

PRACTICE INTEGRATION OPPORTUNITIES FOR PLASTIC SURGEONS



- REPORT OF THE GROUP PRACTICE TASK FORCE -



AMERICAN SOCIETY OF
PLASTIC SURGEONS

GROUP PRACTICE TASK FORCE WHITE PAPER EXECUTIVE SUMMARY

Practice Integration Opportunities for Plastic Surgeons

As health care markets continue to evolve, some plastic surgeons are finding that integration with other physician practices or hospitals is a proactive solution to helping them stay competitive. Integration can offer such potential advantages as collective bargaining with health insurers, lifestyle benefits, improved quality, lower costs, and enhanced professional interaction. While integration is not a completely novel concept, plastic surgeons have traditionally been solo practitioners and may not be fully aware of the possibilities for forming legal partnerships, which include some exciting new business models currently involving ASPS members. The ASPS Board of Directors convened the Group Practice Task Force to examine integration strategies and recommend additional resources to assist members who are considering forming a group practice.

Members of the Task Force have compiled their findings into a white paper. Due to state law concerns and numerous other factors, the intent of this guidance is not to provide an exhaustive review of all available group practice options. Instead, the Task Force endeavored to analyze and describe some long-standing and tested group practice models along with some new and unique models that may work for plastic surgeons. Many case studies are provided throughout this document, which is divided into four major categories of group practice: formal corporate practice; independent practice with shared facilities, personnel, etc.; unique group practice models; and centers of excellence. Many of the cases represent actual plastic surgery practices, and the information was often collected via interviews of one or more members of the particular group practice.

The reasons why most plastic surgeons are in solo practice as well as reasons they should consider forming or joining a group practice are explored in the white paper. Factors that can cause a group to fail are also included. The group examined strengths and weaknesses of various models with respect to plastic surgeons and presented recommendations pertaining to all models. The white paper includes an extensive discussion of relevant legal considerations including Stark law and anti-kickback statutes and a special section on legal concerns for shared facilities such as ambulatory surgery centers. Finally, physician relationships with hospitals and universities are discussed in depth.

The case studies include an analysis of plastic surgery's largest and longest continually running group practice, as well as advice on affiliations with an independent practice association or a practice management company, and centers of excellence. Some of the new and unique models discussed include a virtual group practice and a hybrid private/academic practice (termed a "cooperative").

Clearly there are a lot of choices for plastic surgeons considering forming a group practice and a wide range of pertinent and individual variables to consider. The intent of this white paper is to provide a starting place for interested surgeon members, and a list of recommended resources is provided for further guidance.

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As health care markets continue to evolve, some plastic surgeons are finding that integration with other physician practices or hospitals is a proactive solution to helping them stay competitive. Integration can offer such potential advantages as collective bargaining with health insurers, lifestyle benefits, improved quality, lower costs, and enhanced professional interaction. While integration is not a completely novel concept, plastic surgeons have traditionally been solo practitioners and may not be fully aware of the possibilities for forming legal relationships, which include some exciting new business models currently involving ASPS members. The ASPS Board of Directors convened the Group Practice Task Force to examine integration strategies and recommend additional resources to assist members who are considering forming a group practice.

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THE PRACTICE OF PLASTIC SURGERY – BUSINESS STRUCTURES

Plastic surgery is amenable to both individual and group practice. Some surgeons prefer the independence and control that an individual practice provides. For others, the traditional group practice of plastic surgery can be a great alternative. Groups take many forms: single specialty groups of two or more plastic surgeons; multi-specialty groups like an Independent Practice Association; corporate-based groups like Kaiser Permanente; or faculty members in an academic hospital. Regardless of group size, the structure of the organization is important and variable. This may be an LLC, Partnership, S or C corporation, and each of these will be described in detail. The alternatives will be discussed with an eye to the benefits and costs associated, as well as pitfalls to avoid. However, first, consider the perspective of many plastic surgeons today who are in solo practice.

SOLO PLASTIC SURGERY PRACTICE AND WHY GROUPS SOMETIMES FAIL

Currently, the majority of plastic surgeons remain solo practitioners. In almost any city, you will find plastic surgeons that once were in practice together. The experienced plastic surgeons can often relate their city's group genealogy. Partnerships and groups seem to come and go within each major metropolitan area.

For instance, in one contributor's location, there are six plastic surgeons in solo practice. Four of them were previously in a group practice. In one mid-western state, there are only three groups (two two-man partnerships

and one group of four). Of the 75 percent that are in solo practice, over 60 percent were previously in a partnership. In a densely populated northeastern state, there is only one large group (four members) with a stable history. Why do plastic surgery groups fail, and why do plastic surgeons fail to form successful groups?

Despite the advantages of a group (better coverage, shared expenses, lower costs, professional interaction, better protection for short term disability, longer vacations, ability to afford more technology, and shared business management), plastic surgeons have not formed groups to the extent of other medical specialties. It has been said that it is much harder to go from one to two plastic surgeons than from two to three or more plastic surgeons.

Why do groups break up, or never form in the first place? Could it be due to a unique plastic surgeon personality? Plastic surgeons are known to be perfectionists and may rate higher on the ego scale than other specialists. Well-known senior surgeons may feel little need for a partner since a totally cosmetic practice does not require taking emergency call at hospitals, and they might rarely provide inpatient care. Groups can fail because there may not be enough work for all to share. There may be competition for the "better cases," whether they are better paying cosmetic, or simply the more interesting cases. Some plastic surgeons prefer less emergency call, or may prefer to work fewer hours than other plastic surgeons. This can lead to controversy over how to share responsibilities and overhead costs.

Plastic surgeons are not immune to other difficulties such as the dishonesty of a partner, unfair treatment by a partner, or senior partners wanting to make money from the work of a junior partner. Some senior partners demand an unrealistic buy-in to the practice for a junior partner.

Young plastic surgeons may also be the instigator in the failure of a group. Residents seeking employment may have unrealistic expectations of beginning salaries. A junior associate may take advantage of the senior partner(s) who put in the effort to hire staff, establish the business, pay all the upfront costs, and do all the work just to get the junior surgeon started, and then they have to divert cases to him. The junior associate may feel he/she is being unfairly treated salary-wise, even though joining a group made it much easier to establish themselves professionally and they avoided the time, problems and cost of starting a solo practice.

Some junior partners enter a group with no intention of making it a permanent arrangement; they just want the guaranteed salary and to avoid the headache of starting an office and becoming known in the community. After a time, they can split off and set up shop down the street. When this happens, the senior partner may no longer have the wherewithal to hire another associate, and the negative repercussions and increased expenses may leave bad feelings all around.

Other reasons for group failure include differences in practice style, surgical speed, expenses, patient management, competition, or personality. In order to be successful, there are many issues to resolve involving how to divide income, call, expenses, and work.

Failure may result when senior partners want too much control, or refuse to share work. There may be a senior partner who "cooks the books" in his favor, or a partner who is willing to bend the rules when it comes

to insurance or billing. There may be junior associates who enter the practice in order to have the guaranteed salary, and then make no effort to build a practice.

One contributor states, "I have been in solo practice and group practice. I wanted group practice, but it did not work out. I have gotten used to the advantages of making all the decisions. All the cases that come in are my own. I make the decisions on vacation, expenditures, practice style and hours, for better or worse. I can work as I please, with no repercussions, and if there is no work, I can head home."

With so many potential headaches and obstacles involved with forming a group practice, why would anyone consider it? The current medical climate is making group practice more advantageous. Despite the challenges, plastic surgeons should consider making this transition as there are many benefits in lifestyle, negotiating power, costs, and professional interaction.

SINGLE SPECIALTY PLASTIC SURGERY GROUP PRACTICE

Affiliating with one or more plastic surgeons offers the following benefits: shared costs of personnel and supplies with some economy of scale; shared marketing of the practice with perhaps better name-recognition; and more efficient use of office-based surgical facilities and personnel. A group may be more attractive to health plans since one contract can cover all the plastic surgeons in the group, and the larger number of surgeons can more likely provide a wider variety of services in a timely fashion. Spreading the cost among the partners may make it feasible to purchase the building in which the practice is located, thus saving on rent and creating equity. Similar cost-sharing may also make it possible to provide value-added services such as a MediSpa or Laser Center.

The camaraderie that comes with group practice also allows for an "instant second opinion" when faced with a difficult problem. Another partner can examine the patient as well and provide insight. Peer review, a pooled library of books and journals, and the sharing of information gathered at educational meetings can help the partners maintain a good knowledge base. Having partners you trust also provides peace-of-mind when you are off-call or on vacation. Knowing that your partner will "do the right thing" for your patient improves your overall patient care.

If you are considering joining a group practice, you will need to make sure it is a good fit. You'll need to feel comfortable with the partners and their style of practice. Since you'll be covering each other's patients when on-call, you'll each need to have the appropriate skill set to handle potential problems. You'll also need to know the costs of the practice. What is the monthly overhead cost? Does the overhead seem reasonable? How is overhead divided amongst the partners? How much of what you bring in do you get to keep? Is the compensation plan fair? Do you enter the practice as a partner or employee? If you enter as a partner, is there a buy-in cost? What is the buy-in based on and does it seem fair?

If you enter as an employee you will need a contract that specifies your salary and benefits. Are there productivity incentives? Will your health insurance and professional liability insurance costs be covered? How about educational expenses? How much vacation time will you get? How long will it take before you are considered for partnership?

You'll need to understand how the group is managed. Is there one surgeon who acts as the administrator of the group, or does that duty rotate among the partners? Is there an administrator/manager that handles day-to-day tasks? Is power shared equally among the partners, or is one partner "top dog?" Who decides when to hire and fire personnel? Does an individual partner have any choice regarding with which employees he works most closely? Does each partner have access to adequate operating room time?

Finally, you will need to examine the group's retirement plan. Is there a formal profit-sharing plan or 401(k), or does each partner have an individual plan? How is retirement funded, and when do you start contributing? How long before you become fully vested? What happens to your retirement funds if you leave the practice early? Does the group have other investments in which you will be allowed or expected to participate in?

