

Practice Management: The Road Ahead

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The Road Ahead: Practice Integration in Gastroenterology

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Roadmap to the **FUTURE** of PRACTICE

Consolidation is occurring at every level of health care. When we (at Minnesota Gastroenterology) began in 1996 to build a single large practice from 3 smaller ones, the concept was rare if not unique in gastroenterology. The vast majority of GI specialty care was delivered by physicians in small (<5 physicians) practice settings. Now, there are over 25 large or “mega” practices throughout the country, and more are developing each day. In this article, Dr Cohen has teamed up with 2 attorneys who have experience in practice mergers. They have written about the risks and benefits of consolidation and provided a detailed “Roadmap” that you can follow.

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Consolidation in health care is nothing new. Hospitals began consolidating more than 30 years ago when, under pressure to reduce costs, they came together in an effort to reduce operating expenses through resource sharing, centralization of administrative services, and elimination of redundancy. By becoming larger, hospitals were also able to raise their reimbursement rates, in some instances quite significantly. Adopting a similar strategy, commercial insurers too have been able to increase market share and revenue while reducing costs. In response to the shift in market forces, doctors too have increasingly combined with other physicians¹ to achieve the benefits of scale. Both single and multispecialty group practices are aggregating with centralized business offices to provide their members with a wider array of ancillary services and to negotiate with third-party payers as a single entity.

As part of the series entitled Practice Management: The Road Ahead, this article examines the trend toward practice consolidation and integration within the specialty of gastroenterology. This article has 2 primary objectives. First, it reviews the potential benefits and pitfalls of physician integration. Second, it provides a step-wise, practical approach for successfully merging practices into an efficient and well-organized operation, while avoiding antitrust, anti-kickback, and anti-referral compliance concerns.



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Practice Integration: A Response to the Challenges of Health Care Reform

The practice of gastroenterology is poised to undergo sweeping changes as federally funded health programs and private payers begin implementing the Patient Protection and Affordable Care Act of 2010. Achieving the “triple aim” of health care reform—higher quality, lower cost, and improved population health—will require a significant transformation of our current model of health care. Although the full impact of health care reform on medical practice is uncertain, some changes are certain. The adoption of electronic medical records and outcome registries will be nearly universal. Widespread use of electronic health records will provide payers with an opportunity to assess patterns of resource utilization and clinical outcomes among an increasingly broad swath of practitioners. The accountability and transparency that result will foster competition among providers who, it is hoped, will become motivated to reduce the cost of services and improve quality. The dominant method of payment for physician services will also shift from fee-for-service to a risk-sharing model, wherein doctors assume some financial risk for the outcome of their services. Last, greater emphasis will be focused on efficient and cost-effective management of chronic diseases, end-of-life care, and the delivery of preventive care services.^{2–4}

In the new health care landscape, many doctors will belong to large networks of physicians that are closely aligned with hospital systems. Integration will be accomplished through information technology systems. The emphasis will be on patient-centered, clinically integrated care through the continuum of inpatient and outpatient settings. Performance measures, designed to assess quality and cost efficiency, will be captured and closely monitored. Compensation to individual physicians will include shared financial risk that is based on patient outcomes. Management of patient populations will require an appropriate infrastructure and technology to support such operations. These changes, which have already been implemented in some areas, will continue to evolve during the coming years. To succeed, practices will have to invest both time and money. Solo physicians and smaller group practices that are unable or unwilling to make such commitments may want to consider other options such as hospital employment or practice consolidation.

Group integration may begin either with the merger of several solo practitioners or the consolidation of physician groups. Some achieve a critical mass at inception, whereas others begin smaller with an

Abbreviations used in this paper: DHS, designated health services; IGP, integrated group practice; MSA, member services agreement; OA, operating agreement.

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expectation that additional physicians will join them later. To achieve sufficient scale and a reasonable likelihood of success in larger markets, however, a group should strive to ultimately attain sufficient size to have a voice in the strategic decisions involving their specialty within that market. With increased market size and presence, integrated groups have been able to negotiate professional fees from private payers that are significantly higher than those offered to smaller groups. Integrated groups may also experience additional benefits:

- Greater purchasing power and lower operating costs;
- Increased efficiency of administrative services operated through a centralized business office;
- Reduced administrative burden for member physicians;
- Greater access to capital; and
- Greater opportunity to develop and offer new service lines and complementary ancillary services to their patients.

