ARNOLD & PORTER LLP

# Strategies for Successful Hospital-Physician Alignment:

## *What Physicians and Hospitals Need to Know*

**Program Overview**

**Jeffrey R. Ruggiero**

**August 10, 2010**

# Hospital-Physician Alignment
# Deja Vu All Over Again?

- **1990's**
  - ✓ Response to rise of HMOs - prospect of capitated payments
  - ✓ Predominantly PHO strategies - vehicle for joint managed care contracting and reducing utilization of services
  - ✓ Hospital purchases of physician practices
- **WHY STRATEGIES FAILED**
  - ✓ Failure to recognize differences between managing physicians and managing other hospital staff
  - ✓ Hospital-dominated management - leaving physicians in the cold
  - ✓ Specialty physicians lacked motivation to affiliate
  - ✓ Hospitals guaranteed physician compensation while neglecting to tie payments to productivity
  - ✓ Commercial health plans preferred to negotiate separately with hospitals and physicians
  - ✓ Loose affiliations lacked sufficient integration - relationships disintegrated

# Hospital-Physician Alignment
# Deja Vu All Over Again? (cont'd)

- **WHAT'S DIFFERENT NOW?**
  - ✓ Today's strategies driven by harsh economic realities
  - ✓ Hospitals
    - Intense competition - reduced referrals
    - Shrinking market share
    - Deep cuts in Federal and State funding
  - ✓ Physicians
    - Eroding income
    - Increasing practice management expenses
    - Inability to raise capital for upgrading facilities, equipment and IT
  - ✓ Market Realities/Legislation Pushing Hospitals and Physicians to Join Forces

# MEDICARE SHARED SAVINGS PROGRAM - SECTION 3022 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ("AFFORDABLE CARE ACT" OR "ACA")

- **No later than January 1, 2012, the HHS Secretary must establish a shared savings program specifically relating to Accountable Care Organizations ("ACOs")**
- **What is an ACO?**
  - ✓ Organization of health care providers that agrees to be accountable for the quality, cost, and overall care of assigned Medicare beneficiaries who are enrolled in the traditional fee-for-services program
- **Eligible Organizations**
  - ✓ Physicians in group practice arrangements
  - ✓ Physicians in networks of practices
  - ✓ Partnerships or joint venture arrangements between hospitals and physicians
  - ✓ Hospitals employing physicians
  - ✓ Other forms that the HHS Secretary determines appropriate

# MEDICARE SHARED SAVINGS PROGRAM - SECTION 3022 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ("AFFORDABLE CARE ACT" OR "ACA") (cont'd)

- **ACO Participation Requirements**
  - ✓ Formal legal structure and common governance to receive and distribute shared savings
  - ✓ Sufficient number of primary care Physicians for a minimum of 5,000 beneficiaries
  - ✓ Written agreement with CMS for a minimum 3-year term
  - ✓ Sufficient information regarding participating ACO professionals as the HHS Secretary determines necessary to support beneficiary assignment and the determination of shared savings payments
  - ✓ Leadership and management structure that includes clinical and administrative systems
  - ✓ Defined processes to:
    - Promote evidence-based medicine
    - Report necessary data to evaluate quality and cost measures
    - Coordinate care
    - Demonstrate satisfaction of patient-centeredness criteria, as determined by the HHS Secretary
    - Additional details in CMS Notice of Proposed Rulemaking expected this Fall

# MEDICARE SHARED SAVINGS PROGRAM - SECTION 3022 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ("AFFORDABLE CARE ACT" OR "ACA") (cont'd)

- **Shared Savings**
  - ✓ Based on 12-month period
  - ✓ Upon satisfaction of quality standards, eligible to receive a percentage (determined by HHS Secretary) of any savings
  - ✓ Actual per capita expenditures of assigned beneficiaries must be a sufficient percentage below specified benchmark
  - ✓ Benchmark for each ACO will be based on most recent 3 years of per-beneficiary Parts A and B expenditures for fee-for-service beneficiaries assigned to ACO
  - ✓ Benchmark for each ACO will be adjusted for beneficiary characteristics and such other factors as the HHS Secretary determines, and updated by the projected absolute amount of growth in national per capita expenditures for Part A and B
- **Quality Performance Standards**
  - ✓ To be determined by the HHS Secretary
  - ✓ Minimally will include clinical processes and outcomes, patient experience, and utilization

# LEGAL ISSUES

- **Selection of legal form of organization and operational model**
- **Governance structure**
- **New York State Laws:**
  - ✓ Corporate practice of medicine
  - ✓ Fee splitting
  - ✓ CON
  - ✓ Insurance Law/Public Health Law - HMO/MCO laws, regulations
  - ✓ Patient privacy

# LEGAL ISSUES (cont'd)

- **Federal Laws**
  - ✓ Antitrust
  - ✓ Anti-kickback statute
  - ✓ Stark
  - ✓ Civil monetary penalty
  - ✓ Internal Revenue Code, Section 501(c) - tax exempt status, private inurement
  - ✓ Patient Privacy - HIPAA, HITECH
  - ✓ Safe Harbors - Act of Congress; OIG Regulatory Authority - notice and comment period required
  - ✓ OIG advisory opinions
  - ✓ HHS Secretary has authority to waive certain fraud and abuse prohibitions

# *Strategies for Successful Hospital-Physician Alignment*

## *What Physicians and Hospitals Need to Know*

Daniel Sisto, President

August 10, 2010

HANYS
Healthcare Association of New York State

# Federal Health Care Reform

## *What Happens Next?*

"Health reform that does not reduce health care expenditures is not health reform."

*Nancy-Ann DeParle*
*Director of the White House Office on Health Reform*

# Hospital Cuts

- **Medicare Update Cuts**
  - The package would reduce the Medicare update (inflation) factor for hospitals by $112 billion over ten years. This would mean $7.7 billion in cuts to New York's hospitals and health systems.
- **DSH Cuts**
  - Would reduce the overall Medicare and Medicaid Disproportionate Share Hospital (DSH) payments by $36 billion over ten years. This equates to as much as $4.5 billion in cuts to New York hospitals.

# U.S. Reform to Hurt Non-profit Hospitals

## Moody's Rating Service

*"The key longer-term challenge for not-for-profit hospitals is the reform's reliance on extracting long-term cost efficiencies from hospitals, probably resulting in diminished hospital revenues.*

*The reform squeezes savings out of Medicare and Medicaid and places private health insurers under stronger regulatory oversight, potentially straining negotiations with commercial and managed care payers.*

*Consequently, many not-for-profit hospitals will struggle with these challenges and we expect reform will contribute to already existing market forces favoring larger health systems."*

***Mark Pascaris, Analyst***

***Moody's***

# What the Law Will Do

Intended to expand coverage to 32 million individuals by 2019, including almost 1.6 million of 2.7 million uninsured New Yorkers

Includes health insurance reform intended to protect consumers

Includes delivery system reform that holds promise for improving care

$13.5 billion in Medicare reductions to NYS health care providers

# The Effect of Coverage Mandates on Plan Behavior

Many of the new coverage mandates address what could broadly be described as underwriting concerns.

Providers believe that they are improperly underpaid because two things happen:

## "Front End" Squeeze

- An Insurer has found a way to re-underwrite its coverage or its contract with an enrollee or provider to redefine an area of exposure.

## "Back End" Squeeze

- The insurer could challenge the claim for services based on utilization or authorization standards or claims processing and payment standards.