A group practice must be prepared for a partner leaving the practice, either to work elsewhere or retire. If you decide that group isn't working out for you, are there any costs or practice restrictions associated with leaving the group? If you ultimately become a partner, you will need to understand the mechanics of retirement from the group. If there was a formal "buy-in" to the group, there will need to be a formal "buy-out" of the dissociating partner, so that the tangible assets remain intact, and the group can perpetuate itself.

ACADEMIC-BASED GROUP PRACTICE

All plastic surgeons, to varying degrees, pursue academic careers, utilizing outcomes assessment, peer review and continuing medical education to enhance their clinical skills. Those surgeons who choose to practice in an academic setting will face an ever increasing myriad of options for the professional and financial relationships with the university, their peers, and the hospitals and surgicenters in which they practice.

GENERAL

The applicant for an academic plastic surgery position must consider the pros and cons of this practice. The intangible advantages of teaching, a stimulating academic environment, the "prestige factor," facilitation of basic science and clinical research, and the scope and quality of clinical cases must all be considered. The cohesiveness of the group and the retention of faculty should be assessed. Frequent turnover is, of course, a bad sign.

While traditionally those seeking a high level of financial remuneration do not focus on academic careers, a reasonable salary is necessary for morale, loyalty and longevity to the program. The financial aspects of an academic practice do bear scrutiny as it is traditionally one venue where initial compensation is "guaranteed." However, the applicant must thoroughly investigate the ability to retain this income and/or increase it after the initial salary guarantee period, as this has become problematic in the recent economic climate. The quality of health insurance, fringe benefits (such as college tuition), retirement benefits, etc., may all sway the applicant.

The plastic surgery community is small, particularly among full-time academic practitioners, and it is advisable for the applicant to provide full and candid disclosure of his/her considerations during recruitment. As in all positions, the applicant must consider the importance of obtaining board certification and refining clinical expertise in the first several years in practice. While traditionally academic surgeons have moved geographically from program to program with each academic promotion (i.e. assistant professor, associate professor, full professor and/or chief), this is becoming less common, but remains an important facet of an academic career. The applicant should expect to stay three to five years in his/her first position, with advancement pending academic progress.

The means of academic progress/promotion is highly variable from institution to institution. The applicant should know the specifics of the academic practice he/she wishes to join, and consider the pros and cons of tenure or non-tenure track positions, and the potential of job loss if he/she fails promotion. Making the switch from a full time academic practice to private practice may be logistically simpler and less costly than the reverse (no malpractice tail coverage, lease buyouts, etc.), but should be considered carefully. Initiating a private practice later on will cost the practitioner in terms of time needed to establish him/herself. In other words, the merits of a full time longitudinal career in academic medicine should be weighed and found favorable when the applicant is making these important decisions. Opting for several years of academic medicine only with no plans for progression should be avoided.

FINANCES

Traditionally, “academic practice” was a full time, hospital-based practice, with subsidies for teaching and other academic roles to compensate for time away from clinical practice. A salary with or without a bonus was generally reliable, but typically lower than that of a surgeon in private practice. As reimbursements for reconstructive procedures have fallen, outpatient surgery and private-pay (aesthetic surgery) procedures have increased, and the practice of plastic surgery has evolved. Fees paid to individual providers have decreased (while reimbursements to facilities have increased), particularly in hospital-based practices. Provider fees for aesthetic cases are generally significantly higher proportionately to the effort and time expended by the provider, causing a shift in profits to the outpatient venue, and compromising the traditional academic payment structure.

Current economic climes have spawned different pro formas out of necessity. In general, junior faculty will be granted 2-3 years of a “guaranteed” salary (often at an equal or higher scale to that of starting alone in private practice). After this initial period, the variability between individual situations begins. If the junior surgeon works diligently on poorly-reimbursed, complex cases (as is often the case) he/she may ultimately fail to support his/her salary due to a poor payer mix. Many programs offer outpatient/off site “private” practice venue for augmentation of income. This arrangement works well, but often favors the senior members of the group who have better name recognition and sometimes a higher pay scale based on academic rank.

The group or department chair may determine overall compensation based on a variety of common methods, each of which has their advantages and disadvantages:

Straight salary with possible bonus
(for academic or clinical accomplishments)

Compensation based on RVUs
(regardless of the actual collections for the RVUs)

Compensation based on actual individual collections

A “blended” model incorporating any of these variables: RVUs, charges, collections, base salary, academic productivity (research, grants, publications, etc.), uncompensated services (leadership positions, committee work, etc.) and program development.

RVU compensation arrangements pay the faculty member such that individual effort is recognized without regard to net collections. This scheme has the advantage of limiting inter-group rivalry for money, cases, or payer mix. It may act as a disincentive for the “less motivated” surgeons in the group and cause friction, but may, however, work well in a productive group.

A collections model rewards “cash in the door,” and encourages individual practitioners to seek out better paying cases, thereby shifting efforts to more favorably compensated work (more aesthetic and less complex reconstructive). While beneficial on the surface, an unintended consequence is competition within the group for case types and payer mixes, and the possibility of decreased attention to certain patient groups. Individuals wishing to focus on isolated clinical problems (which may happen to reimburse less favorably), but which may be beneficial overall to the group, the medical center, and to society, may find disincentives in this model.

While paying attention to the specific financial interactions within the group of plastic surgery faculty is important, applicants to a given program should be cognizant to the broader organizational structure of the institution they are considering joining. Plastic surgery programs that are a division of general surgery may do well under a fair-minded chief of general surgery. However, sometimes more financially sound divisions like plastic surgery are used to fund other necessary programs that run a deficit. This thereby drains financial resources away from the plastic surgery division. A small, but growing number of plastic surgery programs are becoming departments, which is described in the AACPS *White Paper on Departmental Status* by Lawrence, WT, Rohrich, RJ, et al. This shift promises to increase financial control and responsibility. The role of academic plastic surgeons may evolve into practice groups that contract with hospitals to render needed services and better reflect the diverse nature of the practice of plastic surgery. Negotiating with hospitals for adequate reimbursement of emergency and other services may help facilitate the financial solvency of plastic surgery practices.

Regardless of the specific compensation structure, many academic centers require sole employment of their physicians at their center. Some, however, particularly with regard to plastic surgery divisions, support dual practices, allowing individuals the freedom to engage in scholarly, academic and clinical pursuits under the umbrella of the university, while simultaneously maintaining private practices outside the purview of the institution. These blends of academic and private practice

may allow a good balance for the individual in terms of career trajectory, case mix, financial incentives, and academic pursuits.

AUTONOMY

As academic surgeons work as part of a larger group, individual autonomy will typically be restricted when compared to solo private practice or small group practice. Most large organizations are not as nimble or responsive to changes in a plastic surgeons' external environment. On the other hand, the resources of a financially stable academic institution can offer a distinct advantage to a plastic surgery practice once the leadership is engaged. In some cases, the advantages of an academic practice may allow for more freedom to try new ideas since the downside of failure will be less risky than in private practice. An individual surgeon may be able to explore new concepts and advance his/her career in an environment that promotes progress and innovation rather than the financial bottom line. Unlike non-academic practices, a university position will typically serve two or more masters. While the practice plan (physicians group) may focus on the business side of medicine, the medical school dean may have different objectives that may or may not be parallel to the goals and needs of a plastic surgery practice. Veteran's Administration hospital affiliations and state governments (in the case of public universities) may also influence the direction of an academic surgeon's practice.

ACADEMIC PURSUITS

"Academic" involvement varies widely among different centers, and between (and even within) plastic surgery divisions. An applicant should strongly consider his/her motivation for joining an academic institution, and seek out a practice that allows him/her to flourish. Research (basic science, outcomes, or translational) is highly valued at some institutions, with resources for collaboration, space, assistance and time away from clinical responsibilities. Having these interests may prove frustrating, however, if the remainder of the group is not equally engaged in such activities, as friction can develop over clinical productivity and time constraints. At some centers a robust research effort may be supported by a few concentrated researchers, while being balanced by a cadre of purely clinical faculty. Other institutions base their academic pursuits solely around the education of students, residents, and fellows. Some deliberate soul-searching regarding the applicant's desires prior to joining an academic practice will be rewarded with the correct environment to support his/her long-term goals.

CASE STUDY – TRADITIONAL SINGLE SPECIALTY GROUP PRACTICE

Overview: The largest and longest continuously running plastic surgery practice in North America is a group partnership formed in 1948 in New York. It is comprised of 14 plastic surgeons with 10 partners. The following case is based on that practice.

Reasons to Consider this Model/Advantages:

- Profitability and overhead management: In high overhead areas such as New York with extremely high real estate and malpractice expenses, it is important to achieve financial efficiencies. The group currently operates at a 40% overhead (figure includes ALL expenses except physicians' personal expenses).

- High functioning management team focused on the business aspect of medicine: With an MBA for executive director, an MBA for head of marketing, and a JD/CPA for comptroller, the group is able to assemble a team of highly capable individuals to manage the overall practice as a business and let the physicians focus on their practice of medicine. This leads to better cash flow management, better relationships with banks, suppliers, etc.
- Productivity, capacity utilization: The existence of so many single specialty physicians allows continuous use of the office six days a week across all specialties of plastic surgery from burns to hand to trauma to pediatrics all the way to the aesthetic center which means that there is a constant revenue flow not dependant on a few providers.
- Comaraderie and quality assurance: Group practice allows the individuals to share ideas and cases and also maintain a high quality of care based on the culture of the practice.
- Teaching and education: Given the variety of the cases, the group has supervised a residency program since 1954 and now graduates three plastic surgery residents per year and one post graduate fellow with a full complement of medical students and general surgery residents.
- Growth and market domination: A group of this size is able to start a branding and promotion campaign that can compete in the big markets such as New York for attention.
- Superior outcomes reporting: Given the database of half a million patients and over 15,000 new patients per year, the group can drive outcome studies and establish better protocols.
- Future of plastic surgery: A larger group is more dedicated to serve the whole of plastic surgery because many specialists can come together to provide the entire spectrum of the specialty while teaching it all to the next generation of plastic surgeons in a private setting.
- Improved lifestyle!