There are also meaningful challenges in forming an integrated group practice (IGP), including, among other things, reaching consensus for its short-term and long-term mission and goals, the development of a governing structure, drafting organizational documents that correctly represent the desires of the IGP, and implementing the necessary details to move forward in earnest.

Selecting Your Practice Partners

The first step in forming an IGP is the selection of founding partners. To this end, it is important to identify partners with similar values and practice standards. This may involve reaching out to local competitors or to practices in adjoining geographic areas. The importance of selecting the right partners cannot be overstated because the composition of this body will determine the ultimate success or failure of the venture.

The next step is the formation of a steering committee. Ideally, this committee will include at least 1 representative from each participating practice. Members of the steering committee must be committed and willing to invest significant time in negotiating and managing the details of creating an IGP. They must be willing to compromise for the IGP's overall interest and be cognizant of the multiple roles each member will play as a representative of (1) their existing small group practice, (2) themselves individually, and (3) the interests of the IGP. The steering committee members must achieve consensus on the IGP's vision, mission, values, and goals and determine which type of integration model will best serve the interests and goals of every physician serving those roles.

The steering committee can delegate some responsibilities to subcommittees. Typically, the subcommittees include the following:

- A membership and credentialing subcommittee charged with identifying prospective member groups and credentialing existing physician members;
- An information technology subcommittee to research and recommend a practice management system and electronic medical records platforms;
- A human resources and site visit subcommittee to evaluate the operations of prospective member practices and to

make recommendations for unifying the compensation and employee benefit programs for the IGP; and

- A finance subcommittee to assist with the selection of an accounting firm for the IGP and to work with the accountants to provide a financial analysis of the projected benefits of the IGP as well as to develop budgets and other financial statements necessary for financing for the start-up.

The steering committee should also select a physician leader, who often becomes the IGP's chief executive officer. This individual should ideally have leadership experience and an established record of skillful stewardship of a group practice. In addition, for the IGP to have the greatest likelihood of achieving long-term success, the physician leader must be able to communicate a clear vision for the IGP and have the temperament to forge compromise and consensus.

Finally, the steering committee needs to select an experienced health care attorney early in the process; this decision can determine the ultimate success or failure of group integration. The steering committee should vet the candidates to ensure that the attorney is experienced in forming IGPs and that his or her personality and demeanor will blend well with IGP members. If all other factors are equal, it is often the ability to harmonize disparate physician personalities, manage productive meetings, and anticipate potential psychological obstacles to integration rather than a specific legal acumen that determines the degree to which the health care attorney can help ensure a successful outcome of the IGP process. The scope of an attorney's responsibilities and compensation should be made clear before signing a letter of engagement.

Legal and Regulatory Issues

The relevant legal and regulatory issues pertaining to an IGP will differ from one group to another, depending on its operating agreement (OA) and organizational structure. Several fundamental concepts apply to all IGPs, however. First, the IGP must operate as a single legal and economic entity in the relevant marketplace to comply with federal and state antitrust laws. Second, the IGP must have a single, qualified pension under the Employee Retirement Income Security Act.⁵ Third, all designated health services (DHS) performed within the IGP must satisfy the necessary elements of the in-office ancillary services exception of the federal self-referral prohibitions (ie, Stark Law) and their applicable state counterparts, including, most notably, the group practice elements.

True legal, financial, and clinical integration is essential for an IGP to comply with antitrust laws. This means that the group must have a centralized business office for billing and collections, human resources, and other administrative services. Third-party payers do not hesitate to make allegations to the Federal Trade Commission about overaggressive reimbursement negotiations of consolidated physician groups.

The group's commitment to being a unified business is paramount.⁶ The federal Stark Law (and comparable state laws) generally prohibits physicians from making DHS referrals, such as clinical laboratory services, to organizations with which those physicians (or an immediate family member) have a financial relationship. The in-office ancillary services exception allows solo physicians and group practices to provide laboratory, radiology,

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and other DHS without violating the law, provided that they comply with certain requirements, the analysis of which is beyond the scope of this article. Applicable to this discussion, however, is the requirement that the IGP must constitute a bona fide group practice pursuant to the Stark Law and corresponding regulations.⁷ Although flexible in terms of location and specialty-based compensation requirements, the Stark Law requires that an IGP have 2 minimum features: (1) centralized decision-making with effective control over all of the IGP's assets and liabilities and (2) consolidated billing, accounting, and financial reporting. In addition, the IGP must create a methodology for the allocation of income and expenses in advance of providing the services that give rise to the overhead expenses or produce the income. In other words, there can be no retrospective determination as to the allocation of IGP profits. To comply with the Stark Law, physicians cannot be compensated in direct proportion to their DHS referrals. An experienced IGP attorney should be involved in drafting those sections of the OA that deal specifically with ancillary services and the allocation of revenue and expenses.