# “Front End” Predictions

- **Increased Premiums**
- **Reduced Benefits Package**
- **Higher Cost Sharing**
- **New and Increased Deductibles**
- **Dropped Product Lines and Exit from Unprofitable Markets**
  - Implementation of coverage mandates are staggered so plans will not disappear overnight

# “Back End” Predictions

## Increased Utilization Reviews

- Claims challenged for failure to comply with utilization or authorization standards
- Scrutiny of claims processing and payment standards

## Additional Audits

## More Transaction Related Disputes

# Additional Predictions

- Insurers will form strategic alliances resulting in mergers and consolidations
- Contract negotiations will become more difficult for providers
- Federal squeeze on rate increases will result in greater emphasis on prior approvals
- Medical management will become vital for plan survival

*"The impact of healthcare reform, even with the benefits from reductions in uncompensated care, will ultimately be negative…." "Those hospitals that can effectively change their business models and position their organizations for payment reform will be most prepared and best able to adapt."*

Moody's Investor Service
*"Transforming Not-for-Profit Healthcare in the Era of Reform"*
May 2010

*"This report discusses the credit implications of four of the key strategies that leading hospitals will likely pursue in an era of reform and structural change in the industry:*

- *Growth strategies to drive revenues and achieve critical mass*
- *Physician alignment to prepare for global reimbursement*
- *Investment in more information technology to further cost and quality initiatives*
- *Effective management and governance, driving long-term financial sustainability*

Moody's Investor Service
*"Transforming Not-for-Profit Healthcare in the Era of Reform"*
May 2010

*"Conversely, providers that cannot operate efficiently, have weak market positions, undistinguished value propositions, outdated facilities, or poor alignment with their physician staffs, will become increasingly pressured financially and clinically to remain viable."*

**Fitch Ratings**

***Health Reform: Credit Focus Shifts to Provider Readiness***

**May 17, 2010**

*"One of the reasons most often cited for runaway growth in healthcare costs is that physicians are paid for doing more and hospitals are paid for doing less. While this is an oversimplification of a complex and interrelated set of economic incentives, it is evident that quality improves and costs decrease when physicians and hospitals share the same economic and professional goals. While specific programs have yet to be fully developed, one of PPACA's cost reduction strategies is to engineer reimbursement policy and conduct pilot programs that encourage hospitals to work more in concert with their medical staffs."*

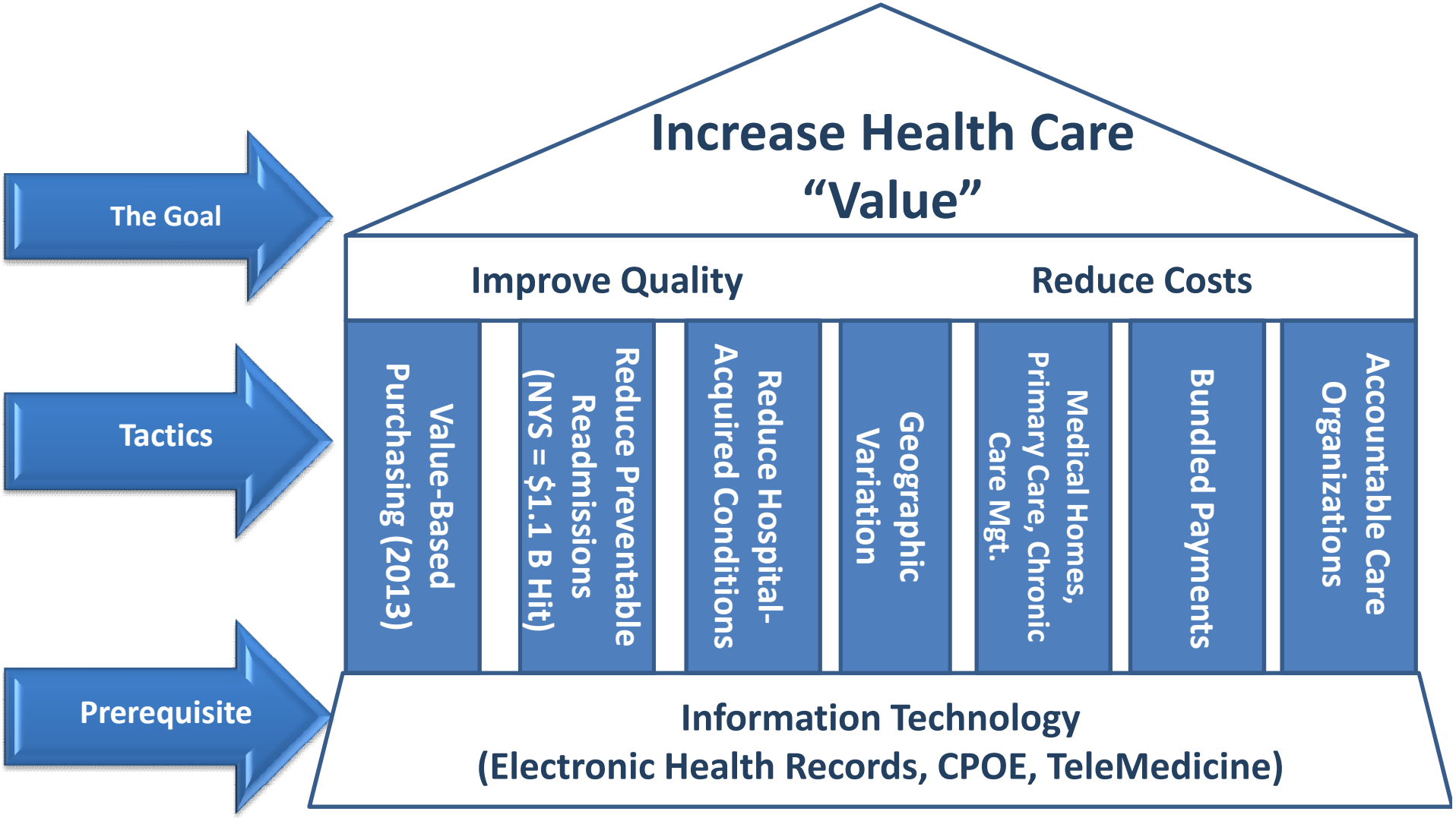
**Fitch Ratings**
***Health Reform: Credit Focus Shifts to Provider Readiness***
**May 17, 2010**

***Healthcare law has more doctors teaming up***

*"…the scramble is so intense that physician groups and hospitals are putting aside rivalries and signing new partnerships almost daily."*

**latimes.com**
**July 28, 2010**

# Builds Health Care Delivery System Reform

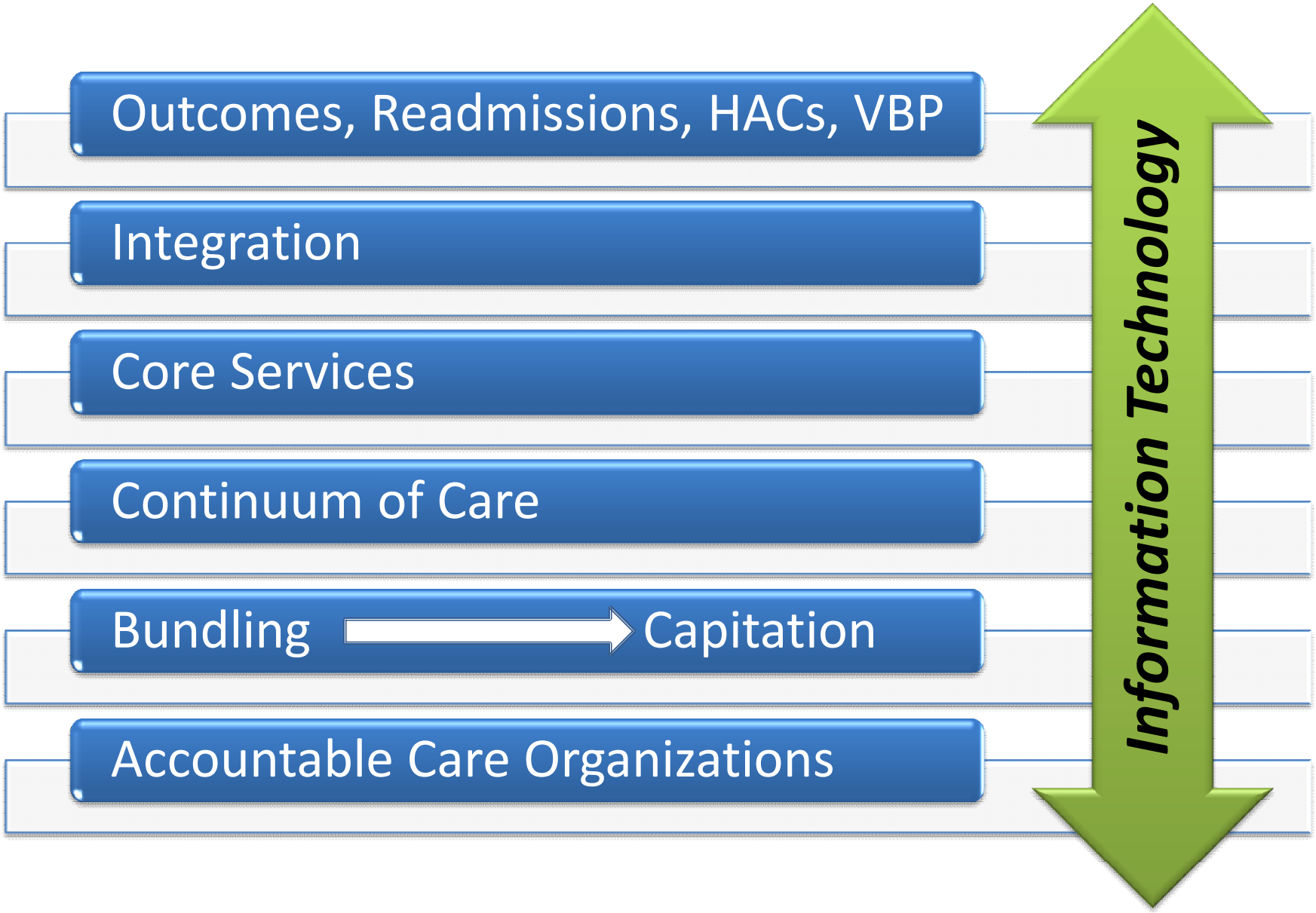



*Source: HFMA-Modified*

# Some Emerging Consensus:
## Although change may be incremental, care will be provided, reimbursed, and reported in very different ways.