Potential Problems for this Model/Disadvantages:

- Decisions are made by consensus so there is a process to get things done (which can also be a good thing)
- The partners have to like and accept the culture of the practice

Legal Ramifications/State Law Considerations:

This is a well-established model that has lasted the test of time for over 62 years. Applicability of individual state laws will vary.

Other Factors/Barriers:

There are generational issues as older partners closer to retirement are not as aggressive as younger associates (though this group has worked that out as well).

Applicability to Academic Practitioners:

We perceive ourselves as private academic practitioners since we teach and educate residents but are not salaried by a hospital or university. This allows us to have full autonomy.

Characteristics of an unsuccessful group practice:

- Haphazard pursuit of growth (partners spread out)
- Contract one-sided with vague partnership terms
- Ego, Economics
- Not cost effective – staff, overhead
- Control issues
- Loss of respect and recognition for each other
- Lost residency

Overall Recommendation:

The partnership model can provide the most equitable and long lasting relationship (if you think of your business partnership as you do “a marriage”).

CASE STUDY – PLASTIC SURGERY AS AN INTEGRAL PART OF A LARGE MULTI-SPECIALTY GROUP IN AN INTEGRATED HEALTH CARE DELIVERY SYSTEM

Overview: One example of plastic surgeons in a large multispecialty group that is affiliated with an integrated health care system is Kaiser Permanente. In this model, Kaiser Foundation Health Plan is affiliated through an exclusive contract with the Permanente Medical Groups to provide comprehensive care for all of the patients who choose their health plan. In most but not all areas of the country Kaiser also owns and administers its hospitals, which are staffed by physicians in the respective Permanente Medical Group. The Medical Groups are structured internally as either partnerships or corporations but most importantly are all led and administered by physicians. The importance of physician leadership cannot be overestimated in its impact on the rewarding practice environment that plastic surgeons are able to enjoy by controlling how care is to be delivered. What follows as an illustration of this practice model is a brief description of the Southern California Permanente Medical Group (SCPMG).

SCPMG is a large multi-specialty medical group partnership with over five thousand physicians, which has an exclusive contract with Kaiser Hospitals and Health Plan to provide comprehensive health care to approximately 3.3 million patients in Southern California. Plastic surgery is an integral part of this delivery system with six individual departments responsible for the plastic surgery care of over ½ million people each and chaired by a plastic surgeon who has equal standing with the chiefs of other specialties. In addition to this local leadership role a Regional Chief of Plastic Surgery, appointed by the Executive Medical Director and Chairman of the Board, serves to both inform senior leadership about the needs of plastic surgery and to convey and help implement the strategic initiatives of the Group as a whole.

This status of plastic surgeons as leaders within a large medical group affords the individual surgeon a significant amount of input into decisions about their scope of practice and the means by which they perform their responsibilities.

A few of the advantages and disadvantages of this model can be summarized in the following bullet points.

Reasons to Consider this Model/Advantages:

- Physician leadership, which affords a significant amount of control over the practice of plastic surgery. The only authorization required for a procedure is the surgeon’s judgment consistent with the guidelines established by and for plastic surgeons in the group which correspond very closely with those advocated by ASPS defining the scope of reconstructive surgery to be covered by insurance.
- Stability and security of a large medical group that affords the autonomy to take time off for pleasure or illness without the fear of losing your practice. Your practice is there awaiting your return.
- Collegial practice environment in which competition is more externally focused as a group vs. internecine in a small group or between specialties in other environments. Disagreements are adjudicated within the context of sustaining the partnership.
- A broad scope of practice representing the full gamut of plastic surgery including fee for service (FFS) cosmetic surgery.
- Academic affiliations and appointments both individual and departmental including serving on rotations integral to university training programs.
- A fair and dynamic compensation system with a competitive base salary plus additional incentive based pay aligned with the strategic goals of the group (e.g. quality, service and access standards) that includes FFS cosmetic surgery.
- Generous retirement plan that includes a defined pension benefit plan, Keogh and 401(k).
- The ability to plan for your future knowing that you have a secure yearly income that increases year by year.

Potential Problems for this Model/Disadvantages:

- Limits on flexibility to determine practice scope and time commitment. Because a large integrated pre-paid system has a responsibility to a whole population for plastic surgery services, the work needs to be evenly and efficiently distributed among the surgeons. A plastic surgeon therefore cannot choose to substantially limit his or her practice to only a couple of days a week or e.g. only breast reconstruction. Vacation and education leave time off though very generous is predetermined and limited by the partnership.
- Limits on individual compensation which is determined through a complex system of relative market value for the specialty as a whole within the group thereby restricting individual entrepreneurship. Although there are opportunities to earn above the base salary (e.g. FFS cosmetic surgery which has a percent of practice cap to assure access for covered benefits), the potential for a sometimes very high income of a private cosmetic practice is not there.
- Group compatibility requires conformity to generally agreed upon norms and the rules and regulations of a partnership that may not always conform to an individual’s specific needs or preferences.

The successful plastic surgeon in this model is a team player who desires to maintain a practice which includes the full scope of plastic surgery. The stability and security of a large multispecialty group practice offers advantages and scope of practice latitude for some that may be viewed as restrictive by others. The most important consideration is to know oneself and what type of practice will result in the most fulfilling and professionally satisfying career.

INDEPENDENT PRACTICE WITH SHARED FACILITIES

The Task Force researched another key integration option, which is the independent practice with shared facilities. In this context, an “independent practice” is defined as a private practicing, solo practitioner who owns the practice. Clearly, there are many benefits to independent practice, including:

- Personal vision unhampered by compromise
- Autonomy
- No delay in incorporating changes, such as website, products, advertising
- No competition for consultations coming into office
- Minimal conflict
- Leadership in office clear
- Liability/Accountability limited to self
- Ability to partner with academic practice locally

However, the Task Force also identified a list of challenges to independent practice including:

- Inability to share costly expenses for equipment, space, and personnel
- Affordable space small
- Lack of negotiating power
- Limited financial resources for start-up (often personal)
- Expense of disuse and coverage when away for vacations, meetings
- Personal life sacrifices
- Limited ability to change clinical spectrum of expertise/practice with downturn in the economy (i.e., lack of time to seek further training to offer more services)
- Expense for continuing medical education to keep the practice competitive (including time away causing loss of production and actual financial cost)
- Business administration for the practice may be burdensome
- Marketing forces and expenses to market your practice
- Finding call coverage when needed
- May be feelings of isolation or loneliness caused by lack of collegial discussion regarding difficult patients and changing trends in practice

To combat some of these problems, and as an alternative to forming a formal corporate structure, there are many potential resources that may be shared with other independent private practices including office space, personnel, an office-based ambulatory surgery center, or expensive technology. Combining resources can provide the practice with the ability to afford a more expensive office space (e.g., more square footage or a better location) or an opportunity to divide up administrative responsibilities. The practice might benefit from increased financial incentives from vendors in exchange for larger orders for implants, injectables, etc.

Of course, there are advantages and disadvantages to consider before choosing to share a particular resource, and these vary according to the resource. While not an exhaustive list, the Task Force identified the following pros and cons pertaining to some of the more common shared resources.

Shared Office Space

Physicians can choose to share office space for their clerical staff, exam rooms, or procedure rooms. Potential models include co-ownership, shared leased agreements, or subletting space that is owned or leased.

Pros

- Reduce overhead expenses such as supplies (discounts for bulk orders; ability to purchase from certain companies with minimum purchase requirements that a solo physician could not meet)
- If sharing with complementary specialty, may result in increased patient exposure and referrals
- Potential collegial relationship

Cons

- Potential disagreement about supplies, décor, exam beds, etc.
- Potential conflicts for scheduling use of space/time
- Accounting/financial balance sheets for physician use of supplies may be difficult to track accurately

Shared Personnel can include office personnel, management, or clinical assistants.

Pros

- Efficient use of time
- May allow hiring of a larger variety of personnel
- Cost containment

Cons

- May raise questions about splitting time equally
- Potential allegiance to particular surgeon
- Honesty in guiding patients to appropriate surgeon
- Absence of employee more consequential on any given day
- May be less expensive to use a billing service than in-house staff
- Stark Law compliance may increase complexity

Shared Office-Based Ambulatory Surgery Center

Pros

- More efficient use of physician time and better control of schedule
- Can be an efficient use of office space
- Staff can crossover from office
- Better negotiating with insurance companies if no Certificate of Need (CON)
- Financial reward if run efficiently

Cons

- Competition for block time
- Regulatory complexity
- Initial financial investment required of the physician/practice
- Need to hire additional staff
- Governance and Quality Assurance measures oversight
- Additional equipment, supplies, expenses

Expensive technology (e.g., lasers, photography)

Pros

- Able to offer patients more comprehensive treatment
- Ability to market yourself as a plastic surgeon who is knowledgeable about current trends
- Can often rent or lease to make them affordable

Cons

- Conflicts over schedule of use
- Can get outdated quickly and may need upgrades often
- Reliability questionable at times

LEGAL CONSIDERATIONS

Sharing of practice facilities and services with other physicians can provide many benefits to the independent practitioner. These include the ability to benefit from financially advantageous contracts negotiated for supplies and services while maintaining independence and personal control over other aspects of one's practice. In addition many of the mundane decision-making and management aspects of daily practice can be eliminated through these associations. The price for these benefits includes the need to cede some measure of personal control and autonomy over these aspects of practice to some central authority and the need to forfeit some personal preferences to the process of group decision-making.

The extent of the sharing arrangement is up to the individuals involved in the agreement. In its simplest form this agreement could cover office space only. More complex arrangements could include provisions for the sharing of virtually all the materials, equipment and staff for the office and could also include surgicenter facilities and, if structured appropriately, the negotiation of insurance contracts. In addition, this arrangement could be limited to physicians of one specialty or could include physicians of multiple specialties. The specifics and the extent of sharing are up to the individuals involved. However, as the agreement becomes more complex, so will the legal ramifications of the association. As more and more goods, services, employees, etc., are included in such an agreement there should be more opportunity to benefit from the ability to negotiate favorable contract prices with providers of these goods and services and even opportunity to benefit from having a greater range of goods and services than would be practical to have in a small office setting. Access to a surgicenter and to expensive technologies including lasers may be particularly attractive but are often too costly for most solo practitioners to maintain and are much more cost effective when utilized by several physicians. There is virtually no limit to the number and types of particular goods and services that may be included in the agreement.