Organizational Structure

The steering committee must select an organizational structure that permits the IGP to accomplish its objectives. The committee must address the tension between the extent of autonomy retained by individual divisions and the operational and regulatory requirements imposed by the formation of a single taxpayer ID group. Some IGPs prefer a Super LLC model, which permits the constituent divisions to retain maximum autonomy while still achieving the benefits of a single group model. This model is commonly referred to as "easy in, easy out" because of the relatively low upfront cost of participation. Although this model may be relatively easy to initiate because outside management services and other organizations often provide organizational documents that can be used as templates, the IGP's steering committee is often unprepared for the inevitable challenges, personality conflicts, territorial claims, leadership failures, and logistical and financial stresses attendant to the formation and operation of an IGP. A Super LLC may also be more easily targeted by government regulators who may perceive this model as an "end run" around the requisite group practice elements.

The authors strongly advocate for a Care Center model that is developed through significant negotiation within the steering committee in which decision-making authority for the IGP is centralized through a Board of Managers empowered to make important decisions on behalf of the IGP, while decisions that primarily affect only one division can be made at the divisional level pending approval by the Board. In this model, each division is responsible for paying its divisional overhead, while assuming a share of the company overhead, which is based on a predetermined formula. The distribution of a division's net revenue to the individual member thereof (excluding DHS revenue) is decided at the divisional level through a divisional compensation plan. Formulas must be developed to determine how the profits from ancillary services such as imaging, laboratory, and pathology will be allocated. DHS income must be treated separately from professional revenue and cannot be allocated by DHS referrals but can be allocated by non-DHS productivity. The authors further advocate that some part of professional and/or ancillary revenue be shared equally by all

partners just as physicians often do within their preexisting constituent practices. It is highly advisable that members and divisions commit to remaining together during the start-up for a predetermined period of time (12–36 months). A division that withdraws before the end of this period would be responsible for its percentage of IGP formation debt plus a predetermined amount of liquidated damages. By entering into this commitment, the newly formed IGP has the greatest opportunity to overcome the inevitable growing pains of creating a new entity.

Governing Agreements

Although the legal structure of the IGP is governed by many factors including state law, for the purposes of this article, we will presume that the IGP will be a professional limited liability company. In all cases, there will be an overarching governance and management agreement for the entity, which will be designated as the OA. In most cases, there will also be a separate agreement between individual physician owners and the IGP and the professional limited liability company, usually titled a Member Services Agreement (MSA). At its core, the OA is the agreement between the IGP and each of its owner physicians (members) collectively. The MSA is effectively the employment agreement for the physician owners that governs the individual professional responsibilities and obligations of each member and the IGP. The OA will be heavily negotiated by the steering committee and will act as the by-laws of the IGP. Although the OA must provide a strong framework on which the IGP will be built, it is a fluid document that must remain flexible and malleable for future change.

Among the many details to be addressed within the OA, the most critical include the following:

- The composition of the IGP's various division cost centers;
- The method of allocating general overhead expenses to the various members;
- The method of allocating DHS revenue and expenses;
- The number and selection/appointment/removal/succession process of the steering committee members and transition to a governing board;
- The relative powers of the governing board, appointed officers, and the members;
- The determination of which issues shall require membership approval rather than that of the governing board;
- The circumstances under which individual members and/or divisions may withdraw from the IGP, either voluntarily or at the request of the entity, and the consequences of such withdrawal;
- The impact of short-term/long-term disability of member physicians; this discussion is too often overlooked;
- The issues of restrictive covenants, to protect both the IGP as a whole and the divisions of the IGP;
- The methodology for valuing members' interests in the IGP and the degree to which that value may be transferred on withdrawal; and

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- The organization, management, and degree of autonomy of the cost center divisions established by the IGP.