- Health care will be more integrated  with and across systems
- Providers will experience greater financial risk and opportunities to reshape care
- There will be increased scrutiny and expectations
  - Hospitals that do well on quality measures will fare better on payment
  - Rapid adoption of evidence-based medicine, efficiencies, and application of best practices will be required
  - Can you measure the cost of variation?
- Focus areas
  - Medical home, medication management, patient satisfaction, infections, ED care, transitions, chronic care

# Do Less With Less



# Readmissions

- Begins in Federal Fiscal Year (FFY) 2013 for inpatient acute care hospitals
- $1.1 billion reduction to NY over ten years
- Reduces Medicare payments when there is a higher than expected readmission rate
- Calculations will be based on prior performance—method to be determined
- Initial focus on heart attack, heart failure, and pneumonia with authority to expand in future

# Potential Number of NYS Hospitals with Proxy Excess O/E Ratio > 1

| NYS Hospital at Risk | Number | Percent |
|---|---|---|
| No Conditions (AMI, HF, PN) | 34 | 18.5% |
| 1 Condition | 38 | 21.0% |
| 2 Conditions | 49 | 26.6% |
| All Conditions | 61 | 33.2% |
| ***148 NYS Hospitals At Risk*** | | |

***Data Source: Hospital Compare: Medicare Claims, July 1, 2005 – June 20, 2008***

# Medicare Value-Based Purchasing

- Starts in Federal Fiscal Year (FFY) 2013 – 1% pool in 2013, grows to 2% pool in 2017
- Budget neutral – all funds cut from Medicare will be distributed to hospitals based on a measure of attainment and/or improvement
- Starts with currently reported measures—heart attack, heart failure, and pneumonia, plus hospital-acquired conditions
- Secretary has authority to expand
- Must include efficiency measure in FFY 2014

# Inpatient Hospital Value-Based Purchasing Measures

- Measures must cover at least the following conditions:
  - Acute Myocardial Infarction
  - Heart Failure
  - Pneumonia
  - Surgeries included in the surgical care improvement project (SCIP)
  - Health-care associated infections
  - Hospital consumer assessment of health care providers survey (HCAHPS)

# Medicare Inpatient Hospital Value-Based Purchasing

2013 – implement VBP for inpatient hospitals

2014 – incorporate efficiency measures into inpatient VBP

2015 – implement MD payment modifier for VBP for specific physicians and physician groups

2016 – implement VBP pilot programs for inpatient rehab, inpatient psych, LTC and cancer hospitals, and hospice

2017 – MD payment modifier applied to all physicians, groups and other eligible practitioners

# Medicare and Medicaid Health Care-Acquired Conditions (HACs) Payment Policy

**Effective dates:**

- New Medicare HACs, inpatient hospital policy begins FFY 2015.
- Medicaid HAC policy begins July 1, 2011.
- By January 1, 2012, the Secretary must report to Congress on current hospital policy and recommend extension of it to other care setting.

**Impact:**

- $1.4 billion reduction nation-wide over ten years.

**Implementation:**

- The new Medicare HAC policy will be implemented through the Inpatient PPS rule for FFY 2015.

**Policies:**

- Additional payment penalty for hospitals with Medicare risk-adjusted HAC rates in highest 25$^{th}$ percentile. -- 1% reduction in payments.
- Accurate present-on-admission coding critical.
- Medicaid programs must adopt policies consistent with Medicare HAC non-payment policy. Secretary may exclude HACs not applicable to Medicaid population.
- Secretary must report on hospital HACs and on extending inpatient HAC policy to other settings.

# Medicare Health Care Acquired Conditions (HACs)

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcers – Stage III and IV
- Falls
  - –Trauma: fracture, dislocation, intracranial injury, crush injury, burn, electric shock
- Catheter-associated UTI
- Vascular catheter-associated infection
- Deep vein thrombosis (DVT)/ pulmonary embolism (PE)
- Manifestations of poor glycemic control
  - Hypoglycemic coma
  - Diabetic ketoacidosis
  - Nonkeototic hyperosmolar coma
  - Secondary diabetes with ketoacidosis
  - Secondary diabetes with hyperosmolarity
- Surgical site infection
  - Mediastinitis after coronary artery bypass graft (CABG)
  - Certain orthopedic procedures
    - Spine, neck, shoulder, elbow
  - Bariatric surgery for obesity
    - Laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery

## Geographic Variation in Health Care Spending

**Intense debate during health care reform focused on:**

- Geographic variation in Medicare per beneficiary spending;
- Overall geographic variation in health care sending; and
- Medicare wage index inequities.

Atul Gwande's "The Cost Conundrum," in *The New Yorker* and *The Dartmouth Atlas'* analysis was influential.

Contentious debate in the U.S. House between the Representatives seeking redistribution of Medicare funding from states with highest, **unadjusted** spending to their own, and Representatives seeking to broaden the debate and include the more robust analysis of variation and its causes by MedPAC, Urban Institute, and others.


THE NEW YORKER

ANNALS OF MEDICINE

THE COST CONUNDRUM

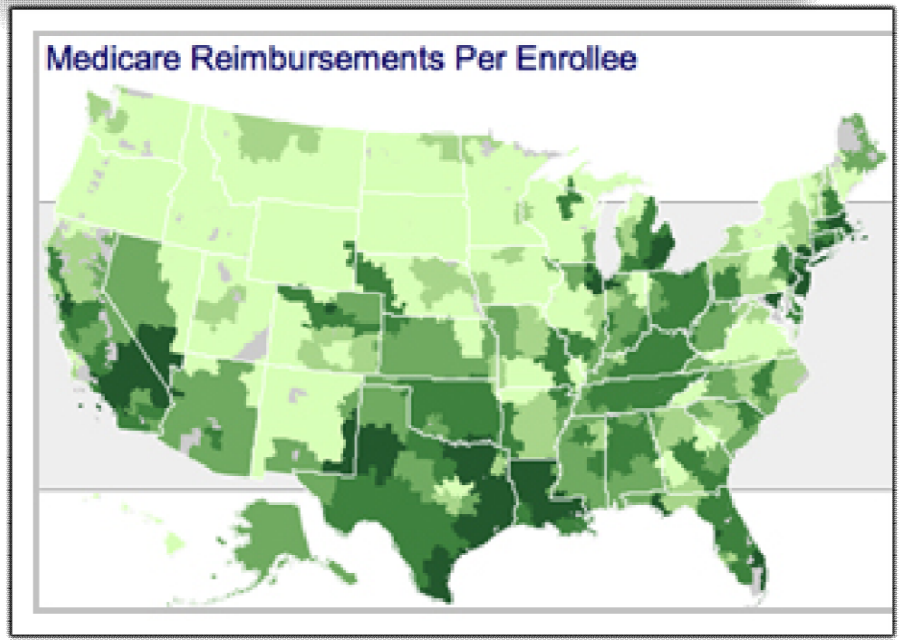
*What a Texas town can teach us about health care.*

by Atul Gawande

JUNE 1, 2009



Costlier care is often worse care. Photograph by Phillip Toledano.



## Geographic Variation in Medicare Spending: Provisions in PPACA

**Effective dates:**

- Efficiency measures to be added to inpatient hospital VBP by FFY 2014
- Temporary payment increases to hospitals beginning FFY 2011

**Impact:**

- $400 million in new Medicare funding nationwide over two years

**Implementation:**

- The policy will likely be included in a regulation to be published by the end of May 2010.