LEGAL AGREEMENT

To enter into such an arrangement it will be necessary to have a formal agreement. Even with the simplest of sharing arrangements there will be many issues that need to be addressed. It is necessary to establish a formal management and leadership structure and specify the rights and responsibilities of membership, a process for governance, voting powers and buy-in and buy-out rules. Other issues include methods to address and resolve disagreements and conflicts, how to manage financial transactions, how to disburse any profits, and how to terminate the agreement. Certain services, such as legal and accounting services that are separate from those needed for each individual practice involved, will be necessary. There are also issues of liability and insurance to cover common property that will need to be addressed.

It will be important to consider and address the pertinent state and federal laws that may apply to the practice arrangement. These will vary significantly depending on the extent of the sharing arrangement and the specific services and property involved. Probably the most complex situations will be those where the agreement involves negotiating contracts with insurers and among service providers; and in these situations the state and federal self-referral (e.g., Stark) and anti-kickback laws, as well as antitrust laws, need to be addressed. This will best be accomplished by having an experienced attorney to advise the group.

When the agreement involves provision of facilities and services only, the situation is often much simpler. If facilities are built or modified to suit medical use, there will be applicable building codes which pertain to medical facilities that need to be addressed. In addition, the Americans with Disabilities Act specifies the need to maintain access for individuals with disabilities, including elevators and ramps. These standards are available online at www.ada.gov.

WORKPLACE ISSUES

OSHA has specific rules regarding safety in the work place, and there can be significant fines for failure to comply. Examples include proper labeling of chemical substances and provision of protective equipment. It is important in any office to designate an individual to review OSHA rules and ensure compliance. This may be the responsibility of the individual practice or the group, depending on the nature of the agreement. These guidelines are available at www.osha.gov.

SURGICENTERS

Probably the most complicated issues will revolve around surgicenter facilities, should these be included in the plan. Many, but not all, states have certificate of need laws (CON), which can pertain to the construction of surgicenters. These are based on the concept that such facilities can increase health care expenditures and, therefore, that it is in the public interest to assess and regulate the construction of these. The presentation of a CON is often tied to community obligations such as to provide indigent care, accept certain payer mix, or serve a given geographic area. In addition, some states also regulate medical office buildings and even items such as business computers. The ASPS and ASAPS require all members to operate only in fully accredited surgicenters (e.g., through an organization such as AAAASF, AAAHC or JCAHO). Individual states will have specific laws regarding the management of surgicenters, and it is the surgeon's responsibility to know and understand these laws. When a surgicenter is a joint venture between individual surgeons or between surgeons and an independent entity that provides services such as a hospital, the anti-kickback statutes and Stark Law provisions become particularly important and are the source of much scrutiny, particularly if the center accepts Medicare patients or involves providers that accept Medicare patients. When such a venture includes a not-for-profit entity, additional restrictions and regulations are involved as well, and ensuring there is no adverse effect upon the tax-exempt status (if applicable) of such entity will be an important consideration. Again, it is important to have an attorney to review the particular laws in your state to make sure you are in compliance.

ANTI-KICKBACK LAW AND AMBULATORY SURGICAL CENTERS (ASCs)

The original (federal anti-kickback) proposal protected only Medicare-certified ASCs wholly owned by surgeons. Many in the industry urged that the original proposal be broadened. The expanded final rule protects certain investment interests in four categories of freestanding Medicare-certified ASCs: surgeon-owned ASCs; single-specialty ASCs (e.g., all gastroenterologists); multi-specialty ASCs (e.g., a mix of surgeons and gastroenterologists); and hospital/physician-owned ASCs. In general, to be protected, physician investors must be physicians for whom the ASC is an extension of their office practice pursuant to conditions set forth in the safe harbor. Hospital investors must not be in a position to make or influence referrals. Certain investors who are not existing or potential referral sources are permitted. The ASC safe harbor does not apply to other physician-owned clinical joint ventures, such as cardiac catheterization labs, end-stage renal dialysis facilities or radiation oncology facilities. (See *Fact Sheet, Federal Anti-Kickback Law and Regulatory Safe Harbors*. Office of Inspector General. November 1999.

<http://oig.hhs.gov/fraud/docs/safeharborregulations/safefs.htm>

CORPORATE STRUCTURE

It will also be advisable to consider some form of formal corporate structure, such as an LLC, S corporation or C corporation. S corporations and LLCs are “pass through” organizations with regard to income taxes. All three formats serve to limit individual personal liability for the function and decisions of the group as a whole.

A LLC is a business structure which limits the liability of the owner and which is formed by filing with the appropriate state department. Owners are neither shareholders nor partners but are members. Profits and losses are passed through to its owners and reflected on their taxes. A LLC often provides more flexibility in management than is possible under the more rigid rules of incorporation. Corporations are for-profit entities formed by articles of incorporation with the appropriate state agency. The corporation is a separate entity that has its own rights and liabilities apart from the owners.

A S corporation is similar to a LLC in that it is a “pass through” organization for the purposes of taxes. Usually included is an operating agreement that allows you to structure your financial and working relationships with your co-owners. The owners are shareholders in the corporation, and there can be no more than 100 owners. There is the opportunity for employment tax savings with the S corporation.

A C corporation pays taxes on its profits, and its shareholders pay taxes on dividends. In addition, they can offer tax deductible benefits such as health and life insurance, travel and entertainment and better tax sheltered retirement plans. Each state has laws to set basic operating rules (default rules for LLCs), and unless you have an agreement setting your own operating rules, the default rules will apply. Therefore, it is important to have formal operating rules for a LLC. You should seek the advice of an attorney regarding which business structure best fits your enterprise.

SUPERVISION OF NON-PHYSICIAN PROVIDERS

Non-physician providers may assume many responsibilities previously borne by physicians. In addition to patient evaluation and teaching,

non-physician providers may perform injections, provide hair removal and skin care, and operate IPL and laser devices in many states. Laws vary significantly from state to state regarding which functions may be performed independently, which must be directly supervised, and which a physician may only perform. You must be aware of the requirements and restrictions of your state.

THE CORPORATE PRACTICE OF MEDICINE DOCTRINE

Many states prohibit the “corporate practice of medicine.” This means that, with certain limited exceptions, a corporation or other non-physician cannot employ physicians to provide professional medical services. This often does not apply to not-for-profit institutions, as long as clinical decisions are the province of the physician. The laws vary from state to state, and you should check the laws specific to your state. There is an excellent, if somewhat dated, summary from Michal, MH, Pekarske, MSL, McManus, MK, *Corporate Practice of Medicine Doctrine 50 State Survey Summary*. Reinhart Boerner van Deuren Attorneys at Law (2006).

TAXATION

Some states or municipalities may tax office facilities based on the value of the facilities or may tax goods sold and/or services offered. These may be the responsibility of the individual practice or could possibly become the responsibility of the group. It will be important to have an accountant to advise you regarding the local applicable laws and to attempt to clarify the responsibility in the practice agreement.

STARK LAW AND HOSPITAL RELATIONSHIPS

The relationship between physicians and hospitals has always been symbiotic. In an attempt to prevent that relationship from becoming abusive at the expense of the government and the patient, the federal government has outlined restrictions to the relationship between the physicians and the services offered by the hospital as they relate to Medicare patients. These regulations, which include collectively the “Stark Law” and anti-kickback statute, govern the physician’s ability to refer to another entity in a manner which might result in personal financial gain. These regulations, while pertaining specifically to Medicare (and in certain cases, Medicaid) patients, have impacted all patient referrals, and as an unintended consequence, these laws and the subsequent interpretive regulations have strained the relationship between hospitals and private physicians making the financial workings complicated and cumbersome.

As the medical reimbursement arena has changed through time, the relationships between hospitals and private physicians have been tainted by distrust and regulatory constraints. The collegial exchange for the common good of the patient has been replaced with arguments over who is more valuable: the provider or the supporting institution. Is there a way to work within these regulations and create a mutually beneficial relationship? As the physician workforce has evolved, the nature of relationships with hospitals has as well, with a growing trend towards hospitals employing physicians, particularly hospital-based specialties. Is there a way for the private practice physician to create a dialogue with the hospital that still allows for autonomy, while capitalizing on the financial and quality advantages that often accompany a larger institution? In the past, the Stark Law has impeded the development of non-employment relationships between private physicians and hospital entities. With

careful planning and thorough legal review, these relationships can exist and can flourish. It is important to stay abreast of the evolving regulations and maintain a transparent relationship that can be adapted to changing needs on both sides.

There are many models for collective associations between private physicians and hospitals from single service to all inclusive. Following is a discussion of each of these categories with suggestions for successful application. It is important that any surgeon entertaining a relationship with a hospital or other service provider have all transactions carefully reviewed by legal counsel experienced in health care regulation.

Many physicians receive little or no training in how to start and maintain the administrative part of a medical practice. Management services can be negotiated with a hospital, either directly if they have employed hospital based physicians, or indirectly if they have a separate entity for owned practices. An all inclusive management contract can be negotiated while still retaining ownership of the physician services. This would include leased space, personnel, billing and collection services, scheduling, health information and record retention, and supply purchasing. Alternatively any one of these management streams can be individually negotiated. For young physicians starting their first practice it is reasonable to have an all inclusive management agreement. As your business experience grows, you will begin to refine that relationship in accordance with your personality and needs. Some important things to consider when negotiating a contract are your best interests and your autonomy. Have a written contract that carefully outlines the agreements made between the two parties; do not rely on a "gentlemen's agreement." This contract should be reviewed by an attorney that is retained by you individually and who specializes in medical contracts. Global management contracts should have individual subcontracts or lease agreements for office space, health information and record retention software and hardware, and equipment lease or loans. This allows for dissolution of part without mandatory disruption of all. All good arrangements should have an equally careful plan for the dissolution or modification of the arrangement. This helps to protect your autonomy should the arrangement no longer suit you.

