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The beginning of a new year provides a great opportunity to evaluate the position of your organization. Are you meeting your financial goals, making your patients healthy and happy, growing your practice, satisfying regulatory demands, improving your technology, and working well with your fellow professionals? Whether only one or all of these items are on your organization's radar for the new year, you should take a moment to plan for how you can progress toward meeting your goals in the year ahead.

In this issue of *VitalSigns*, we discuss the growth stages of a hospital-owned physician network, regulatory reporting requirements, incentives of CMS reporting, finding the best doctor to hire for your practice, and standardized patient surveys.

We wish the best for you and your practice in the coming year and hope that, if nothing else, we are finally moving past the economic hurdles our nation has recently faced and will be able to once again fully focus on both the practice *and* business of medicine.

## So you want to grow a hospital-owned physician network ...

### Recognizing the 3 stages of maturation

**Ever wonder why your hospital-owned group is less organized than its competitors? What makes your peer group outperform the group you are forming? Many hospitals and health systems have begun to employ groups for many reasons. Most hospitals invest their limited funds in physician salaries and not the infrastructure necessary to run the practices. They start with one practice and quickly grow to 25 or more physicians.**

The relationship between physicians and hospitals is becoming more and more complex, especially with health care reform and the innovations with electronic health records, medical homes, etc. Newly graduating residents are expecting to be employed and are less interested in an entrepreneurial medical model than in the past. Developing a physician network or employed group is a progression. The resources necessary to acquire, manage and sustain one or two practices with less than 15 physicians are different from those required for groups of 25 to 50 physicians. The complexity increases significantly once the group grows to more than 75 physicians.

For this reason, it's important to recognize the three stages that hospital-owned physician groups go through as they mature. Here's a closer look at each.

#### 1. Initial stage

The initial stage of the physician group development typically has a senior executive of the hospital responsible for an employed physician group of about 25 physicians. This person typically reports directly to the hospital chief executive officer or chief financial officer.

On many occasions, the executive charged with group management is the person who also is in charge of business development or recruitment. In the initial stage, the group outsources the billing to the physician group or an outside vendor. The characteristics of this phase are a lack of dedicated senior management, minimal middle management, and unsophisticated reporting tools.

#### 2. Adolescent stage

When the number of physicians swells from 25 to about 75, the group moves from the initial stage to the adolescent stage. This step is typically a result of physician dissatisfaction with the model or a lack of financial information. The hospital or health system realizes that controls aren't in place to manage an organization that has \$10 million plus in revenue.



In response, the adolescent phase group begins to add a middle management layer to the organization that includes:

- Practice managers,
- Outsourcing of some management duties to for-profit management service organizations,
- Simple business plans,
- Practice-level financial statements,
- Productivity measures for physicians and staff, and
- A budget process similar to that of the health system.

Human resource issues become important as the staff level grows and contractual issues such as leases and insurance equipment increase in scale. The other issue that starts to be addressed is physician on-boarding and new practice development. In the adolescent phase, the hospital begins to address business planning for the physician organization and tying it to the hospital's strategic plan. More sophisticated financial measures are started.

#### 3. Mature stage

Once they have 75 or more physicians on board, most systems move into the mature phase. It includes a fully developed infrastructure with professional management and sophisticated reporting tools.

Here the group begins to develop a management infrastructure that includes a professional management team, including an administrator or chief executive officer; internal accounting and financial staff; and support staff, such as human resources professionals. A chief medical officer is usually added to the organization to deal with physician issues, quality and clinical programming.

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# Would your hospital-physician arrangement pass regulatory and public scrutiny?

Physicians and hospitals work in a highly regulated environment. The Office of Inspector General, the Centers for Medicare and Medicaid Services (CMS) and state regulators all want to obtain information regarding financial relationships between physicians and hospitals. In the Deficit Reduction Act of 2005, CMS was required to consider the issue of annual disclosures for physician ownership and investment interest in specialty hospitals. CMS has announced that it will periodically require hospitals to provide information about compensation arrangements with physicians.