### Use of Efficiency Measures in VBP

- Include efficiency measures in the inpatient hospital, budget-neutral, value-based purchasing (VBP) program by FFY 2014
- Medicare spending per beneficiary adjusted for age, sex, race, severity of illness, and other

### Temporary, Increased Payments to Hospitals in Low Spending Counties

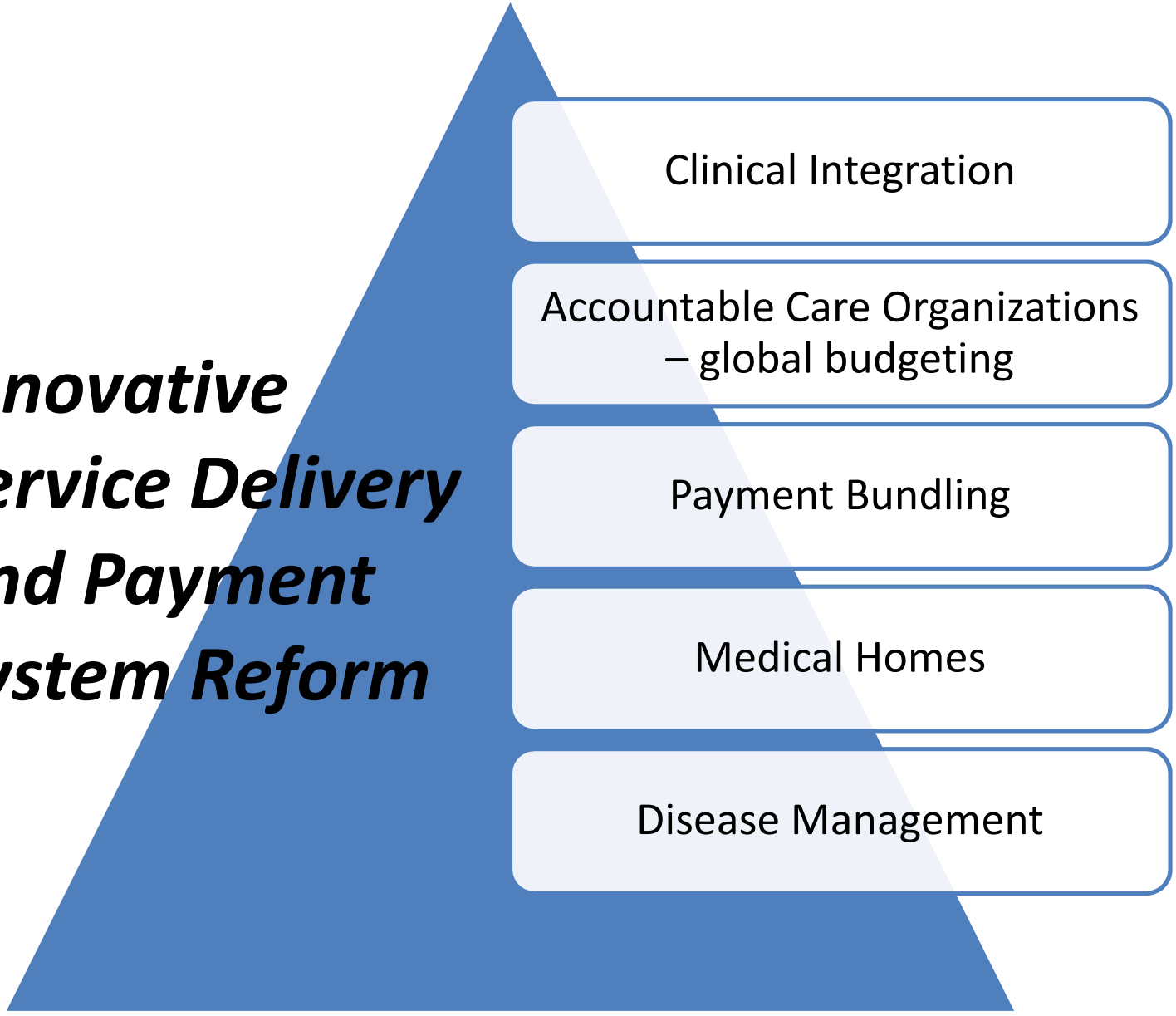
- Beginning in 2011, provides $400 million in new funding over two years to hospitals in counties in lowest quartile of total Medicare Part A and Part B spending per enrollee
- Spending adjusted to account for age, sex, and race
- A number of New York counties may fall into the lowest quartile

# Innovative Service Delivery and Payment System Reform

- Providers assume greater risk than fee-for-service, but have the potential for greater rewards
- *"We expect the leaders in this new era will be successful at creating more effective alignments with physicians beyond contractual arrangements."*