Starting with leased space, remember that while long-term leases are often cheaper, they can also commit you to a space for a longer period of time than the space suits your needs. The hospital is required to offer leased space at fair market value, so do your homework and be prepared to know that relative value. Do not be afraid to insist on your desired quality and size for your space. Oftentimes the hospital is used to dealing with primary care physicians or general surgeons and may not understand the vision you have for a plastic surgery office. While a new practice needs to be cost effective, some aesthetic details will pay for themselves with patient referrals for cosmetic cases. If part of your lease agreement is shared space with another practitioner, make sure the contract is clear as to the future retention of the space in the event that the relationship between the two providers does not work out, or additional space is needed prompting the separation of the two practices. Do not wait until each party is firmly entrenched to decide who has the right to the space in the long term. Some office use agreements can be negotiated on a short term basis similar to renting a furnished apartment.

This may allow you to have different space in which to see certain patient populations, such as seeing breast reconstruction patients one day a week at the hospital's Women's Center, or seeing skin cancer patients at a hospital owned satellite clinic. Be open to opportunities to expand or improve your access to patients.

Early in a practice, shared personnel is an excellent way to limit the cost of overhead. Contract employees from the hospital will allow for a great pool of part-time employees. Contract employees also allow you to pay a simple payroll fee with the benefits provided by the hospital. These benefits are often much more attractive (better health insurance, disability and retirement plans) than the same money would buy without the advantage of their larger numbers. You should participate in the hiring process for employees placed in your office. Ideally you should participate in determining which employees are chosen to work on your accounts and your contract even if they are not exclusive to your practice or in your office. You should always retain the right to remove an employee from your office. If the hospital is unable to comply with firing a contract employee because of regulations that pertain to EEOC, you should still have the right to remove them from your office. The complexity of HR regulations for the hospital is a disadvantage compared with the more streamlined "at will" statutes for small businesses in most states.

While sharing overhead with another plastic surgeon would seem to be an ideal scenario, it is often a complex issue similar to a marriage. Sharing with an unrelated surgical specialty or even a medical specialist can have the advantages of reduced overhead without competition for business. It is good to carefully outline the relationship including exit strategies and timeline for reassessment. Time commitments of shared personnel and space should be as defined as possible to avoid scheduling conflicts. Divided loyalties of shared staff are always a potential problem and should be considered when making the agreements. It is important to understand that while not all professional relationships will work out, all work relationships should be conducted professionally. Regularly scheduled office meetings are an important avenue for open communication. Shared equipment such as front office equipment, computer hardware, and even some clinical equipment such as autoclave and surgical equipment also reduces initial outlay costs. It is important to remember that it does increase the amount of usage each item gets shortening the life span of the equipment. Highly specialized equipment such as lasers and some surgical instruments require very careful use agreements, not only to avoid conflicts, but also to limit each individual's liability.

You should personally review your billing and accounts receivable with the representative assigned to you. For young surgeons this provides on the job training in an area that is neglected in our residencies. As time goes by, you will become more familiar and will need less time for review. Ultimately you will establish relationships that with a transparent system will allow for quick assessment on a quarterly basis. If you are lucky enough to have someone you trust who has the skills to take over this part of office management you can ultimately surrender this task and bring this outsourced element into your own office. You should also carefully track all office expenditures and collections with strict protocols

for daily cash reconciliation that can be reviewed closely. Again, early on this is a learning experience, and will protect you from fraud from staff. You can negotiate as part of a management contract the use of hospital linens and linen service. Private services are often expensive. Be careful of using the hospital linen processing if you decide to invest in high quality spa garments as they will wear quickly when subjected to the mass processing and potentially be lost within the larger hospital system.

Some less obvious advantages to a management contract with the hospital are found in the standard exposure your practice will be given to other managed or owned practices. Hospitals tend to offer coding and compliance meetings to their contract employees who then interact with their counter parts from other offices.

A Physician-Hospital Organization can be a separate entity which allows a pooling of resources for negotiating contracts with regional insurance carriers as well as single source credentialing with participating carriers. This same entity would be a resource for the clinical needs of a community and as such can provide information to determine critical specialties for recruitment. This group acts as an oversight to ensure diversity of clinical coverage for the community at large and the hospital in particular.

Stark phase III has changed the way hospitals can offer recruitment and retention packages. With appropriate legal counsel, physicians can receive some compensation for relocating or avoiding relocation that is separate from any management contract entered into. This includes funds to physically move or salary guarantees to offset the financial lag in establishing a new practice. Retention packages are a bit more complex and must be triggered by a bona fide offer by an outside party for the physician to relocate somewhere else.

Compensation for emergency department call is another evolving relationship with the hospital which has the potential to help in tough economic times as well as mitigate the loss of appropriate specialists in the ED call roster. It is felt to be justified for those specialists with particularly busy call, a lot of uninsured patients, in areas of high malpractice claims by ED patients, or for those physicians who take more than expected amounts of call (more than one in three or four nights). There are several models for determining compensation including flat stipend, balanced coverage stipend (aimed at offsetting uninsured care), tier-based stipends, fee-for-service RVU based compensation, and complex combinations. It cannot be repeated too often that regulations change and all agreements between a private physician practice and a hospital entity must be reviewed by legal counsel.

As the push for electronic medical records intensifies, a negotiation for shared investment in EMR software with hospitals or their owned practices is an evolving trend. This is not only a financial advantage, but also a communication advantage of one system between the hospitals and the referring physicians. Similarly, as the federal government is increasing scrutiny on quality performance tracking, more automated systems and greater physician involvement can result in shared software that allows for more efficient tracking that will also be compliant with physician quality assessments for maintenance of certification.

Collaborative ventures such as free standing surgery centers that are owned by the hospital and individual surgeons are another means of helping each other fulfill a need that individually may be out of reach. Similar projects include outpatient care centers, and centers of excellence such as comprehensive breast care centers which will be examined separately later in this document. The models that exist provide for differing incentives to indirectly increase utilization of hospital services or reduce the overall cost of providing care. These are complex relationships that merit more discussion and very extensive legal review to ensure compliance with the Stark Law and anti-kickback legislation. Note, investments in hospitals by physicians under the so-called "whole hospital" ownership exception to the Stark Law, were limited to investments existing as of December 31, 2010 by the Patient Protection and Affordable Care Act of 2010.

One often overlooked shared resource that the hospital provides is professional networking. Most hospitals have a patient directed newsletter and providing patient education pieces for this publication helps to educate the community and put your practice forward. Similarly most hospitals have patient education seminars for the community and volunteering to talk at these showcases your interests, as does participation in hospital sponsored physician education. Physician listing on the hospital webpage and in physician directories broadens your practice visibility as well. Understand that Stark regulations do limit what the hospital can do for you as an individual, but many of these opportunities are open to all physicians at the hospital and are therefore legal.

Participation in hospital governance is a valuable means of creating relationships both clinical and administrative and allows you to have a voice in the running of the hospital. The better the relationship between administrators and clinicians, the more effective is the hospital mission of caring for the community. This relationship should be viewed as a shared resource for your practice. While federal regulations clearly complicate the interactions of private physicians and hospitals, the mutually beneficial relationship between these entities should not be overlooked when considering shared resources.

REAL WORLD EXAMPLES

The following case studies are provided to demonstrate how the concepts of the Independent Practices with Shared Facilities model can be put into practice in the "real world."

CASE STUDY - SOLO PRACTICE WITH AN INDEPENDENT PRACTICE ASSOCIATION (IPA)

Overview: Solo practice doctors find themselves at a competitive disadvantage in the current medical marketplace where corporate hospitals and insurers keep driving down physician reimbursement. The solo practice doctor either accepts the presented terms or is denied access to the corporation's patient population.

An interesting model for evaluation is the Independent Practice Association or IPA. This is a doctor owned and operated corporation whose members agree to accept terms negotiated for the group by the

corporation. This is a multispecialty group whose members are providers but also shareholders in the greater corporation. The physicians maintain their own offices and staff. In fact, they are completely autonomous in the practice of medicine, but now share a contract with the hospitals and insurance companies to care for the patients managed by the hospital and insurers.

Physicians decide who is allowed to enter the group and how many of each specialty. Patient care and expenses are monitored throughout the year. All departments are budgeted. Physicians receive the agreed upon compensation for patient care. At the end of the year, if additional monies are present, the dividend is divided amongst the providers according to formulas generated by the IPA.

This organization brings the power of collective bargaining to the physician creating a better balance to the negotiation with hospitals and insurers and improves physician compensation.

Reasons to Consider this Model:

- The future of medicine is clearly moving to increased regulation and government involvement. The greater your organization and resources, the more power you have to control your own destiny. Hospital and insurance lobbyists have proven this for years. Physicians need to organize to protect the practice of medicine and the patients we care for and about.
- The IPA is a means of unifying the medical community to speak with one voice in negotiations with hospitals and insurance companies; not only for appropriate reimbursement but also to influence policy on coverage.

Advantages:

- Preserves practice autonomy
- Allows access to larger pool of patients
- Allows better reimbursement than might be negotiated by the solo practitioner
- Improves bargaining power of all physicians involved on local and possibly even regional level
- Improves physician camaraderie and creates an “esprit de corps”

Potential Problems:

- Number of specialty members is limited and determined by the IPA
- Solo physicians must relinquish some autonomy upon joining the IPA
- Care must be taken to monitor state laws regarding collective bargaining and antitrust
- IPAs are independent entities established by physicians and are generally run by physicians. There can be great variability in how the IPA is structured and run. Like all businesses they can be structured poorly and fail

Other Factors/Barriers:

It can be difficult to organize physicians. Entrepreneurial, intelligent, and opinionated people are difficult to bring together. The magnitude of the current medical environment should scare enough of us into creating appropriate alliances.

Overall Recommendation:

This can be a powerful model when applied as an addition to a solo practice. However, it is one component of a diversified practice and not a stand alone formula for practice building. This is likely to become an important tool in structuring plastic surgery practices in anticipation of the changes coming over the next few years, and further investigation into structuring a subspecialty IPA with the associated advantages would probably prove fruitful.

