I. Current Industry Trends

II. Strategic Alignment
   • Professional Services Agreements
   • PSA Case Study

III. Future Directions

IV. Q & A
Industry-Wide Comparative Overview

- Preparation for ACA’s “Full Implementation Year”
- Increasing efforts toward alignment and integration
- Greater skill in reimbursement methodologies (from volume to value)
- Greater focus on value-based reimbursement initiatives
- Improved ability to manage costs
- Increased provider involvement in decisions
- Stronger focus on improving care coordination

*Processes further along the year, still falling in development but gaining in prevalence

Provider Concerns in 2013 for 2014

Please rate the following factors in regard to the strategic concerns of your facility.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rating</th>
<th>Importance</th>
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<th>2014</th>
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- Reimbursement and alignment rated as the top two most important concerns of a health system
- Alignment is still considered a primary strategic response to the continuing financial challenges
- Alignment is also Stage 1 of an organization’s accountable care strategy (without alignment, clinical integration is highly unlikely)


Five Industry-Wide Alignment Trends of 2014

1. ACA/PPACA is a real threat to hospital financial wellbeing and increasing pressure on providers to develop accountable care models.
2. “Alignment” in advanced stages of accountable care structures will continue, analogous to what we have termed as “Stage 1.”
3. Compensation and pay reform for physicians within alignment structures will be continuing for many years through base, incentives, and cost savings.
4. Bundling and shared savings programs will continue to grow, which, increasing value among participating providers, will become a common practice.
5. Sharing of the gains (expecting physician-hospital alignment) will continue with the number of transactions considered increasing within 2014. As a result, physician-hospital alignment will be one of the most practiced initiatives as all providers “have” to do this for years to come.

Top Three Trends to Watch Out for in Orthopedics

1. With a growth in value-based payments such as bundled payment programs, orthopedics will likely continue to be a prime target for quality improvement and cost cutting initiatives.
   - As these continue, an increasing focus on accurately and appropriately measuring quality and the cost structure will likely result.

2. Operational improvement initiatives and care coordination efforts to rise in prevalence.
   - Orthopedics is gaining notoriety as a "team sport," where care coordination and operational streamlining can lead to better value for patients, physicians and payers and ultimately, more volume for the provider.

3. Adoption of technological capabilities that facilitate the value-based movement.
   - Orthopedics has also become a prime target for technology/IT vendors offering services and products geared toward cost cutting (in terms of decreased time/increased efficiency) and quality improvement (in terms of greater precision and reliability).

Source: Advisory Board, "What’s new in orthopedics: Top three takeaways from AAOS 2013," April 8, 2013

Orthopedics in the Accountable Care Era

- Focus on conservative treatment
- Decrease LOS, readmissions, and use of ER
- Look for shift in patient flow
  - Less inpatient
  - Have PCP and mid-levels handle more
- How to eventually address the metric of patient satisfaction

In-office Ancillary Services (IOAS) Bill

- Summer of 2013, bill was introduced that, in effect, would narrow the definition of Stark-exempt IOAS
- For orthopedics, this could ultimately impact in-office ancillary services such as advanced imaging and physical therapy services and reimbursement
- While the bill intends to control physician self-referrals, strong pushback from medical groups has resulted
  - With value-based care becoming a larger emphasis in healthcare, providers feel that IOAS could lead to improved care coordination and ultimately higher value for patients and payers
Driving Forces for Change: Paradigm Shifts

Traditional healthcare delivery model

- Fragmented care management focusing on sick people
- Episodes of care; utilization management
- Production (volume); Fee-for-service payments
- Disjointed provider base

Integrated care management focusing on preventative care

Coordinated delivery of care rendering appropriate services at appropriate place and time

Accountable care era health care delivery

Coordinated delivery

Deliver Value

Driving Forces for Change: Evolving Payment Models

- Fee-for-Service
  - Pay provider a good enough amount for each service provided

- Pay-for-Performance
  - Incentivize higher quality measured by evidence-based standards

- Value-based Payment
  - Percentage reimbursement at risk, awarded based on high quality outcomes

- Bundled Payments
  - Pay provider the episodes of treatment, shaped by bundled and discounted

- Shared Savings
  - A shared savings model where costs are cut in care, they share in the benefits, and savings

- Global Payments
  - Pay provider a lump sum payment that manages the patient across the delivery system

*It All Culminates to Value...

- Increase Quality
- Decrease Costs
- Deliver Value
The Ultimate Provider Challenge

Alignment vs. Integration*

- **Stage I: Alignment**
  - Common goals and objectives
  - More structural than functional
  - Medical staff membership
  - PSA
  - Employment
  - Tied together by legal and economic connections

- **Stage II: (Clinical) Integration**
  - Merged clinical and business models
  - More functional than structural
  - PCMH
  - ACO
  - Quality collaborative
  - CIN
  - Tied together by clinical and cultural connections

*Can be via both physician-hospital and physician-physician strategies

II. Strategic Alignment
Spectrum of Alignment Models

Independence → Increasing Integration → Hospital Employment

- Models that Fall Short of Employment
  - Managed care networks
  - Joint ventures
  - Medical directorships
  - Clinical co-management agreements
  - Professional services agreements
- Increasing Integration
  - Recruitment
  - Independent practice associations
  - Quality Collaboratives
- Limited Integration
  - MSO/ISO
  - Equity Group Assimilation
- Moderate Integration
  - Service Line Management: Management of all specialty services, within the hospital
  - Joint Ventures: Unites parties under common enterprise; difficult to structure; legal hurdles
- Full Integration
  - Employment: Professional services agreements (PSAs) and other similar models (such as the practice management arrangement) through which hospital engages physicians as contractors
  - ACO/CINs: Part of an organization focused on improving quality/cost of care for governmental or non-governmental payers; may be driven by practices or hospital/groups

Employment is not the only viable “full” alignment model!