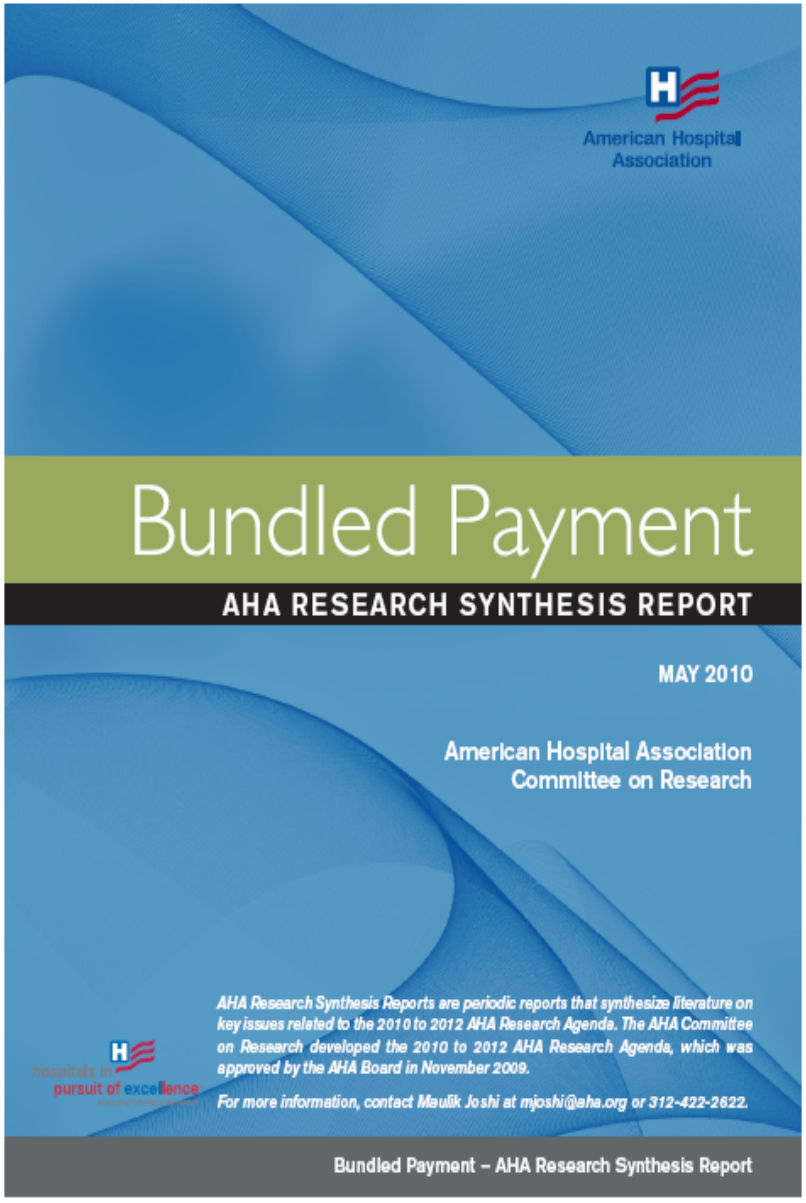
*Moody's, May 2010*

***Innovative Service Delivery and Payment System Reform***



# Bundling

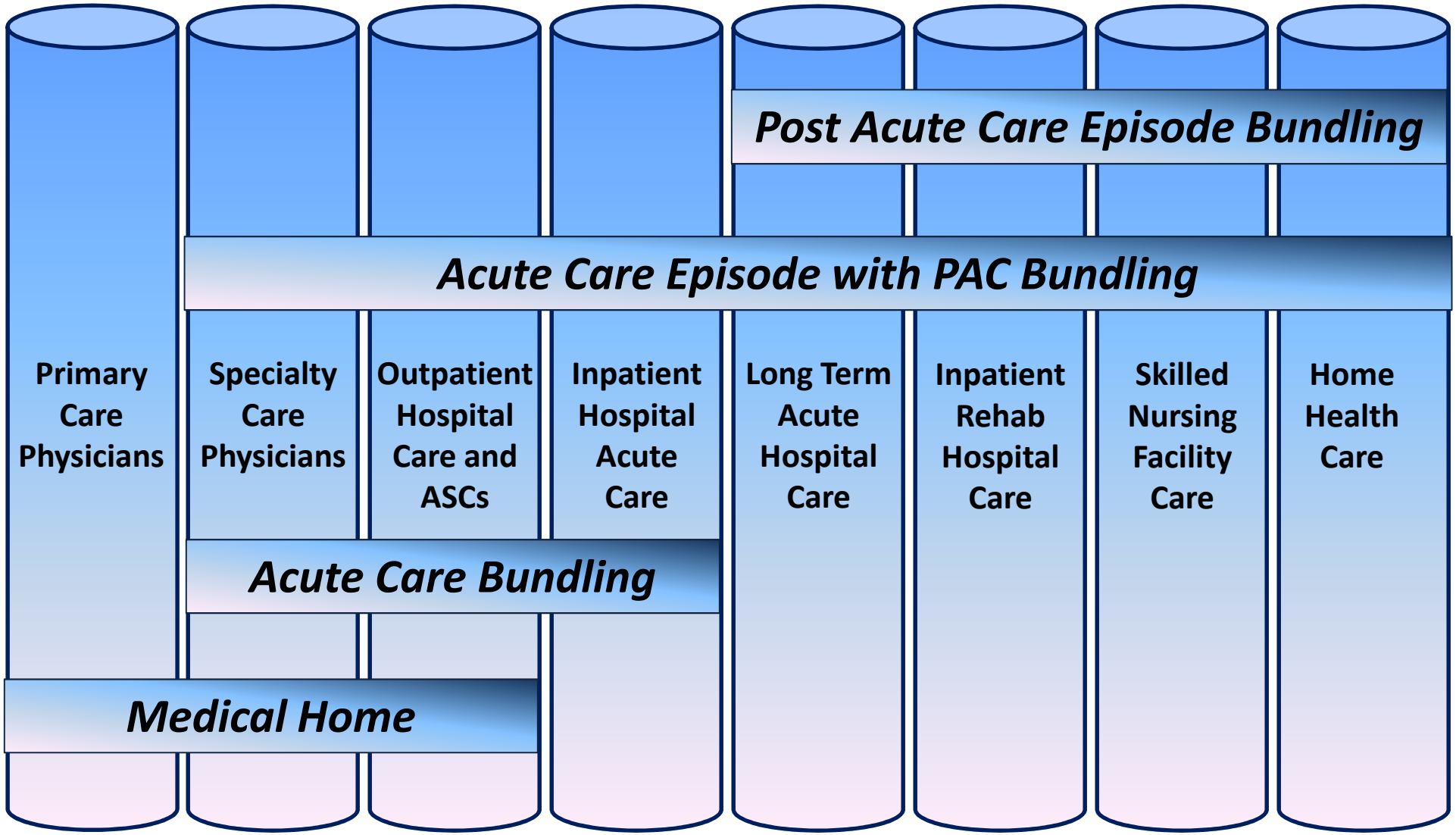
- Expanded, DRG-like payment for specific disease episodes
- Includes pre-hospital care, hospital care, and a time-limited (30-45 days) portion of post-acute services
- Medicare pilots will include physician component
- Provider assumes “performance risk” for limited period covered
- Requires freedom from legal barriers (anti-trust, Stark, gain sharing, etc.)


American Hospital Association
Bundled Payment
AHA RESEARCH SYNTHESIS REPORT
MAY 2010
American Hospital Association
Committee on Research
AHA Research Synthesis Reports are periodic reports that synthesize literature on key issues related to the 2010 to 2012 AHA Research Agenda. The AHA Committee on Research developed the 2010 to 2012 AHA Research Agenda, which was approved by the AHA Board in November 2009.
For more information, contact Maulik Joshi at mjoshi@aha.org or 312-422-2622.
hospitals in pursuit of excellence
Bundled Payment – AHA Research Synthesis Report

# AHA Paper
# Key Issues for Consideration

- To which conditions should bundled payments be applied?
- What providers and services should be included?
- How can provider accountability be determined?
- What should be the timetable for bundled payments?
- What capabilities are needed for an organization to administer bundled payments?
- How should payments be set?
- How should the payment be risk-adjusted?
- What data are needed to support bundled payments?

# Accountable Care Organizations



## Medicare Shared Savings Accountable Care Organization (ACO) Program

**Effective date:**

- By January 1, 2012 the Secretary must establish the program.

**Impact:**

- $4.9 billion in shared savings between ACOs and the Medicare program nationwide over ten years.

**Implementation:**

- The Secretary must establish the program through a notice and comment rule-making process. The rule is expected to be released in the next 30 – 90 days.

## Medicare Shared Savings / ACO Program

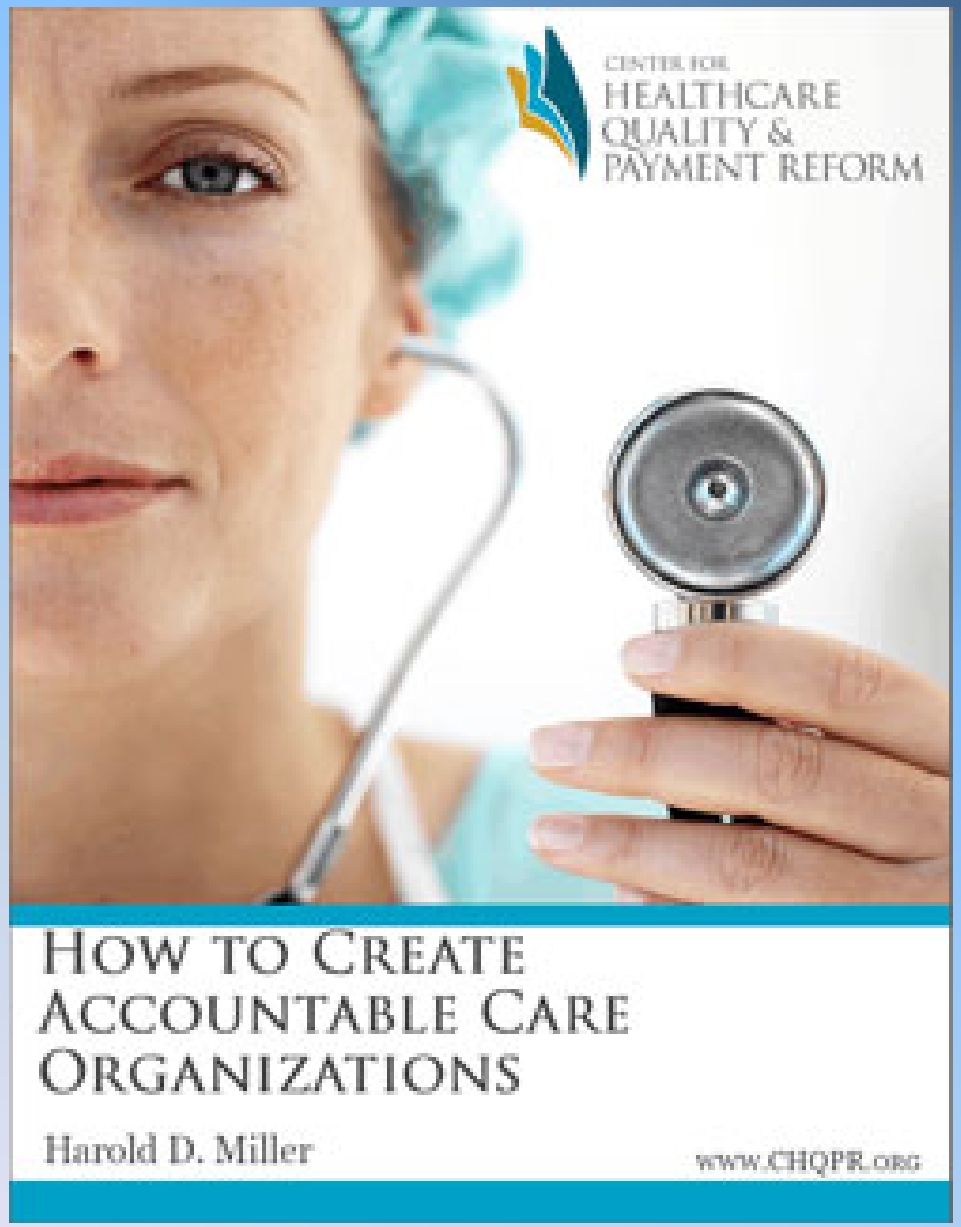
- Move from FFS to "performance risk" with potential for shared savings.
- ACO providers can share in the cost savings they achieve for the Medicare program if they meet quality performance standards yet to be established and if the average per capita Medicare expenditures are below a benchmark based on the claim history and characteristics of the patients assigned to the ACO.
- ACOs must act as the primary care provider for at least 5,000 Medicare-fee-for-service beneficiaries and agree to do so for at least three years.