CASE STUDY - SOLO PRACTICE WITH A PRACTICE MANAGEMENT COMPANY OR MBA AS MEDICAL PARTNER

Overview: Solo practice doctors are not just doctors, they are small business owners. Our educational system tends to create wonderful doctors but terrible business people. Managing and running an office is a full time job which requires as much effort as staying abreast of medical knowledge and caring for patients. Practice management companies have recognized this and created services which can be outsourced or delegated to the nonmedical professional. A physician can customize the services they wish to outsource from medical billing all the way through a turnkey operation including staffing and payroll. Private companies exist, and now hospitals have begun offering these same services.

Some financial management companies can offer a variety of services to independent healthcare practitioners that otherwise they may not be able to afford alone. These services can be chosen from an “a la carte” style menu and can be tailored to the practice’s needs to include:

- Insurance contract negotiation/renewal
- Physician credentialing
- Fee analysis
- Financial audits
- Utilize the messenger-model process for participation with managed care contracts
- Offer group purchasing contracts
- General financial practice consulting

Reasons to Consider this Model:

- Advances in medicine and medical care require more of physician’s time to stay abreast of the craft.
- The changing marketplace of cosmetic medicine has made advertising, Internet presence and office efficiency more important than ever. The changes in Internet and electronic medical records (EMR) alone necessitate an expert in these fields to grow a practice. Understanding business and being good at it is far more important today than ever before. Government regulation, hospital and insurance manipulations and a fiercely competitive marketplace will destroy an inefficiently run practice.

Advantages:

- Frees the doctor to concentrate on medicine
- A fixed pricing structure can be arranged to manage overhead
- The management company hires and fires employees
- Minimal outlay of capital and can reduce number of employees
- Physician has a central point of contact for conflict resolution
- Autonomy to select from a menu of services depending on need
- MBA partner has a vested interest in the financial success of the practice

Potential Problems:

- Employee loyalty
- Physician must still monitor services and money to assure quality and honesty. You cannot assume your company is running things well. Ultimately it is your business.
- Little control over year on year costs
- No equity building in the practice over time
- MBA partner will be more expensive than traditional office manager

Overall Recommendation:

This appears to be a promising model when applied as an addition to a diversified solo practice. Physicians need to work on their strengths and hire to address their weaknesses. As a doctor you can not do it all, and rarely can a limited office staff do everything that needs to be done well.

CASE STUDY - SOLO PRACTICE IN ACADEMICS WITH SHARED RESOURCES

Overview: An academic group practice now with five physicians formed five and a half years ago for the purpose of opening a new satellite suburban office 22 miles from the base to facilitate the growth of cosmetic surgery practice for the faculty and the residency educational program. The University Physician practice group had recently completed construction of a small ambulatory surgical hospital with a nice office facility 100 yards away in an area of town with very positive demographics. For the first two years the model involved sharing resources between plastic surgeons based at the Children's' Hospital and the University. For the past three years, the group has grown to include a facial plastic surgeon from ENT.

The Department of Surgery at the University took all the initial risk for the lease, build out, and support personnel as part of a recruitment package when this contributor assumed responsibilities as Division Chief. Our childrens' based faculty had an interest in maintaining an adult practice, and we are closely linked through the residency program and cross coverage for the adult/pediatric practice at the home base. Allocation percentages of expenses were linked to an agreed-upon percentage of utilization.

The practice is based on referrals/positive experiences from reconstructive work, an extensive skin care practice "medispa" in the office, and some traditional marketing. The financial risk of the skin care program-salary for a very experienced aesthetician, laser/IPL leases/inventory management-rests with the Department of Surgery. Profits from the skin care go directly to reduce the overall fixed expenses of the office.

Reasons to Consider this Model/Advantages:

Higher resource utilization goes toward reducing individual expenses. All the practitioners in the group share an interest in maintaining some balance of a "hard core" academic/reconstructive practice and a very customer focused practice that supports the practice of cosmetic surgery.

Potential Problems for this Model/Disadvantages:

Group members will have different ideas and levels of commitment about office operations/expenses/investments. Some additional "keys to survival."

- An on-site competent office manager who is respected by all parties
- Regularly attended meetings of the business managers from the different groups with transparent reporting and tracking of calls/referrals/office visits/surgery done
- Significant personal trust of the groups' leadership and MDs
- Someone needs to take the risk and lead. In this case, the contributor and the Department of Surgery made the initial commitment and took (take) the ultimate financial risk. It is important to try hard to be fair and reach consensus with the group, however, ultimately someone has to make the major decisions about the office.

Legal Ramifications/State Law Considerations:

Be careful about state regulations regarding delegation/supervision of an aesthetician (this is not specific to group practice).

Other Factors/Barriers:

It is challenging balancing academic responsibilities and maintaining quality service at locations 22 miles apart.

Overall Recommendation:

This effort has significantly helped grow this aesthetic practice and enhanced the resident educational program. The residents go with the attending physicians for surgery and also see pre/post-op patients there.

Characteristics of an unsuccessful group practice:

This type of model can become unsuccessful when the following factors develop:

- Uneven distribution of resources
- Non-collegiality and unfair competition
- Inequitable marketing of physicians within and outside the Center by the Center
- Unequal charges to physicians for the same session time and space
- Staff loyalty to particular physicians
- Minimal group communications/poorly attended meetings
- Lack of effort by all physicians involved to make it successful

CASE STUDY - SOLO PRACTICE JOINT VENTURES WITH HOSPITAL; OUTPATIENT SURGERY CENTER, LLC

Overview: A group of individual surgeons with separate independent practices began the process of planning a joint venture for a freestanding surgery center. The community hospital at which all had their primary surgical privileges entered into the venture and a jointly owned and operated free standing surgery center was created. They formed a Limited Liability Corporation with 50% ownership held collectively by the surgeons, and 50% ownership held by the hospital. Each investor paid the same value for an individual share which provided seed money for the project, and were required to promise additional funds if needed to get the enterprise going up to a preset limit with the board approval of additional need. Each member is considered a part of the corporation and pays individual taxes from the profits of the center, and each member retains its separate clinic practice.

Advantages:

- Shared risk of start up
- Surgeon investors have motivation for success and bring clinical perspective to the business, while hospital brings business experience to the project.
- With literal surgeon buy-in they are more willing to consider the financial aspects of the project and to cooperate with cost containment.

Limitations/barriers to success:

- Joint venture with the hospital changes the regulations governing the enterprise which can complicate the project.
- Each owner investor has the potential view that they are entitled to preferential treatment (best OR time, best resources) because they are a part owner.
- A small group of surgeons can result in potential conflicts of interest between individuals as well as the hospital.

Factors critical for success:

- Diversity of case types with strong recruitment of surgeons, including non-investors.
- This type of complex joint venture requires careful planning for development and operation to be compliant with Stark Law and Anti-Kickback regulations. This particular venture was protected by anti-kickback safe harbors regarding investment in ASCs and physician investment in underserved area as defined by a community evaluated certificate of need.

Overall Recommendation: This particular shared surgery center model can be very successful and profitable in a tight economy allowing for efficient outpatient surgery in an attractive environment with less traffic and parking issues of the hospital. It utilizes a very diverse case mix and is responsive to the needs of the surgeons.

UNIQUE GROUP PRACTICE MODELS

The Task Force identified several unique group practice models that recognize the changing environment within which medicine is practiced as well as the distinct needs of plastic surgeons. As clinical innovators, plastic surgeons must translate this skill set to the business and administrative aspects of their practices so as to remain economically competitive. The following case studies examine two of these business models in depth.

CASE STUDY - VIRTUAL GROUP PRACTICE

The virtual group practice concept is already being applied in at least one existing plastic surgery partnership. In this case, the plastic surgeons maintain their own independent cosmetic practices and have formed a separate legal entity with other plastic surgeons for the reconstructive (i.e., insurance-based) component of their practices. To our knowledge, this represents a new concept in group practice, and this “reconstructive corporation” could exist within a town, state, or across state lines, with no apparent limit as to the number of practitioners. The goal of this model is to develop a long-term, sustainable practice platform which is responsive to the rapidly changing healthcare environment.

Reasons to Consider this Model/Advantages:

The proposed advantage of this model is it allows the individual practitioner to maintain his/her independence in the cosmetic aspect of the practice (if desired), yet achieve the potential benefits of group contracting and economies of scale for their reconstructive practice. In addition, the “reconstructive corporation” (i.e., corporation or LLC) can explore the possibility of tax-exempt status. The potential advantage of this includes tax benefits should this “reconstructive corporation” choose to purchase property (e.g., real estate or surgical facility), although states are increasingly reluctant to grant this exemption to not-for-profit organizations. There are many additional advantages:

- **Economies of Scale:** cost advantage that a business obtains as a result of expansion-average cost per unit decreases as scale is increased.

The majority of ASPS members are solo (or small group), private practitioners with a blended practice (mix of cosmetic and reconstructive). The changing environment of medicine is threatening the survival of the traditional solo or small group practice model. The opportunity to achieve economies of scale is essential in remaining financially competitive in a depressed economy with increasing overhead costs.

This economies of scale can be translated to advantages in purchasing (i.e. bulk buying), managerial expertise (i.e. increased specialization and expertise of office managers), financial (i.e. group contracting for insurance contracts, liability insurance premiums, lower borrowing costs for lines of credit, etc...), group marketing, and clinical specialization (i.e. ability to recruit specialized physicians-microsurgery, craniofacial, etc...).

The following specific examples illustrate current threats to the traditional solo or small group practice model:

1. **Payment Bundling:** a concept currently implemented by Medicare on a trial basis. This new payment structure will limit the ability of the plastic surgeon to contract with third party payers. Perhaps more importantly, this will strengthen the bargaining power of the hospital at the expense of the physician. The proposed model would allow physicians to engage in group contracting with the hospital.
 2. **Electronic Health Record:** the decision for implementation of an EHR is no longer if, but when. The advantages of the EHR include the ability to gather and track clinical and outcomes data for the purposes of patient care and improved reimbursement. Additionally, the ability to compile data from multiple providers may represent a competitive advantage for negotiation with third party payers and/or hospitals. However, implementation of the EHR is expensive. The ability to distribute this cost over multiple providers is helpful. Furthermore, if data can be provided from multiple providers, this may help satisfy some of the proposed “meaningful use” requirements.
- **Flexibility:** This model allows the individual plastic surgeon to maintain his/her own identity for the cosmetic portion of the practice. Individuality and flexibility are important for many ASPS

members and may represent a primary reason for their initial decision to embark on solo practice. While the opportunity to fully integrate their practice into the “reconstructive group” would likely exist, this may be done on a transitional basis.

