not automatically seen as a ‘Deep Pocket’. Physician Limits often matched sustainable severity loss. They will now be ‘Sole Defense’. The Sustainable Severity may not alter, but the impact may drive up the need for a higher Inherent layer

Community Hospital in Oregon

- Catastrophe Layer - $10,000,000
- Transitional Layer – $5,000,000
- Inherent Exposures Layer- $250,000/$2,000,000

Community Hospital in Oregon

- Catastrophe Layer - $10,000,000
- Transitional Layer – $5,000,000
- Inherent Exposures Layer- $1,000,000
Smaller Hospitals may find that the Employment of Physicians is not through (those with?) pre-existing privileges, but from through other sources.

• Out of State
• Out of Country
• Affordability drives selection
• Availability drives selection
• Who needs who more – Contract limitations
• Quality Control and the Golden Rule
Frequency will have the biggest impact.

Large facilities
  QA
  Peer Review
  Culture
  Known Commodities

Smaller Facilities
  New services
  Learning Curve
  Financial constraints
Economies of Scale

Large Facility - 4,000 to 15,000 OBE
100 new class 4 physicians with multiplier of 2 = 200 new OBEs.
An increase of between 1.33% and 5%.

Smaller Facilities – 500 to 1000 OBE
25 new class 4 physicians with a multiplier of 2 = 50 new OBEs.
An Increase of between 5% and 10%

OBEs drive rates

Where smaller facilities have enjoyed SIR aggregates, these may be
Increased or removed in favor of Each & Every Loss amounts
But as we’ve seen from other exposure increases – Endoscopic Surgery, Bariatrics that knowledge of causation, result and financial impact with improved Quality Control and management can reduce the impact of exposure increase to a bump in the road, rather than impenetrable and permanent wall.
Date of Employment

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By others
Reporting Standards Different
Quality of Service Different
Batch & clash exposure

The Unknown

The known
Major entity RM.

1. 10 years ago the entity was forced to increase their retention.
2. A captive was created to cover exposures excess of the SIR
3. They sought a greater understanding of Quality Control, risk control implementation and teaching.
4. Past and prospective liabilities are funded based upon these philosophies, and strive to improve results.
5. They now have $xxx,xxx,xxx which we believe contains y% of redundancies.
6. We are not going to gamble the funding twice. Once on our controlled risk, and again for unknown, uncontrolled exposures for third parties.
7. They understand ‘Substance over form”.
8. They know the rules for their captive, and the difference between our risk and third party risk.
9. They will adhere to the captive’s rules and regulations and not assume third party risk.
10. They will not expose the captive to liability that may have occurred prior to the captive’s start up date.
Risk Mitigation

Enforce ERP purchase by Physicians from their expiring carrier.
1. Expensive, and probably payable by the new employer
2. Lack of claims control for ERP claims.
3. Lack of unified defense
4. Some expiring carriers not as secure as others. No guarantee of unlimited tail.

Enforce the purchase of stand alone ERP by each physician from a carrier of their choice.
1. Terms and conditions will vary from carrier to carrier.
2. Does not solve severability of defense
3. Does not set minimum coverage parameters
4. May create holes in Physician Coverage
• Best opportunity is to create a partnership arrangement with a single carrier of choice
• Creates wrap around coverage for Physician
• Creates standard protection and coverage
• Creates a negotiating instrument during employment discussions.
• Allows for preferred pricing
• Allows for profit sharing, or premium reimbursement
• Allows preferred selection of Physicians for inclusion in program
• Allows for Joint or individual defense
• Allows Risk Management department to control loss
• Allows seamless transition
Employment of Physicians by Providers:
There will be a continuing pressure to control costs, which will result in continued growth of larger providers, either by purchase, merger or acquisition.

The control of external costs will grow along with the establishment of systems to keep the dollars in house.