


PARAGON
HEALTH
Cardiology Management & Consulting

Integration Considerations

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Illinois ACC



Disclaimer # 1

- No financial relationship with industry



Disclaimer # 2

- Each market and integration is unique
- Motivations driving integration vary considerably by market
- The long-term success of an integration will be dependent upon the first two
- Today's discussion is a summary of our market observations over the past 6-24 months




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MOTIVATIONS TO COLLABORATE


Financial Pressures

- The increasing financial pressures that exists within cardiology practices is driving collaboration between hospitals and physicians
- Hospitals and cardiology practices both have motivations for collaboration



Hospital Motivations

- Stability of cardiovascular service line
- Physician Alignment
- Performance/Quality
- Physician staffing shortages
- Growth in market share
- National reform – global reimbursement

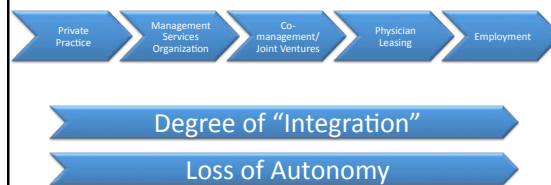


Cardiologist Motivations

- Personal income security/stability
- Increasing private practice overhead
- IT strategies
- Access to capital
- Managed care pressures
- Opportunity to cash out



The Spectrum of Considerations



Practice Options

- Stay the course
- Practice Mergers
- Employment
- Lease



EMPLOYMENT

Keys to a Successful Integration

- Trust
- Well defined governance
 - Decision-making process
 - Access to senior hospital leadership
 - Conflict resolution
- Stability of hospital partner
 - Financial
 - Leadership



Elements of Employment Model

- Employment Agreement/Compensation
- Asset/Stock purchase
- Governance



Contractual Issues

- Income guarantee
- Term of employment agreement
- Compensation methodology
 - Revenue less expenses
 - \$\$ Per RWU
- Termination of physicians
- Benefits



Compensation

- Supported by FMV
- Physician Compensation
 - Conversion factor x individual RWU/physician
 - Compensation for non-RWU activities
 - Incentive plan (business and clinical targets)



Compensation

Direct Employment

- ▶ FMV must be established for RWU (assume \$52/RWU)
- ▶ Individual physician RWU compensation (no group model)
 - Doctor 1 – 12,000 RWU's/year = \$624,000
 - Doctor 2 – 11,450 RWU's/year = \$595,400
 - Doctor 3 – 6,700 RWU's/year = \$348,400
- ▶ Notes:
 - Expense side has little impact on physician compensation
 - Benefits are paid in addition to compensation
 - "Provider based" non-invasive billing, "facility fee"
 - Better commercial provider agreements



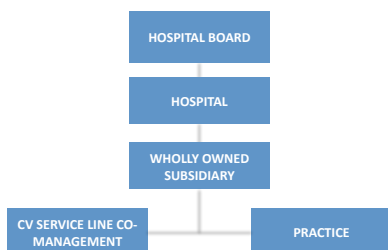
15

Asset Purchase

- Practice purchase (tangible & intangible)
 - Assets (equipment & real estate)
 - Revenue stream
 - Medical records
 - Work force in place
 - Accounts receivable



Governance/Management in Integration



Legal Residence of Physicians

- Direct employees of hospital
- Employees of a wholly owned subsidiary
- Employees of an existing hospital multi-specialty group
- Some groups are employed by the SYSTEM rather than any one hospital



Governance Continuum

- Direct employment
 - Physicians have individual employment agreements
 - Practice operating committee
 - Medical Directorships
- CV Council
 - Much like a clinical co-management program
- Practice line authority
 - The group can be delegated line authority over hospital and practice operation



Decision-Matrix

- Hospital “reserve powers”
 - Set general parameters/approve budget
 - Set general parameters/approve strategic plan
 - Charity policy
 - Specific hospital/system initiatives
 - Approve employment of physicians



Decision-Matrix

- Authority of Subsidiary Board/Heart Council
 - Establish clinical objectives (M&M, ACO)
 - Establish business objectives (LOC, CPC)
 - Business development/improve patient access
 - Establish new clinical services



Decision-Matrix

- Authority delegated to a “Physician Management Committee”
 - General practice operation
 - Elect/remove physician representatives from leadership
 - Physician schedule
 - Physician assignments
 - Physician compensation
 - Physician and staff discipline
 - Implement budget and business plan



Employment

- Pro's
 - Best time to sell (maximal practice value)
 - Income gains over structured timeline
 - Maximal Group-hospital alignment
 - Preparation for reform/global reimbursement
 - Greater market security/stability
 - Potential for improved physician recruiting
- Con's
 - Some loss of control – depends on governance
 - Heavy reliance on PBR
 - Will it resolve practice governance issues?
 - Changes in hospital leadership
 - Uncertainty regarding renewal (at 5 or 10 years)



LEASE

Lease

- Many of the same components as employment
- Negotiate PSA & Co-management Agreement
- Establish a lease payment & Co-management agreement \$\$ with FMV support
- Lease a physician, sub-group of FTE physicians, or the whole practice
- Provider Based Reimbursement



Lease

- Maintain practice assets and structure
- Will not be able to secure full practice purchase price
- A viable alternative to employment
- Theoretically works better when group works at multiple systems
- Easier to unwind



Post-Integration

- Existing problems do not disappear
- Budgets
 - Operating
 - Capital
- Not all hospital support services are better
- Hospital payor contracts are usually better, but not always



Lessons Learned

- By comparison hospitals move at glacial speed
- Compensation plan
 - Hospital is happy to let physicians determine compensation formula
 - Practice expenses usually do not impact physician compensation, but they are still important
- Maintain data analysis function with in the practice



Lessons Learned

- Data reporting format may change
- Hospitals need practice management
- Physician leadership is even more critical
- Retaliation from competing health systems
- Have a well defined exit plan
- Physician meetings are less about finance and more about patient care



Questions

Martin B. O'Neill
817-421-8700

moneill@paragonhlth.com
www.paragonhlth.com