CMS and other government agencies, including the Office of Management and Budget, are going back and forth about the details of the reporting. Regardless of the details, the rules for physician-hospital relationships are known. What's not known is how an arrangement with physicians may look written as a lead story in your local newspaper. The question to ask is: Would all of your physician deals pass regulatory and public scrutiny if made public?

## Develop a policy

All arrangements must adhere to current fair market value principles and standards. Moreover, physicians who have contracts must understand the rules and ensure that all payments and contracts are in compliance. To this end, develop a well-defined policy for physician arrangements and have it approved by senior management. The policy should be published and transparent. All physicians who are considering or already have an arrangement should be shown the policy.

If you haven't already, appoint a compliance officer to create a checklist based on the policy that guides all decision makers. Do not waver from the approved policy when it comes to your physician contracts. Have attorneys draft fair contracts that cannot be altered by the physicians or their advisors, with no exceptions.

Going forward, the compliance officer must perform ongoing periodic audits that ensure the policy is being followed. The compliance officer also must verify that payments are in compliance with contracts, verify that all documentation is complete, identify contracts that must be renewed or revised, ensure the necessity of contracts, and follow up on payments made to physicians that aren't tied to any contracts.

## Stay organized

Once your policy is in place, start reviewing all physician arrangements. Implement contract management tools and processes that monitor physician financial relationships through hospital compliance officers and other administrators. Develop a database that tracks:

- Contract length and terms,
- Payments due,
- Actual payments made,
- Duties,
- Fair market value assessment,
- Total payments to physicians (from various contracts), and
- Legal signoffs.

Also, perform audits of contracts and payment terms. Use the hospital check registry to start the audit process.

In addition, organize all contracts and arrangements by type. Develop a clear system

for approval that identifies responsible parties. The process must be organized and every step must have clear signoff by responsible parties, including the compliance officer and legal department. You must avoid a disorganized process that allows for selective amnesia by hospital administrators in case a deal/contract is questioned in the future. A file for each contract must be developed that includes the reason for the service, community need assessments, fair market values, and other supporting materials.

## Be absolutely sure

As reimbursement declines for physicians and hospital programs move toward service lines, medical homes and employed groups, hospitals will pay physicians for services. Many hospitals, however, won't be able to provide their communities with access to needed physicians without some sort of financial arrangement — whether for anesthesia, emergency medicine and other hospital-based groups, or for on-call arrangements with difficult-to-recruit specialties such as orthopedics, neurosurgery and cardiology.

Remember that both regulatory and public scrutiny of these arrangements will likely become more complex and aggressive in the near future. So you need to be absolutely sure that you meet all the requirements.

## Incentivizing the CMS quality health care reporting measures

Most medical practices are familiar with the acronym PQRI — Physician Quality Reporting Initiative. Yet, despite the potential to earn a 2% incentive payment, many providers have chosen not to implement reporting under the Centers for Medicare and Medicaid Services (CMS) measures.

Admittedly, when the program first started in 2007, even Medicare's representatives had difficulty explaining the qualification of the measures and how to participate in the plan. Because of the ambiguity of the program language and the lack of clear explanation on qualified reporting, many providers felt they would be doing a lot of extra documentation with no guarantee of reaping a reward.

Since 2007, there have been marked improvements in the language and additional reporting methodology; there is now less reason than ever not to participate. The CMS Web site ([cms.hhs.gov](http://cms.hhs.gov)) provides specific program guides on topics such as eligibility, measures and reporting mechanisms in understandable terms.

## 4 steps to getting started

Now is the time to start reviewing the information for the 2010 program year. Don't be intimidated by the number of measures that are part of this program. Rather, single out those you wish to actively report. In all

likelihood, you are already performing and documenting these same quality care aspects in your patient records. Here are four steps to get you started:

**1. Review the measures and determine which have the potential to apply to your specialty.** For example, if you are the primary care provider, you may choose to report on preventive measures, such as osteoporosis, tobacco screening, alcohol screening, immunizations, and BMI, either as a grouping or individually.

**2. Familiarize yourself with the qualifying E&M and diagnostic codes associated with any measure you report.** The process will go much more smoothly if you know what to expect when it comes to the coding requirements.

