

Case Study: ER Physician Group Subsidy

Hospital A is a tax-exempt organization under I.R.C. §501(c)(3) and a level-two trauma center, with a service area that extends through much of the central part of the State, as well as into a neighboring state to the north and west. The service area includes a Metropolitan Statistical Area, as well as poor, rural areas in surrounding counties. The area is also served by two other acute care hospitals, of which one is also a trauma center.

The physician community consists of several freestanding single-specialty and multi-specialty physician group practices. Group Z, a physician-owned emergency medicine group, is contracted by Hospital A under an exclusive agreement to provide complete emergency department (ED) coverage. Group Z has been in existence for 10 years, contracting with Hospital A for the entire life of the group, and is comprised of 5 physician-owners, 5 employed physicians, and 8 nurse practitioners.

The contract between Hospital A and Group Z provides for 24/7 exclusive coverage of the ED and other emergency services furnished to the hospital's patients. The obligations of Group Z under the exclusive agreement include the following:

- Full-time physician on-site coverage and necessary backup and on-call services
 - Sufficient on-duty physicians to serve patients presenting to the ED
 - The amount of coverage is agreed upon by Hospital A and Group Z
 - Group Z is responsible for scheduling physician and mid-level provider coverage and furnishing the schedule to Hospital A
- Respond to code calls in the house if other physicians are unavailable
- Maintain active medical staff membership in good standing for all its physicians
- Group Z may employ or contract with physicians not a member or employee of Group Z and may contract with *locum tenens* firms at Group Z's own cost in order to ensure required coverage
- Furnish a physician to serve as medical director over Hospital A's emergency services
- Group Z will bill and collect for all physician and mid-level provider professional fees

As a trauma center, the payer mix of Hospital A has long included indigent, self-pay and Medicaid patients. With changes in the local and state economies, the payer mix has recently evolved into one of greater low-paying patients. This has resulted in an increase in the low-paying payer mix for Group Z's professional services as well. Approximately 50 percent of Group Z's professional fee billings will be collected at or below Medicaid rates, if at all. While Group Z has always been proud of its low physician turnover, the group's members are demanding higher personal compensation. Further complicating the process is the fact that retention of nurse practitioners also requires more money. To the physicians of Group Z, making ends meet financially means subsidized operations from the hospital.

In consideration for the coverage and availability of the physicians, Hospital A agreed last May to pay Group Z a fixed subsidy amount of \$80,000 per month. Now, Group Z is requesting \$90,000 per month, citing increasing hours of ED coverage to meet the hospital's demands and higher cash requirements to retain employed physicians and nurse practitioners.

In a recent meeting with Hospital A's CEO, just 45 days before the anniversary date of their contract with the hospital, Group Z leadership threatened to terminate its contract, cease coverage of the ED at midnight on April 30 (the anniversary date of the contract), and go to work as employees of the competing trauma center. Stunned by the group's demands and threats, the hospital CEO agreed to "do whatever it takes" to retain the group and agreed that their request "would be in a contract delivered next week."

Describe the legal and financial analysis that should take place prior to issuance of the contract by Hospital A to Group Z.

Case Study: Chief of Staff

Hospital A is a tax exempt 501(c)(3) in a major urban area. It is part of a multi-hospital system of 30 hospitals in a relatively concentrated market. Hospital has compensated its chief of staff a fixed stipend of \$15,000 annually for the past ten years. Historically, there has been no discussion of the stipend by recipients. However, the new chief of staff is a busy orthopedic surgeon who has requested payment of \$50,000 in recognition of the reduced productivity and decreased income that will result from the responsibilities of the job.

A survey of Chief of Staff positions at other hospitals in Hospital's A region found:

- 38 hospitals covered by the survey, 14 of which are owned by the parent system of Hospital A
 - Each of the 14 hospitals negotiates physician contracts locally, through local management with local physicians
- 50% of hospitals in the survey do not pay a stipend, half of which are members of the system
- Only one surveyed hospital in the region varied payment by physician specialty

Questions:

1. Can the survey be used to establish FMV for Hospital A if affiliated hospitals comprise 37% of the survey results?
2. If not, can survey results from a less geographically relevant region be used to inform the fair market value analysis?
3. Is there a basis for varying payment based on physician specialty?
4. What factors could be used to determine the appropriate level of payment for the particular physician and specialty?
5. What data would be needed from the physician and hospital for the analysis?
6. What other positions or types of positions might fall under similar types of analyses?

Case Study: Cardiovascular Co-Management Arrangement

Background

Hospital Z is an independent, 300-bed tax-exempt community institution in a city of approximately 45,000 residents. The hospital is a Level II trauma facility and provides a comprehensive array of health services including a nationally recognized cardiovascular institute. Hospital Z has maintained specialty outreach clinics in surrounding communities and recently acquired a critical access hospital located 2 hours away by car. There is one other hospital in the city which is part of a regional health system.

Hospital Z directly employs only a few primary care physicians, and recently entered a professional service arrangement with three cardiovascular surgeons. The hospital is encountering growing pressure from community physicians to provide increasing practice support to include direct employment options.

A Group of 16 cardiologists have maintained a successful practice in the community for almost three decades. The Group consists of primarily non-invasive and interventional cardiologists offering a limited scope of in-house diagnostic services. The Group has maintained exclusive privileges at Hospital Z and has sought strategic alignment rather than competition over such services such as cardiac catheterization. The Group has provided cardiologist staffing to Hospital Z's outreach clinics. Historically, the relationship between Hospital Z and the Group has been supportive and productive, but has grown strained in recent years.

Issues

As a result of the strained relationship, the Group was prepared to discontinue an array of activities including outreach services, and just focus on their core practice. Among other issues, the chief factors causing strain between the Hospital and Group included:

- 1) Increasing burden on physicians to support outreach clinics as well as other developmental activities on behalf of the Hospital;
- 2) Erosion of physician incomes due to changes in reimbursement and growing practice expenses;
- 3) Inability of physicians to formally influence operations as well as quality improvements within the Hospital's cardiovascular institute;
- 4) Decreasing demand for interventional procedures due to improvements in the treatment of heart disease as well as competition from other providers;
- 5) Hospital's desire to maintain its level of quality and reputation in cardiovascular services;
- 6) Increasing difficulty of recruiting new cardiologists, especially electrophysiologists; and
- 7) Mutual perceptions of insufficient support to the other party.

Solution

Recognizing the problems, both Hospital Z and the Group agreed to consider strategic options to improve their relationship as well as maintain their respective positions as market leaders. Neither entity favored a direct employment scenario, though it was viewed as a possible option. Joint Venture and gainsharing were explored as other options. In light of the potential costs and regulatory uncertainties along with a desire to walk before they ran, the Hospital and Group agreed that the development of a Co-management Arrangement (CMA) would be an appropriate solution.

The objectives of the CMA were devised along with operational tactics to achieve them. At the heart of the CMA were quality improvement initiatives toward five different clinic outcomes as well as overall program management. To support the initiatives, the Group would dedicate the time and talents of key physicians designated as Medical Directors for each clinical initiative. Hospital Z would provide remuneration for the Medical Directors plus incentives for improvement in specific quality measures.

Questions:

1. Identify the factors that influence the determination of fair market value of services provided by the Medical Directors.
2. What analytical approaches would be appropriate for conducting the valuation?
3. How would one evaluate the value of quality improvements?
4. What activities should the Group and Hospital Z perform to ensure continued compliance with fair market value expectations?