- **Physician Decision-Making and Autonomy:** This model maintains the physician at the center of both medical and administrative decision-making in their practices. While it is likely that business managers would be required for the functioning of this model, they would report to a board of directors comprised of physician-members. This serves to maintain the integrity of the physician-patient relationship which is core to the practice of medicine.

Potential Problems for this Model/Disadvantages:

- **Change in Physician Thinking:** This represents a new business model and requires a change in the traditional beliefs as to the structure of solo and small group practices. It requires an acknowledgement that a business-as-usual approach will not represent a sustainable, long-term practice model.
- **Applicability:** Over the past several years, there was a shift among ASPS members to a more cosmetic-based practice. This resulted in many ASPS members foregoing reconstructive surgery. The ramifications of this strategy included a loss of relationships with hospitals and referring physicians (i.e. general surgeons for breast reconstruction) as well as a potential loss of advanced skills (i.e. microsurgery, cranio-maxillofacial surgery, etc...) or failure to acquire new reconstructive skills.

Perhaps inherent in the proposed model is the ability of member surgeons to perform up-to-date reconstructive procedures (DIEP flaps, cranio-maxillofacial surgery, hand surgery, etc...). These may be services which hospitals and/or insurance panels consider important when negotiating services and professional fees. For surgeons who no longer perform complex reconstructive procedures, their inclusion in this group model may be limited.

- **Implementation:** Once physicians have agreed with the concept, implementation of the model will likely be a challenge. Although potential implementation difficulties are not unique to this model, guidelines for participation will need to be established at the beginning of the process.
- **Decision-Making:** Although the member-physicians will retain autonomy outside of this legal entity, there will be the need to have a coordinated mechanism for decision-making within this entity. Whether this is a medical management group or board of directors, the member-physicians will relinquish independence of certain functions.

The purpose of this is to achieve the benefits of group contracting and economies of scale. Furthermore, as opposed to other models, (i.e. hospital-employed), decision-making would rest with a physician group.

Legal Ramifications/State Law Considerations:

- **State Laws:** Applicability or feasibility of model across state lines or within certain states may be limited depending on the given state.
- **Anti-trust Concerns:** If the corporate structure is appropriate, these concerns can be addressed.

Other Factors/Barriers:

This model may also be used as a transition model for a fully integrated practice. While some physicians may be reluctant to integrate their entire practice within a new corporate structure in a single step, this model may allow them to transition into a larger entity over a period of time.

Applicability to Academic Practitioners:

This model does not preclude member-physicians from engaging in academic pursuits. Although the member-physicians may not receive income from a university, this model allows for educational and research opportunities within the proposed structure. Also, this model may be applicable to university-based physicians and may have some advantages (i.e. the ability to separate salaries and liability insurance from the university). However, possible drawbacks from the perspective of the university include the potential for loss of control over member physicians (i.e. ability to hire/fire, ER call, etc.).

Overall Recommendation:

This model may represent an alternative to a traditional large group practice. The potential advantage of this model as opposed to a single, large group practice in which all physicians are employed by a single entity is flexibility. This model will allow the physician to retain a certain degree of independence outside the corporation, while achieving the benefits of participating in a group.

Characteristics of an unsuccessful group practice:

- **Lack of Mission Statement:**
Although differences within the group structure will occur, the group must be committed to the concept of a group practice with a clear understanding of the overall goal.
- **Lack of Transparency:**
The processes by which decisions are made should be clear, and it is the responsibility of the executive committee and/or board of directors to articulate the rationale behind important decisions.
- **Lack of Method to Resolve Disputes:**
The processes by which disputes and disagreements are resolved should be clear to the member-physicians.

CASE STUDY - COOPERATIVE GROUP PRACTICE (ACADEMIC/ PRIVATE PRACTICE HYBRID)

Overview: An ASPS member formed this department of Plastic and Hand Surgery about 14 years ago. It has provided consistent coverage of the county hospital (a Level I trauma center and teaching hospital affiliated with the local university). The department experienced steady growth from a single physician to a group of seven, with three PAs and a nurse practitioner. The practice is affiliated with a nonprofit integrated health system. All health systems in this state must, by law, be nonprofit. It is a cooperative, meaning that members (e.g., purchasers of insurance products) play a role in determining the direction of the company. For example, the Board of Directors is composed of community members of the health system. The goals include provision of health care for “members, patients, and the community” which is “patient and member-centered, safe, effective, timely, equitable and effective.”

Plastic and Hand Surgery is a department within the health system

(giving us individual negotiating power) but a Section within the hospital's Division of Surgery. Physicians are hired by the multispecialty corporation, but recruited by the department. Reimbursement is negotiated by each department within the group and may be based on RVUs, flat salary, or other methodologies. Each plastic surgeon is compensated based on individual productivity and receives the same payment per RVU generated. Reimbursement is benchmarked against Medical Group Management Association (MGMA) standards. Half of all monies received for cosmetic procedures go to the physician who performed them. The hospital reimburses the department for teaching and certain leadership positions. Departmental overhead includes allied health personnel, administrative staff, office rental, and professional fees, while liability insurance is covered by the corporation. Some departments contract with the hospital directly and are not health system physicians (e.g., Orthopedic Surgery, Radiology, Anesthesiology).

Reasons to Consider this Model/Advantages:

- Stable patient populations: Purchasers of the health system's insurance are encouraged to seek care through its physicians, thereby resulting in a large patient population. The hospital and clinics accept most insurance plans (including Medicare, Medicaid, State assistance (GAMC) and Workers' Compensation).
- Focus on clinical care: Plastic and Hand Surgery physicians are reimbursed based on RVUs generated, not on collections, allowing physician judgment to direct patient care.
- Cost/Overhead management: The group and the hospital negotiate prices for supplies and equipment, with minimal need for physician involvement in the business aspects (i.e., hiring/firing, negotiating contracts, inventory, etc...) of the practice. The system has installed an electronic medical record for both inpatient and outpatient care.
- Systems to optimize quality and safety: Physicians are heavily involved to ensure that reasonable measures are created.
- Collegiality: As long as basic needs of the institution are covered, members of the group may develop focused practices (if the group allows). There is also the capacity for cross-coverage of patients.

Potential Problems for this Model/Disadvantages:

- Compliance with institutional guidelines: Physicians must comply with institutional guidelines (though there is the opportunity to affect them through committee structures.)
- Lack of flexibility: Institutional decisions (i.e. use of unionized employees) decrease the flexibility in hiring decisions.
- Employment Structure: Employment may be at-will; the contract may be terminated without cause at any time. Physicians may not be comfortable with this arrangement.

Legal Ramifications/State Law Considerations:

- State Laws: In this state, all integrated medical groups must be non-profit. This may vary depending upon the state.
- Legal Risk: Because of cross coverage arrangements, there may be shared liability. Trust and selection of congenial partners are necessary.

Other Factors/Barriers:

This structure requires a large home institution. Trauma centers work well due to their need for specialty coverage as well as a continual source of patients for physicians.

Applicability to Academic Practitioners:

This practice is modestly academic. Residents from the university spend much of their time at the hospital, and the hospital has several independent residencies and fellowships. The health system has a large Research Foundation which provides internal funding and can assist with extramural grants. There are no research requirements for attending physicians, but each plastic surgery resident and hand fellow is required to participate in an annual project (most are clinical projects, but there is limited laboratory space).

Overall Recommendation:

The private/employee/academic hybrid is an underappreciated model, but a reasonably stable construct. It provides an interesting case mix, the opportunity to train surgeons, and does not require surgeons to become business people. It allows for patient care, without the physician monitoring the patient's insurance status. This model was featured in an October/November 2009 *Plastic Surgery News* article.

CENTERS OF EXCELLENCE

Centers of Excellence is a term widely seen in the realm of medical marketing. It can be defined as an outstanding program in a specific specialty that is developed to attract more patients, more physicians, more recognition and more revenue. It can make a hospital or group of physicians a destination in an area of care and confer a competitive advantage in recruiting patients or new physicians.

There is no accrediting body to the term "Center of Excellence" (hereafter referred to as COE). A practitioner can self-designate his practice as a COE, and this self-designation is seen in some plastic surgery practices around the country. However, the ASPS Ethics Committee has cautioned against using the term when the practice has not engaged in a formal credentialing process. The COE designation can come from industry, with Cynosure applying the term to practices that meet their criteria for state-of-the-art laser medicine. A society can create the designation. The American Society for Metabolic and Bariatric Surgery founded the Surgical Review Corporation to create Bariatric Centers of Excellence. Finally, government can get in on the act, with the National Cancer Institute designating 65 Cancer Centers across the country.

Many of the different types of COEs for plastic surgeons dovetail with the myriad of group practice options. Given the majority of plastic surgeons in solo or small group practices, the most logical progression to a COE would be partnering with a hospital. As previously discussed, any relationship between a physician and hospital creates a number of legal concerns, not the least of which are the federal anti-kickback statute and the Stark self-referral law.

The leaders of any COE development effort must be able to defend the proposition from both a legal and business perspective. The major question to be asked is whether the plan is one that will expand a specific area of care, or one that simply attempts to capture referrals. The overall goal is to become dominant in a specialty area. Specific strategies are

developed to carry out the goals. Is the program trying to be the regional leader in breast reconstruction or aesthetic medicine? Will research or teaching be part of the program? Such goals would be a responsibility of the leaders of the project.