## Medicare Shared Savings / ACO Program Participants

- ACOs may include:
  - group practice arrangements;
  - networks of individual physician practices;
  - partnerships or joint venture arrangements between hospitals and practitioners;
  - other groups of providers and suppliers; and
  - hospitals employing practitioners.

## Key Issues for Consideration

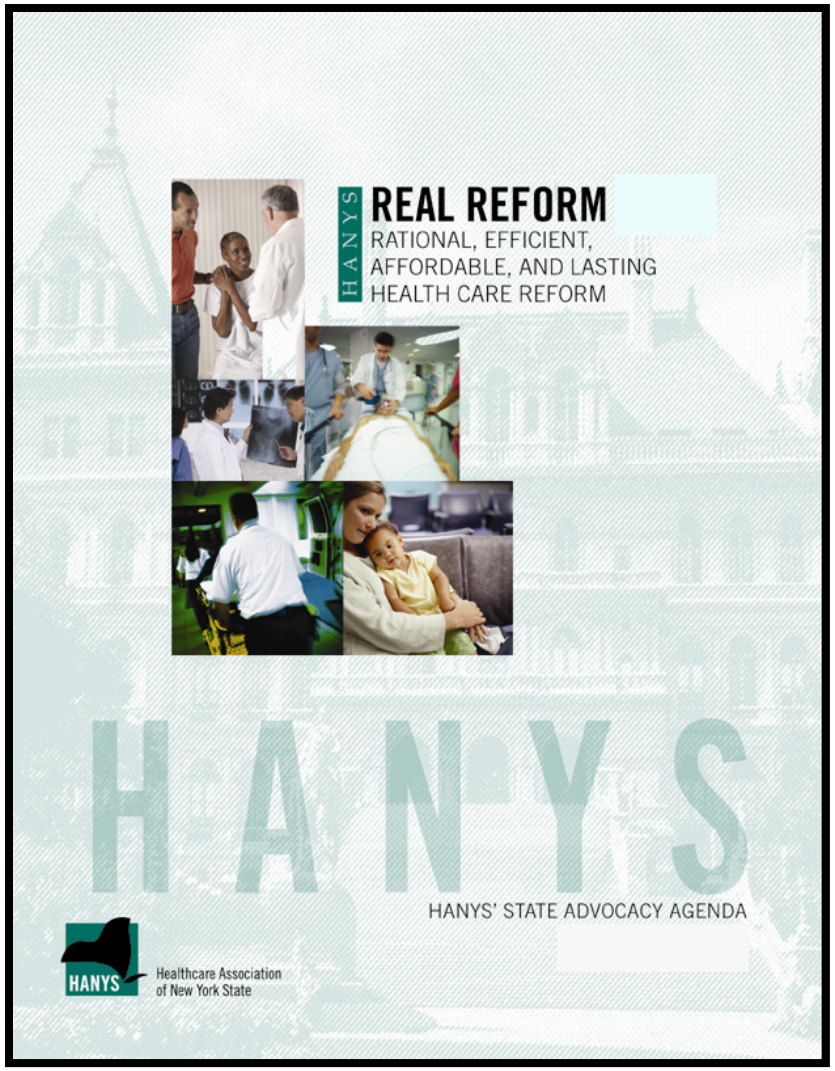
- Legal barriers to clinical integration that must be waived.
  - Secretary has the authority under the law to waive some – False Claims Act, Anti-kickback Statute – but not others, such as those related to Anti-Trust.
  - Waiver protection ends after program concludes.
- Will the program be structured in such a way that providers just beginning to look at integration can participate.
- Health Information Technology.


CENTER FOR
HEALTHCARE
QUALITY &
PAYMENT REFORM
How to Create
Accountable Care
Organizations
Harold D. Miller
www.CHQPR.org

# General Member Views

- Some are more ready than others to pursue demo
- Concerns relate to assuming greater risk, willingness of MDs to participate, inadequate data systems, lack of capital
- General support for state demo authority; help with legal barriers
- Strong interest in education on concepts, operational challenges

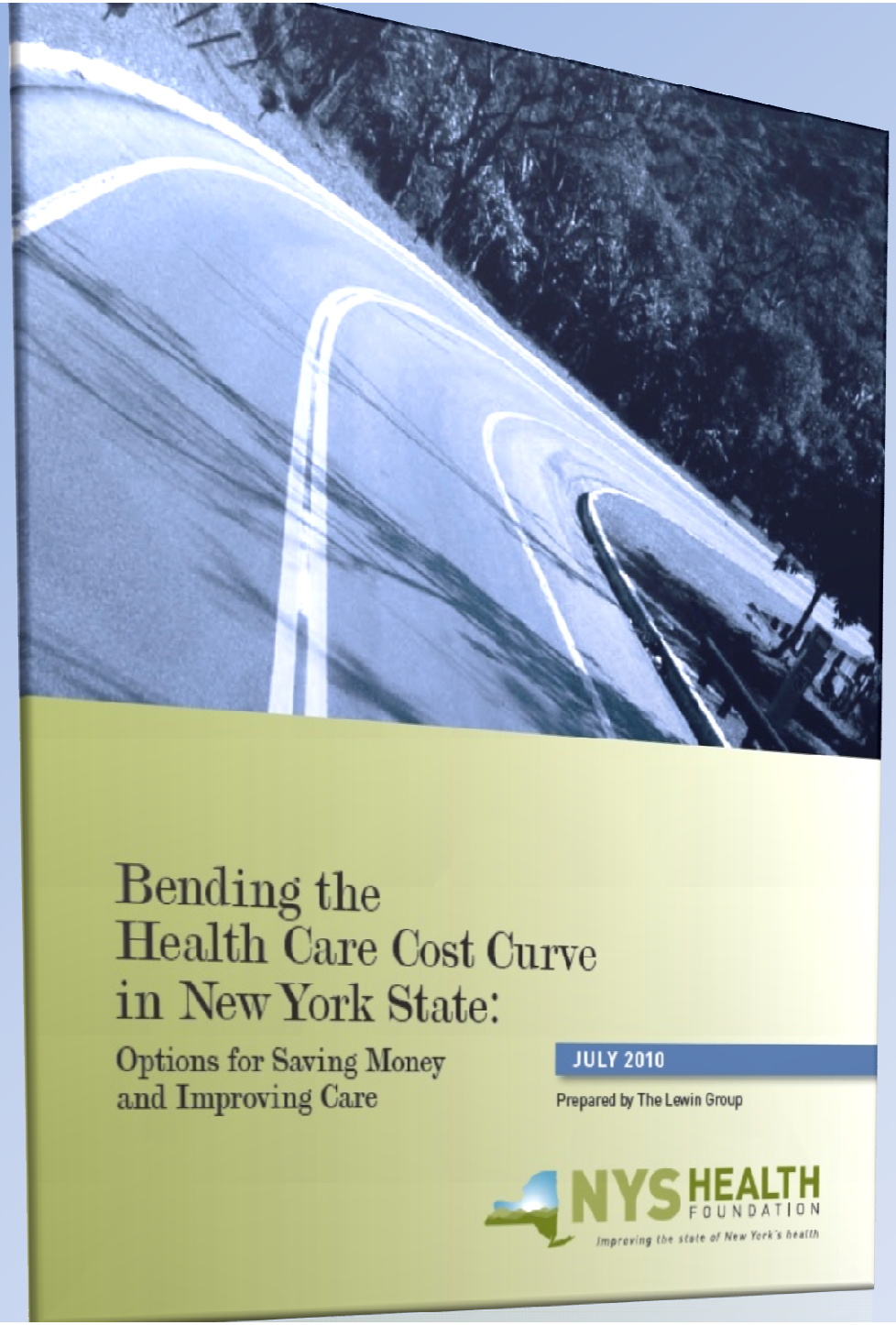
# HANYS' Reform Agenda




- Streamline CON
- Ease Regulatory Burden
- Medical Malpractice Reform
- More Reasonable OMIG Protocols
- Chronic Care Management and Coordination
- Managed Care Reform
- Clinical Integration
- Access to Capital
- Transitional Care
- Tackling physician, nursing and/or workforce shortages