The MSA will likely be more familiar to the members because it is similar to an employment agreement in form and structure. It will set forth rights and responsibilities of the member and the IGP. The protections afforded to a member would typically be broader than for a traditional employee in terms of the ability of the IGP to terminate the member without cause and the duration in which such member may be disabled before forfeiting the right to his/her position. As a template for all members from all divisions, the MSA will require significant negotiation so that the policies and customs of each member's constituent practice are adequately addressed. For this reason, the personal involvement of the steering committee and the IGP attorney are far preferable to the use of boilerplate agreements.

Accounting and Financial Considerations

The start-up costs for an IGP, which vary according to the size of the entity to be formed, average \$5000 per physician. A requirement that all potential members deposit funds into a central escrow account creates a commitment and sense of individual investment in the process. Invariably, as the process moves forward, there will be additional expenses. Thus, it is good practice to have the accountants selected by the steering committee provide a pro forma and other financial projections that are based on the financial data provided by each member or member group, as well as the proposed allocation methodologies being considered. The accountants must have expertise in medical practice reimbursement issues so as to interpret data and make assumptions, particularly regarding ancillary revenue to which the constituent groups would not otherwise be entitled. The accountants will need to project both the costs for a centralized business office and the potential cost savings that it would mean for each constituent practice. The accountants should review the OA to ensure that it reflects accurately the income and expense allocation methodologies agreed on by the steering committee.

Another key accounting issue for IGPs is the management of assets that the constituent practices bring to the merged entity. In some instances it is advantageous from a tax perspective for the IGP to lease the equipment at fair market value from a division rather than purchasing the asset outright. The cost of the lease remains a direct expense of the division(s) that uses the asset. Alternatively, assets that are shared by all divisions, such as a pathology laboratory, must be treated under a different financial arrangement. In such cases, great effort is required to fairly represent the interests of all parties involved. A forensic accountant may be helpful in some cases to provide a fair market valuation of the asset.

Developing an Infrastructure and Going Live

In making the transition from individual practices to an IGP, member physicians need to address their employees' concerns as to how they will be impacted by this new entity. The employees from each constituent division will be understandably concerned as to how integration will impact their individual employment circumstances. It is imperative to communicate the benefits of the

IGP in a manner that generates excitement about the prospect of long-term growth and opportunity for employees.

In addition to dealing with personnel issues, the IGP must create a functional infrastructure before the "Go-Live" date, including the following:

- Establishment of the IGP's books and records;
- Development of a banking relationship and negotiation of the terms and conditions of the various forms of start-up and/or capital needs financing;
- Establishment of the employee benefit structure;
- Development of an employee manual;
- Establishment of a qualified benefit/profit-sharing plan;
- Credentialing of all providers;
- Negotiation of new contracts with third-party payers; and
- Development of a billing system with an appropriate practice management platform and an interface with members' existing electronic medical records.

An attempt to Go Live before putting this infrastructure in place threatens the viability of even the well-planned integration.

Conclusions

Physicians considering practice aggregation or integration with a health system need to assess their local market conditions. The creation of a weak or ineffective group because of insufficient scale or poor leadership can be problematic and can result in the loss of considerable time and money. Alternatively, an IGP that has been thoughtfully planned and carefully implemented can provide its members and the community it serves with enormous benefits.

References

1. Cascardo D. Physician practice mergers: what makes them succeed? *J Med Pract Manage* 2012;27:277–280.
2. Allen JI. Roadmap to the future of practice. *Clin Gastroenterol Hepatol* 2012;10:692–696.
3. Mergener K. Impact of health care reform on the independent GI practice. *Gastrointest Endosc Clin N Am* 2012;22:15–27.
4. Dorn SD. Gastroenterology in a new era of accountability: part 2—developing and implementing performance measures. *Clin Gastroenterol Hepatol* 2011;9:660–664.
5. Grant PN. Medical practice consolidation: structural and legal issues (BNA's health law and business series). Bureau of National Affairs, 1996.
6. Casalino LP. The Federal Trade Commission, clinical integration, and the organization of physician practice. *J Health Polit Policy Law* 2006;31:569–585.
7. Federal Physician Self-Referral Law 42 U.S.C. §1395nn et seq. and 42 C.F.R. 411.352.

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Conflicts of interest

The authors disclose no conflicts.