Virtual Center of Excellence

A center without walls would be the simplest option for a private practice plastic surgeon who wishes to remain as such. Numerous such virtual centers exist in the university setting. A Northeastern Medical Center recently added six new COEs in areas including addiction, skin cancer and musculoskeletal disease. Independent plastic surgeons, subject to antitrust requirements, could join with a hospital to build a brand around specific services, such as aesthetic surgery or postbariatric body contouring. A joint marketing program can be developed in which the physicians and their hospital counterparts work together to decide how they can approach the market in as aligned a manner as possible. Regular strategic meetings would be held to discuss marketing and implementation options, which could include financial relationships and compensation.

For the practitioner who wishes to remain in private practice, aside from the added revenue from increased patient volume, what form might any additional compensation take? A hospital partner could pay physicians for call or trauma coverage, teaching, research, medical directorships or administrative roles. Any arrangement must be in writing and cannot vary or have payments tied to the volume of referrals to avoid running afoul of federal anti-kickback laws. Similarly, if a physician were to rent office space from a hospital with which a COE were developed, any rental charge has to be consistent with fair market value, and the space rented should not exceed that which is reasonably necessary to accomplish the business purpose of the rental.

Semi-Integrated Centers of Excellence

Similar to the evolving models of medical practice, physicians can pursue semi-integrated models for centers of excellence. These could revolve around joint ventures for surgery centers, joint ventures for equipment and real estate or joint ventures for management services. A surgery center, together with its core plastic surgeons, could market a particular COE for its aesthetic or reconstructive services. Any legal roadblocks would presumably have been addressed during the by-laws and contract negotiations for the ASC.

Another type of semi-integrated COE would be a professional services agreement whereby a hospital would purchase the services of members of a group, but the group would remain independent. These physicians could form the sole basis for a COE, or they could be integrated with existing salaried hospital physicians. Of course, all such contracts have to be pursuant to the Stark Act.

Fully Integrated Centers of Excellence

If a hospital acquires a solo or group practice, and the physicians become hospital employees, the foundation for a fully integrated COE is in place. Many markets have shown that physician employment is often a critical part of developing a dominant service line. A less common example of a fully integrated model is a joint venture between a hospital and physicians, essentially a specialty hospital. Physicians have a

financial stake in the facility, but the hospital may be part of a larger hospital system. In this latter case, the entire facility could be viewed as a COE. The success of specialty hospitals has led to a debate as to their detrimental effect on the entire health care system, with cherry-picking of the healthiest and best-insured patients. There is no debate as to their success in dominating a specialty market.

Managed Care Strategies

Getting involved with a managed care entity may have the least appeal to a plastic surgeon, but physician-hospital organizations have marketed a package of specialty services to a MCO. Less common now than a decade ago, this approach may have a revival with increased consolidation of payers. Not a COE in the strictest sense, it nonetheless is another way for providers to come together for purposes of marketing a specialty service. This needs to be distinguished from the cosmetic surgery networks offered by some insurers in which discounted fees are being offered as a member benefit. The quality of the surgeons in these networks has been one of the criticisms by those plastic surgeons who have steered clear of any managed care contract.

Overall Recommendation:

If a change in one's practice structure is not an immediate consideration, getting a group of plastic surgeons to work with a hospital to create a virtual COE seems one of the easiest ways to get up and running quickly. Any reputable hospital confers instant legitimacy to a physician venture. The hospital's marketing and legal teams are in place, and presumably the plastic surgeons involved would already be part of a call group so that further physician recruiting would not be needed. This COE concept is one more reason why plastic surgeons in the coming decade abandon hospitals at their own peril.

CASE STUDY - CENTER OF EXCELLENCE AFFILIATED WITH A UNIVERSITY (PRIVATE/ACADEMIC AFFILIATION)

Overview: This case is based on a discussion with the head surgeon from a private small, four-surgeon group that has been affiliated with a university for around 20 years. It is really only the main head surgeon that interacts with the residents. This relationship was established rather informally a long time ago and has continued with modifications. No guidelines or formal contracts were used, and there is no financial remuneration. The residents spend currently less than one day per week with the head surgeon for cosmetic exposure and it is case dependent.

Advantages (from the head surgeon's perspective):

- Satisfaction of training young surgeons
- Help (and authorship) with writing chapters, publications
- Educational – residents are inquisitive and ask a lot of questions which motivates him to keep up with topics that aren't necessarily relevant to his cosmetic practice
- Benefits to resident training (unique surgeries, exposure to private setting, greater cosmetic exposure)
- Potential to move forward to subsidized fellowship as some have done in other states

Risks/Barriers:

- Competition if the residents stay in town (not a huge issue in this case)
- Coverage policy needed for resident when not operating at a facility associated with the university – formal letter required verifying coverage

CASE STUDY - UNIVERSITY-BASED CANCER CENTER

Overview: The Director of Marketing, Communications and Physician Services, and the Executive Director of Research and Business Administration from a university-based Cancer Center were interviewed for this case. These individuals noted that the center of excellence concept is not really a term used by their Cancer Center, although clearly it is a “center of excellence.” The interviewees feel it is a rather vague concept with no clear definition per se and without a universally standardized or accepted set of criteria. Rather it is defined by specialty as it pertains to their area and interests.

The Cancer Center has unique NCI (National Cancer Institute) and NCCN (National Comprehensive Cancer Network) designation, and each of these do have specific criteria. The NCI designation is based on a grant and requires components of basic science, clinical research, and prevention and control. The NCCN designation is more specific to clinical practice and translation and even more selective. But there are other societies/ organizations that do offer a “center of excellence” certification based on their own defined criteria and for a fee. The Center recently received a proposal from the American College of Surgeons to establish itself as a center of excellence for breast cancer management but for multiple reasons they were not interested.

The university does have several other areas recognized as centers of excellence including vascular and urologic surgery. However none of these centers has anything to do with the other in terms of meeting standards or criteria for such a designation because they are all defined by their respective specialty societies on their own terms. It seems analogous to physician claims of ‘board-certification’ which may or may not be meaningful based on the certifying body but is perceived by the lay public as a unified and standardized certifying process and can therefore be misleading.

Advantages:

The benefits seem to be more toward the perceptions of referring physicians than the lay public. It tells the lay public that the Center has access to cutting edge translational therapies and treatments and that this is an area of specialty. Referring physicians have a better understanding of the implications of such designations and to them it is probably more meaningful in that regard. For the Cancer Center itself, other benefits exist for the recruitment of professionals, students, fellows, and staff.

Potential risks:

There are some risks and hurdles. To establish a center of excellence, various support systems may need to be created that may not already exist, such as human resources for maintenance and upkeep per criteria required by the certifying body, and a centralized IT system and infra-structure for data management and sharing. System changes/ modifications may be needed as COE criteria change.

CONCLUSIONS

Clearly there are a number of options for plastic surgeons considering forming a group practice, and a wide range of pertinent and individual variables to consider. Before you enter or change your practice, you need to know yourself and what you want to accomplish. You need to make a five-year plan and a 10-year plan. Spend some time for introspection. Write it down. Then, and only then, look carefully, check the options, make a decision that is right for you and your own personality and have a healthcare lawyer check any contracts.

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References

- 1) Allen, HS, Biga, CB, et al. *Practice Opportunities: Practice Integration, Management Contracts, Hospital Integration*. American College of Cardiology Foundation, Report of the Ad Hoc Task Force on Practice Management Strategies. March 2009. <http://www.acc.org/practicemgt/practiceintegration081209.pdf>
- 2) *Competing in the Marketplace: How physicians can improve quality and increase their value in the health care market through medical practice integration*. American Medical Association, Private Sector Advocacy Unit. March 2008.
- 3) *Fact Sheet, Federal Anti-Kickback Law and Regulatory Safe Harbors*. Office of Inspector General. November 1999. <http://oig.hhs.gov/fraud/docs/safeharborregulations/safefs.htm>
- 4) *How to fund the recruitment and start-up costs of a new surgeon*. Medical Group Management Association e-Source, June 2007.
- 5) Korman, JM, Furnas, HJ. *The Business of Plastic Surgery: Navigating a Successful Career* World Scientific Publishing Company; 2010. http://www.amazon.com/Business-Plastic-Surgery-Navigating-Successful/dp/9814277290/ref=sr_1_1?ie=UTF8&s=books&qid=1265130711&sr=1-1
- 6) Mabry, CD, Preskitt, JT. *Practice Management for Residents and Young Surgeons*. American College of Surgeons, Division of Education. Volumes I-III. Revised September 2009. Available on CD-ROM <http://www.facs.org/education/practicemanagement.html>
- 7) Michal, MH, Pekarske, MSL, McManus, MK. *Corporate Practice of Medicine Doctrine 50 State Survey Summary*. Reinhard Boerner van Deuren Attorneys at Law. 2006.
- 8) *Statement of Antitrust Enforcement Policy in Health Care; Statement 8: Enforcement Policy on Physician Network Joint Ventures*. Department of Justice and Federal Trade Commission. August 1996. <http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.htm>
- 9) Weiss, GG. *Is it time to team up?* Modern Medicine. June 1, 2007.

ADDITIONAL ONLINE RESOURCES

Centers for Medicare and Medicare Services (CMS): <http://www.cms.hhs.gov/physicianselfreferral/Starklaw.org>

Health Advisory Council: www.advisory.com (provides excellent detailed analysis of models already in practice for many of these categories with associated grades from hospital as well as physician perspective; must be a member to have access to this information)

EA Health Corporation: www.eahealthcorp.com

Medical Group Management Association: <http://www.mgma.com/about/>

American Health Lawyers Association. <http://www.healthlawyers.org/Pages/Default.aspx>

Healthcare Financial Management Association: helps members and others improve the business performance of organizations operating in or serving the healthcare field. <http://www.hfma.org/about/>

RECOMMENDED PROFESSIONAL RESOURCES

- ASPS and ASAPS for advocacy and continuing medical education courses on CPT and financial/practice management
- State medical and plastic surgery societies for assistance with recruitment, state law, and potential legislative obstructions
- American Medical Association for assistance with advocacy and legal issues
- The American College of Medical Practice Executives (ACMPE) certification organization for group practice professionals
- CPA
- Attorney
- Professional consulting groups – Karen Zupko, Dana Fox, Mentor Solutions/Inform & Enhance

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