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Evaluating Physician Affiliation Options

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As boards seriously consider their health system's options relative to physician affiliation, they should explore the numerous forms and structures that exist. Exhibit 1 provides a concise summary of these options.

These alignment models represent varied areas to evaluate and ultimately develop a strategy for how best to respond. A *pluralistic* approach to these forms of affiliation is likely best, as it is not "one size fits all." Moreover, as the board considers specific levels of integration (i.e., limited, moderate, and full), the form of affiliation may vary, even within these three major classifications. Hybrid or multiple forms of affiliation may result as well. While such things make for more complex structures, health systems will likely experience more success adopting these pluralistic models.

Exhibit 1: Traditional Alignment Model Descriptions

Limited Integration	Moderate Integration	Full Integration
Managed Care Networks (Independent Practice Associations, Physician Hospital Organizations): Loose alliances for contracting purposes	**Service Line Management:** Management of all specialty services within the hospital	**ACO/CIN/QC:** Participation in an organization focused on improving quality/cost of care for governmental or non-governmental payers; may be driven by practices or hospital/groups
Recruitment/EPPM/PSM: Economic assistance for new physicians	**MSO/ISO:** Ties hospitals to physician's business	**Employment "Lite":** Professional services agreements (PSAs) and other similar models (such as the practice management arrangement) through which hospital engages physicians as contractors
Group (Legal-Only) Merger: Unites parties under common legal entity without an operational merger	**Clinical Co-Management:** Physicians become actively engaged in clinical operations and oversight of applicable service line at the hospital	**Employment*:** Strongest alignment; minimizes economic risk for physicians; includes a "PE-Like" model
Call Coverage Stipends: Pay for unassigned ED call	**Joint Ventures:** Unites parties under common enterprise; difficult to structure; legal hurdles	**Group (Legal and Operational) Merger:** Unites parties under common legal entity with full integration of operations
Medical Directorships: Specific clinical oversight duties		**Private Equity Affiliation:** Ties entities via legal agreement; sale to private investor/ operator

Legend (box border colors): Purple = Typically Physician-to-Physician; Red = Typically Physician-to-Hospital; Green = Either Physician-Physician or Physician-Hospital; Yellow = Physician to Private Investor

Border colors by item: Managed Care Networks (purple), Recruitment/EPPM/PSM (purple), Group (Legal-Only) Merger (purple), Call Coverage Stipends (red), Medical Directorships (red); Service Line Management (red), MSO/ISO (red), Clinical Co-Management (red), Joint Ventures (green); ACO/CIN/QC (green), Employment "Lite" (red), Employment* (red), Group (Legal and Operational) Merger (purple), Private Equity Affiliation (yellow).

* *Includes the Physician Enterprise Model (PEM) and the Group Practice Subsidiary (GPS) model both of which allow the practice entity to remain intact even after employment of the physicians by the hospital.*

Areas of Consideration for Health Systems

Health systems' administration and leadership, including boards, have various strategic and tactical things to consider. First, when dealing with physician specialties, there is the *relational* consideration; how does a health system continue to work with a physician group, depending on the current level of integration? Likewise, there are the *economic* areas of consideration for compliance purposes and the overall fiscal ramifications of any affiliation structure. Next are the *functional* areas of consideration; what works best in a day-to-day practical manner relative to the form of affiliation considered? Finally, there are *confrontational* matters, meaning exactly how far the negotiation of terms, both economic and non-economic, extend. Because of the need for a continued relational and functional relationship, many health systems are reluctant to be confrontational, yet should consider such, depending upon the level of integration.

Key Issues for Medical Practice Groups

For health systems and their leadership, it is best to understand the issues that medical groups are trying to navigate. These are basic but varied and warrant serious consideration for the group and their health system partner to consider. For example, medical groups are grappling with the fundamental question of whether to remain private and independent versus affiliate with another group, a private equity firm, or a health system (or sometimes, a combination). They are also considering the basic premise of whether to align on a more limited basis (see **Exhibit 1** on previous page) or commit to full alignment with the right partner. Most now consider whether private equity sale to an outside investor group has strategic and tactical merit. Some are also considering whether to align with fellow physician groups through a merger. Finally, there may be hybrids wherein limited integration with a health system could still exist while further integration with private equity results.

Medical Group Challenges

With these things in mind, health systems appreciate the stresses that medical groups are experiencing and the resulting challenges of fiscal viability. At the core is the inevitable tug-and-pull within groups between the younger and the older (closer to retirement) physicians. As they formulate their succession plans, senior physicians are more amenable to a sale to private equity, which often

offers the best option. For the younger physicians, less so. A private equity model typically entails a compensation *scrape* or *haircut* post-transaction, creating EBITDA (earnings before income taxes, depreciation, and amortization), to which the private equity firm applies a multiple and results in up-front value. Older physicians are more equipped to handle a reduction in ongoing pay than younger ones and thus are much more interested than younger physicians in such affiliation scenarios.

Many practices struggle to determine how they will grow and procure the capital for such growth, given their reluctance to take on debt or distribute and dedicate profits toward capital growth (as opposed to distributing these profits to their physicians). Acceptable compensation is a major factor for groups as they consider possible forms of affiliation. Ultimately, many medical groups align with health systems for this primary reason. Secondarily, it is challenging to recruit and retain physicians depending on their ability to pay a competitive compensation package, both in the beginning and throughout the physician's tenure. Finally, the issue of management expertise and the autonomy of decision making is paramount to many private groups' priorities. All of these things present challenges that are difficult to overcome without some form of compromise and willingness upon the health system to be flexible. And, as stated above, adopting a pluralistic approach to the various affiliation option models is a necessary strategy.

➜ Questions to Ask Medical Practice Groups

- Do you want to remain independent? What does that mean?
- What type of partner are you seeking?
- Do you prefer full or limited alignment?
- Are you open to a private equity sale?
- Do you wish to merge with another physician group?
- What is the best model? Should health systems attempt to apply the pluralistic approach or maintain a "one-size-fits-all" point of view?
- How much does regulatory compliance influence the affiliation model selection?

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Keys to Future Compatibility

When we consider the various challenges and differing points of view, the keys to working together (health systems and physician groups in particular) come down to some basic understandings:

1. There has to be honest, forthright, and open dialogue. Trusting *communication* among health systems and physician groups is imperative.
2. Boards and hospital administrators must be amenable to some new structures of *partnering*. The old singular solution of employing physicians no longer works best. Health systems and their boards must understand that it is indeed a new day, with various options possible and acceptable. Being open to such is imperative.
3. Compliance is also a significant area of consideration and adherence. Hospitals cannot compensate physicians above fair market value and cannot pay them for referrals to their facilities. Thus, no matter the model, this must be at the forefront of consideration for health systems. Private equity firms are not quite as regulatory-minded.

Summary

The keys to future affiliation success are numerous. Health systems should remain nimble and flexible with physician groups as physicians have options that do not require hospital or health system affiliation. As a result, these varied options should be considered for future compatibility purposes, not just potential, with little to no intent to invoke them.

Health systems face more challenges than ever, as do physician groups. Both parties should understand the other and work diligently to collaborate. If not, neither wins, and the healthcare consumer loses.

The Governance Institute thanks Max Reiboldt, CPA, President & CEO, Coker Group, for contributing this article. He can be reached at mreiboldt@cokergroup.com.

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