***Does "Dysfunctional" Capture it Adequately?***

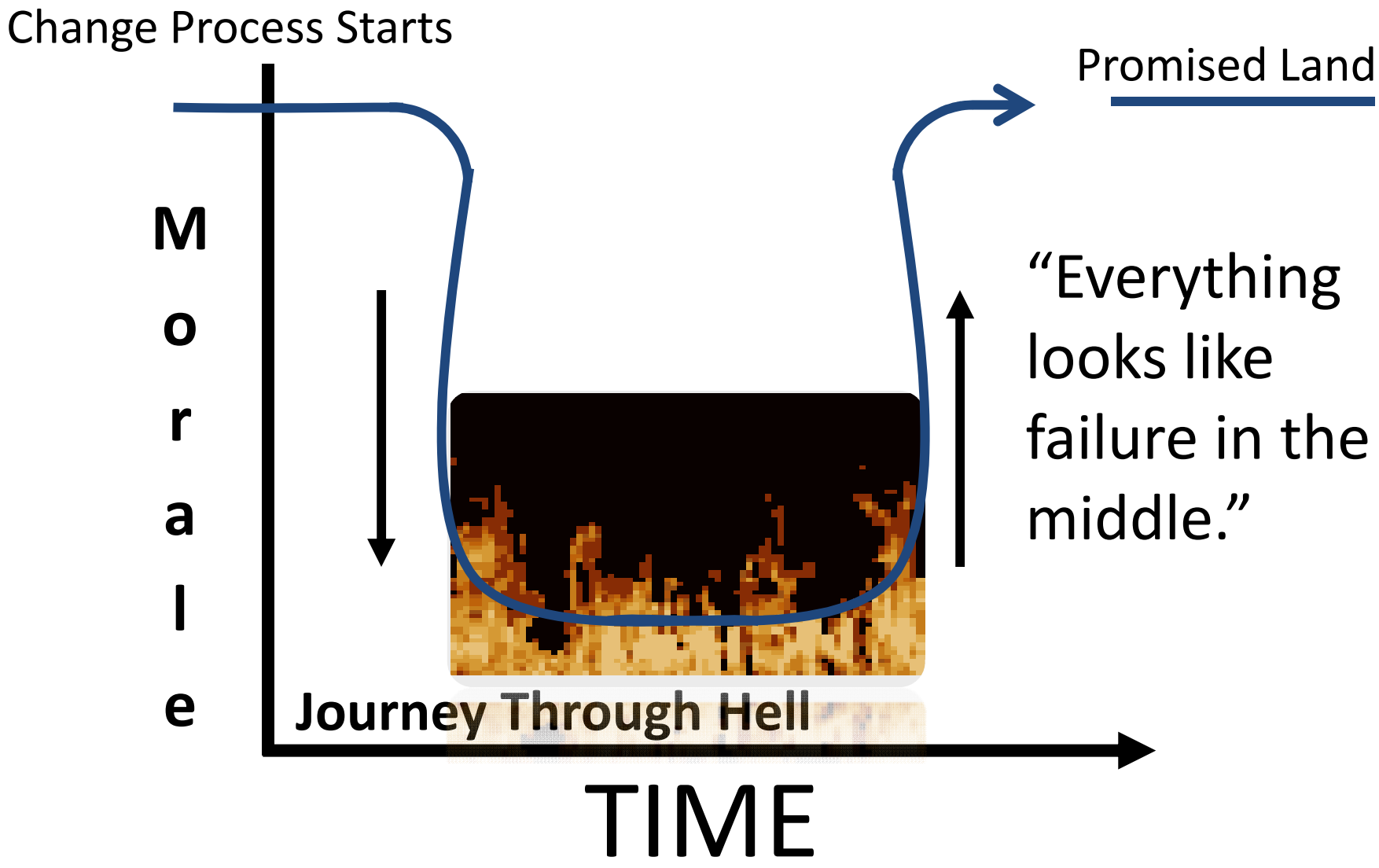

THE CAPITOL
SPECIAL BUDGET ISS
WWW.NYCAPITOLNEWS.COM
MARCH 24, 2010
BUDGET CRUNCH 2010


Bending the
Health Care Cost Curve
in New York State:
Options for Saving Money
and Improving Care
JULY 2010
Prepared by The Lewin Group
NYS HEALTH
FOUNDATION
Improving the state of New York's health

# Ten Policy Scenarios to Help Contain Costs and Improve Quality of Care

- Promoting ACOs
- Modernizing Primary Care
- Expanding Palliative Care
- Implementing Mandatory Managed Care for the Medicaid Dual Eligible Population
- Adopting Bundled Payment Methods
- Imposing a Tax on Sugar-Sweetened Beverages
- Expanding Hospital Pay-for-Performance
- Realizing Administrative Simplification through Health Information Technology
- Rebalancing Long-Term Care
- Using Alternative Delivery Systems

# Journey Through Radical Change



# *Strategies for Successful Hospital-Physician Alignment*

## *What Physicians and Hospitals Need to Know*

Daniel Sisto, President

August 10, 2010

HANYS
Healthcare Association of New York State

# New York Society for Health Planning
# Hospital-Physician Alignment

Presented by:

Ralph Herz, Jr., MD
Medical Director
American Group Practice, Inc.
August 10, 2010

# New York Society for Health Planning
# Hospital Physician Alignment
# August 10, 2010

- Introduction
- What Hospitals Seek
- What Physicians Seek
- Practice Organizational Options
- Case Study
- Where Do We Go From Here?

# What Hospitals Seek

# What Physicians Seek

# Physician Prospects

- Falling Revenue
- Rising Overhead
- Lifestyle Changes

# What are the Physician Practice Organizational Options?

- Low Commitment
- Higher Commitment
- Highest Commitment

# Low Physician Commitment Options

- POs: Physician Organizations
- PHOs: Physician Hospital Organizations
- IPAs: Independent Practice Associations
- Networks
- ACOs ?

# Higher Physician Commitment Options

- Hospital Owned (Group) Practices
- Faculty Practice Plans
- MSOs: Management Services Organizations
- PPMCs: Physician Practice Management Companies
- GPWWs: Group Practices Without Walls
- FQHCs: Federally Qualified Health Plans
- ACOs ?

# Highest Physician Commitment Option

- Physician Owned Solo Practice
- Physician Owned Group Practice

# How are Physicians Organized in New York?

- Every Way Possible
- For Example,.....

# New York Society for Health Planning Hospital-Physician Alignment

Presented by:

Barry H. Kaplan, MD, PhD
President/CEO
Queens Medical Associates, PC
August 10, 2010

# Hospital Physician Alignment Change is Happening in New York

- Introduction: Life in the 20th Century
- Group Practice Development Process
- Where We Are Today
- How This Has Helped Our Hospital
- Are We Prepared For Closer Alignment With Our Hospital?

# 20th Century Training

- BA, NYU (summa cum laude)
- MD, PhD Johns Hopkins University
- PG: JHU, NHI, Bronx Municipal Hospital

# Academic Medicine

- 1967-1992 Albert Einstein
  - Associate Professor of Medicine
  - Director, Medical Oncology

# Private Practice

- Two Physician Practice 1982-1988
- Solo Practice 1988-1995

# Hospital Owned Practice

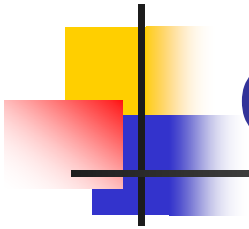
- 1995-2000
- Director Medical Oncology NYHQ
- Clinical Associate Professor, Cornell
- Built staff to five hem-oncs
- Hospital Owned Practice Was Not the Answer

# Learning How to Organize and Operate a Group Practice

- Group Practice Organizational Process
- We Selected American Group Practice
- Interviewed More Than 60 Physicians
- During Process Went from Five to Three
- Queens Medical Associates became operational in 2000

# Key Elements in Developing a Group Practice

- Agreement on Mission, Growth Plan
- Agreement on Governance
- Agreement on Management Positions
- Agreement on Income Distribution, Buy-in, Buy-out, and Many Other Policies
- Agreement on First Year Financial Plan
- We Lent the Practice Start-up Capital



# Governance

- Role of Shareholders
- Role of Board of Directors

# Management Team

- President/CEO
- VP Medical Affairs
- Group Practice Administrator/
  Executive Director/COO

# President/CEO

- Reports to Board of Directors
- Overall Management of the Group Practice
  - VPMA
  - GPA/COO/ED
- Planning
- Resource Allocation
- Representative to Outside World