**3. Review the measure language thoroughly.** There are some measures that capture historical care information. For example,

measure 39 is documentation of a Dexa performed at least one time after the age of 60 for any female 65 and older. No assessment need be part of the reporting documentation.

**4. Remember that the nonperformance of a measure is also reportable.** For example, you can use an 8P modifier appended to Measure 48 code 1090F for the presence or absence of urinary incontinence or to report that this measure wasn't assessed.

## The program's reward

Most important, don't let the difficulties of the past keep you from reaping the rewards of this program in the future. For additional guidance, the American Medical Association, which actually developed many of the measures, has some very user-friendly tools on its Web site ([ama-assn.org](http://ama-assn.org)). These include measures, description sheets, data collection sheets and coding specifications.



# Paging Dr. Right

## How HCOs can best target their physician hires

Before a health care organization (HCO) begins employing physicians and physician extenders, a thought process needs to happen and questions need to be answered. What does the HCO want from the physician? What does the physician want from the organization? These are two of the key questions that the HCO needs to know before starting an employment relationship with a provider.

Other questions are: How will this bring the HCO into closer alignment with its vision and mission? How will a management structure be developed? What investment or risk is the HCO capable of making? By clearly defining what each party needs or wants from this relationship, the best fit will occur between HCO and physician.

Is the HCO looking to fill a community need? If so, the deal will be structured differently than in a situation in which a physician wants to join an HCO to concentrate on medicine and let the HCO take over management. Recognizing the different motivations involved in the HCO-physician relationship will strengthen it.

The overall goal in every employment relationship should be to invest as little as possible in each physician or practice — meaning the HCO should keep an eye on the breakeven point to keep the practice open. If the HCO is filling a need for a trauma surgeon within the community, the investment that the HCO makes may justifiably be higher because its aim in the hire is to fulfill its mission. But in a situation where two OB/GYNs in private practice want to join the HCO to avoid the hassle of administration and management, the agreement should be structured to minimize the HCO's risk.

Let's take a closer look at these two scenarios — hiring to fill an HCO's community need (or otherwise advance its mission) vs. hiring to suit an individual physician's desire to join the HCO in question.

### Hiring to fill a need

Are you recruiting a physician to fill a community need? Or to attract business from a different region or specialty? If so, establishing a clear business plan from the beginning is essential. The plan should answer the following questions:

- What is the vision and mission for this practice?
- How will this physician align with the vision and mission of the HCO?
- Where will patients come from (geographically)?
- Who will refer patients? Primary care doctors? Specialists? The emergency room?
- What will the practice's office hours be? Hospital hours?
- Where will procedures be performed? Inpatient, outpatient, or ambulatory surgery center?
- Does the HCO have an investment that it will make into the practice? How much and for how long should be clearly defined. A pro forma or forecast for the next three years would be an ideal way to illustrate this.

Can you imagine starting a practice and not knowing this information? It happens often and leaves the HCO and the physician



working independently to achieve two different sets of goals. Knowing these key points will help build a strong foundation from which the HCO and the physician can move forward — something strong on which to build a practice.

### Welcoming a physician in need

Sometimes the intensive administrative and managerial needs of a practice create a need for a physician to join an HCO. In doing so, the physician can relinquish some, but not all, of his or her management responsibilities — ultimately regaining some work-life balance.

Meanwhile, the HCO provides accounts payable, human resources, accounts receivable, personnel management, and legal and financial services. Now the physician can participate in these areas at his or her discretion but remain focused on patient care.

Before hiring such a physician, a degree of due diligence should be performed. Items from the physician's existing practice to review are:

- Its last two years' corporate tax returns;
- Financial statements for the last three years;
- The practice management database and electronic medical records database used;
- Charges, receipts and adjustments, by month, for the preceding year;
- The current aging of accounts receivable (totals only, showing aging categories of 60, 90 and 120 days);
- A copy of the practice fee schedule;
- A copy of all forms used in the office for staff or patient tracking, including patient registration, routing slips (fee ticket) and collection letters;
- Patient volume statistics for the past two years, per physician;
- A list of all third-party payor agreements, including managed care contracts, PPOs and HMOs; and
- The National Practitioner Data Bank report for each provider.

If available, look at the current aging of accounts by payor mix. Most systems will provide reports by at least Medicare, commercial insurers and Medicaid. Examine specific insurers, if possible.

### Voicing your philosophy

Leaders of HCOs must be able to determine and clearly voice their philosophies regarding the physician-employment relationship. If a leader cannot map out where this journey should take the HCO in question, it could lead to a flawed hiring and a loss of value within the physician community.

### The keys remain the same

Although the administrative complexity of any hospital-owned physician group increases as the organization moves through these three stages, the keys to success remain the same: 1) Develop a well-defined strategy, 2) remain disciplined in executing the strategy, 3) offer consistent physician contracts (no sacred cows), 4) establish financial reporting systems and make them transparent, and 5) hire and retain good operations staff.

When all is said and done, the phases are less about the number of physicians that are in the group and more a reflection of the maturation of the management skills and systems the group has developed.

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The information systems necessary for this organization include billing and collections, decision support, finance, and electronic medical records. Individual productivity is measured for the physicians; practice and physician financial statements are common; and key indicators for each practice are developed as dashboards.

Moreover, the physicians move from being characterized as an employed physician to a physician group. The group is engaged in achieving the hospital's strategic plan and mission.



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# Standardized patient-feedback surveys extend their reach

In an effort to provide excellent health care to patients, physician practices strive to achieve a high level of service that will complement the quality medical services they provide. How would your patients rate you and your staff? Do you ask for their feedback? Does it really matter?

In the past, satisfaction was an issue between you and your patients. However, in the current competitive environment, significant changes are being made in assessing how patients view their care, and the results are being shared to help patients choose providers that best suit their needs. In addition to Web sites where patients can provide anonymous reviews of their physician that can be viewed by other consumers, patients are now providing feedback about your performance using standardized surveys.

### An evolving effort

A public-private initiative, called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program, has developed standardized surveys for patients to evaluate their health care experiences. The surveys have evolved from their original purpose of providing a mechanism for consumers to report experiences with their health benefit plans to include survey tools that focus on facilities and providers as well.

The CAHPS program is funded and managed by the U.S. Agency for Healthcare Research and Quality. CAHPS surveys focus on topics for which patients are the best source of information, such as skilled provider communication and service accessibility, as opposed to asking them

to evaluate the quality of the clinical care they receive. The survey tools have been extensively tested using focus groups and interviews to ensure the items are consistently understood, the public really cares about them, and the public believes the patients are a good source of information on the items.

### One example

The Hospital Survey, known as HCAHPS (pronounced H-caps), was the first standardized national survey of patient perspectives on their hospital experiences. Results are publicly reported with the intent of enabling patients and families to make valid comparisons across facilities. Implemented in October 2006, the first public reports were released in March 2008. Results are published four times per year on the Hospital Compare Web site ([hospitalcompare.hhs.gov](http://hospitalcompare.hhs.gov)), run by the Centers for Medicare and Medicaid Services. Also, databases exist for the Health Plan and Hospital Surveys, with one under development for the Clinician & Group Survey.

Why would hospitals participate when many already had their own voluntary programs to measure patient satisfaction? Since July 2007, acute care hospitals that have failed to collect and report quality measures (that include HCAHPS) have been subject to a 2% payment reduction.

As of this writing, the Clinician & Group Survey is voluntary. Core measures include:

- How easily patients could get appointments and health care,
- How courteously and helpfully the office staff perform,
- How well doctors communicate, and
- How doctors rated overall.

There is a visit-specific and a 12-month version. Primary care versions exist for children and adults, while specialty care has only an adult version.

### Lessons to be learned

What can physician practices learn from hospitals' experience regarding CAHPS? Given current trends, it would not be surprising if payments for physicians eventually become linked to participation as well. Additionally, physicians need to pay attention to service as well as quality of care.

Consider voluntary participation in the CAHPS Clinician & Group Survey to identify the strengths and weaknesses of your communication and service to patients before it becomes mandatory. A CAHPS Improvement Guide is available with practical strategies for improving the patient experience. For further information on participation, please visit [cahps.ahrq.gov](http://cahps.ahrq.gov).