# Vice President for Medical Affairs

- Reports to President/CEO
- Develops and Maintains Programs for:
  - Quality Assurance
  - Risk Management
  - Credentialing
  - Physician Recruitment/Retention
  - Conflict resolution

# Group Practice Administrator/COO/ED

- Reports to the President/CEO
- Responsibilities
  - Human Resources
  - MIS and Finance
  - Compliance
  - Facilities
  - Marketing
  - + 26 Other Well Defined Tasks

# Challenges Growing the Group Practice

- Physician Management
- Non-physician Practice Management
- Adding Space and New Offices
- Changing Billing/MIS Systems
- Changing EMRs
- Increasing Quality/Cost Effectiveness

# What Queens Medical Associates, PC is Doing for Its Physicians

- Makes Better Use of Physician Time
- Improves Income
- Improves Lifestyle
- Provides Leverage with Payors
- Helps Them Be Better Positioned for Capitation or Whatever Comes Next

# Queens Medical Associates, PC
# New York Hospital Queens Benefits

- Increase in Oncology and Hematology Services
- Decrease in Out-migration of Patients
- Improvement in Quality
- Expansion of Services

# Queens Medical Associates Increased Hospital Alignment? It Depends

- We Would Like to Work More Closely
- We Must Retain Our Physician Owned, Physician Led Group Practice
- We Are Concerned That Most of the Members of the Medical Staff Are in Inefficient Solo or Hospital Owned Practices
- In the Meantime We Are Going to Continue to Grow.

# For Further Information:

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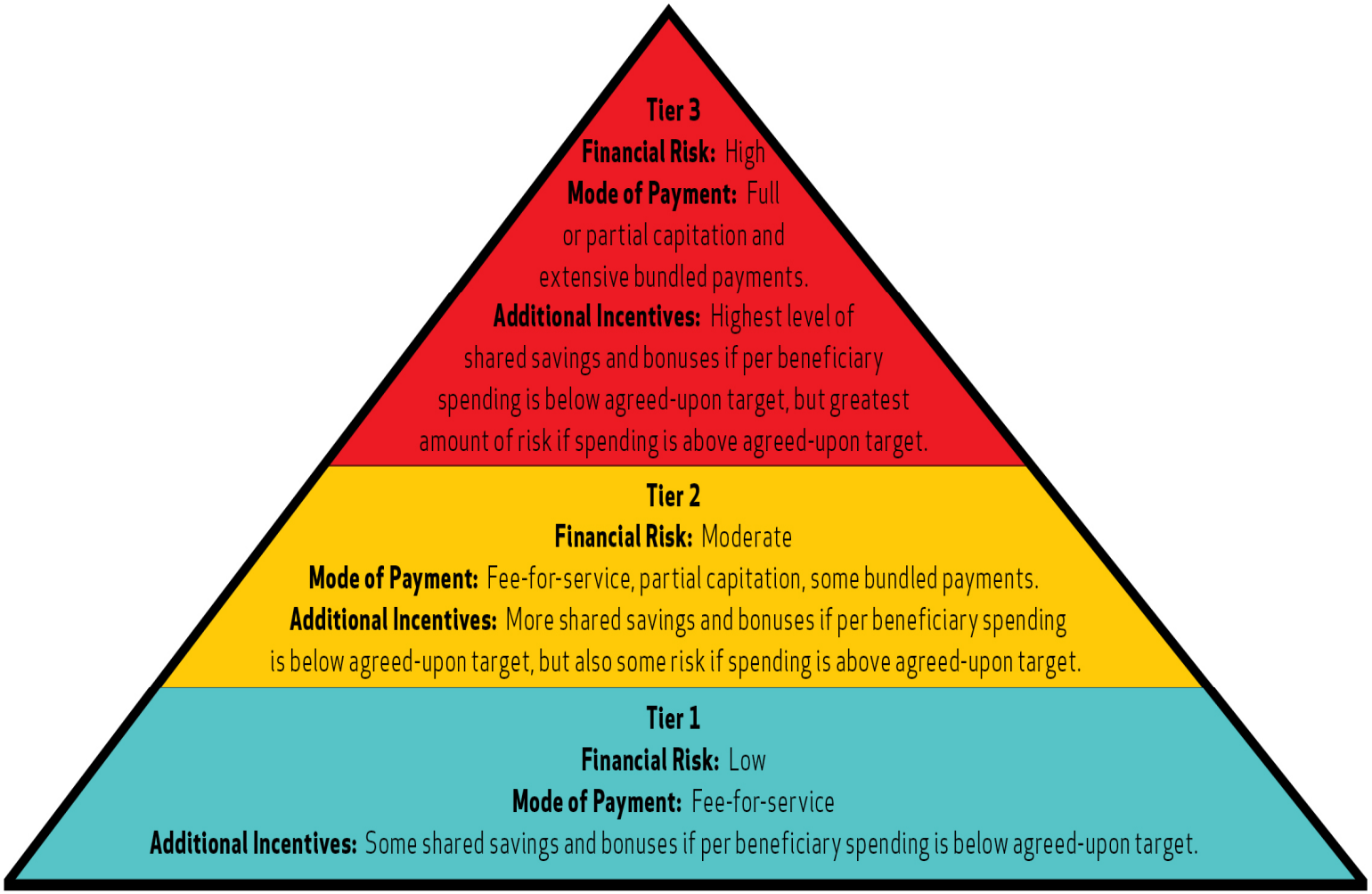
# ACOs: Where Have They Worked?

- Where new Entities are Formed to Better Organize the Non-hospital Physicians in Small Practices?
- Where Hospitals Hire the Physicians?
- Where Hospitals Work with Physician Owned Group Practices?

## Delivery Systems That Could Become Accountable Care Organizations

| Model | Characteristics | Current Examples |
|---|---|---|
| Integrated delivery systems | • Own hospitals, physician practices, perhaps insurance plan.<br>• Aligned financial incentives.<br>• E-health records, team-based care. | Geisinger Health System<br>Group Health Cooperative of Puget Sound<br>Kaiser Permanente |
| Multispecialty group practices | • Usually own or have strong affiliation with a hospital.<br>• Contracts with multiple health plans.<br>• History of physician leadership.<br>• Mechanisms for coordinated clinical care. | Cleveland Clinic<br>Marshfield Clinic<br>Mayo Clinic<br>Virginia Mason Clinic |
| Physician-hospital organizations | • Nonemployee medical staff.<br>• Function like multispecialty group practices.<br>• Reorganize care delivery for cost-effectiveness. | Advocate Health (Chicago)<br>Middlesex Hospital (Connecticut)<br>Tri-State Child Health Services (affiliated with the Cincinnati Children's Hospital Medical Center) |
| Independent practice associations | • Independent physician practices that jointly contract with health plans.<br>• Active in practice redesign, quality improvement. | Atrius Health (eastern Massachusetts)<br>Hill Physicians Group (southern California)<br>Monarch HealthCare (southern California) |
| Virtual physician organizations | • Small, independent physician practices, often in rural areas.<br>• Led by individual physicians, local medical foundation, or state Medicaid agency.<br>• Structure that provides leadership, infrastructure, resources to help small practices redesign and coordinate care. | Community Care of North Carolina<br>Grand Junction (Colorado)<br>North Dakota Cooperative Network |

## Three Tiers Of Accountable Care Organizations And Possible Characteristics




"Health Policy Brief: Accountable Care Organizations. *Health Affairs*, July 27, 2010
http://www.healthaffairs.org/healthpolicybriefs/

# Take-Aways:

- Change Is Upon us
- Strong Forces Favor Closer Hospital-Physician Alignment
- Hospital & Physician Decisions in the Coming Months Will Shape the Future Delivery of Health Care for Years to Come

# For Further Information:

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# *Financial Due Diligence & Tax Issues For Hospitals & Physicians*


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# Scenarios

- Physician Joining an Existing Practice
- Group Practices Joining Together
- Physician Group Joining Hospital
- Physician Group Joint Venture With a Hospital






# Financial Due Diligence

- Get the House In Order
  - Tax Returns
  - Financial Statements
  - Practice Management Report Data
    - Charges, Collections, Adjustments
    - Managed Care Contracts






# What To Look For

- Income Breakdown
- Expense Breakdown
- Summary of Assets
- Summary of Liabilities
- Cash Flow Analysis






# Tax Regulatory Issues

- Stock Sale/Purchases
- Asset Sale/Purchases
- Payments Up Front
- Fair Market Value
- Inurement
- Unrelated Business Taxable Income