Traditional Alignment Model Descriptions

**Limited Integration**
- Managed Care Networks (Independent Practice Associations, Physician Hospital Organizations): Loose alliances for contracting purposes
- Missions/Incentives: Economic assistance for new physicians
- Medical directorships: Specific clinical oversight duties

**Moderate Integration**
- Service Line Management: Management of all specialty services, within the hospital
- Joint Ventures: Unites parties under common enterprise; difficult to structure; legal hurdles
- Equity Group Assimilation: Tenets on legal agreement, joint profit
- Joint Ventures: Tenets on legal agreement, joint profit
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**Full Integration**
- Employment: Professional services agreements (PSAs) and other similar models (such as the practice management arrangement) through which hospital engages physicians as contractors
- ACO/CINs: Part of an organization focused on improving quality/cost of care for governmental or non-governmental payers; may be driven by practices or hospital/groups
- Group (Legal-Only) Merger: Unites parties under common legal entity
- Group (Legal and Operational) Merger: Unites parties under common legal entity with full integration of operations

Orthopedics and Alignment

Alignment strategies that fill short of employment are proving to be of greatest interest to orthopaedic surgeons as they look to invest in the accountable care environment.

Incentives and reimbursement/magnify changes in fee-for-service and make alignment an attractive strategy for orthopaedics in private practice.

- Physician to hospital alignment strategies outside of employment (such as the "SNH") use some or all of these mechanisms for making alignment attractive and increasing financial demands for independent orthopaedics.

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Professional Services Agreements: “Employment Lite”

Professional Service Agreements- Overview

Purpose
Achieve clinical and financial integration without employment

Relationship
Contracted services with multiple options that allow parties to fully align with private practices to stay independent

Services
Clinical (Professional) Services
Wraparounds possible (administrative, call, quality, etc.)

Remuneration
Typically paid on a top-line basis per wRVU. Wraparounds can take other forms of payment for services, if included

Four Popular PSA Models

1. Traditional PSA: Hospital contracts with physicians for professional services; hospital employs staff and “owns” administrative structure

2. Practice Management Arrangement: Practice entity “owns” administrative structure with hospital, administrative management and staff are employed by hospital, but physicians are employed

3. Global Payment PSA: Hospital contracts with practice for Global Payment; practice retains all management responsibilities

4. Hybrid Model: Hospital employs/contracts with physicians; practice entity spun-off into a jointly-owned MSO/ISO

PSA Offerings
• Flexibility in structure
• Opportunity to increase and enhance bottom-line for both Hospital and the Practice
• Stability in relationship with Hospital
• Bonus opportunities for exceptional performance
• Opportunities to expand services together without being fully aligned (i.e., employment and/or clinical integration)
• Easier segue to full employment for physicians and staff

Other Model: Hospital employs/contracts with physicians, practice entity spun-off as a jointly-owned MSO/ISO
1. PSA – Traditional Model

- Professional responsibility for providing medical services
- Compensation based on actual collections
- Support services provided by hospital
- Common overhead costs
- Reduced overhead and administrative costs

2. PSA – Global Payment Model: Economic Components

- Global payment
- Fixed overhead by practice
- Global comp
- PSA
- Practice Overhead

**Example**: For Illustration Purposes Only

**Practice Overhead**
- Fixed cost component
- Variable cost component

**Global Payment**
- PSA
- Compensation and Benefits
- Profit from practice

**Example**: For Illustration Purposes Only

**Practice Overhead**
- Fixed cost component
- Variable cost component

**Global Payment**
- PSA
- Compensation and Benefits
- Profit from practice

**Example**: For Illustration Purposes Only
3. PSA – Practice Management Arrangement

- Physicians retain ownership of their Practice infrastructure
- Physicians operate as the managers of the Practice, providing all administrative services, space, equipment, and support staff
- The hospital contracts with the Practice entity for these services and pays a fair market value (FMV) fee
- The compensation structure for the employed physicians is a productivity-based system
- The arrangement can be easily dissolved, as the Practice entity stays outside the Hospital control structure

### PSA – Model Comparison

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<th>Global Payment PSA</th>
<th>Practice Management Arrangement</th>
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<tr>
<td>Physicians Employed by Practice</td>
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<td>Staff Employed by Practice</td>
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<tr>
<td>Managed Care Contracting Negotiations Completed by Practice</td>
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</table>

*Depends on negotiated agreement

### Employment vs. Employment “Lite” Comparison

**Employment**
- Hospital purchases all Practice assets including all ancillary services
- Practice entity dissolves; Practice becomes subsidiary of the Hospital
- All Practice providers and staff become employees of the Hospital
- Practice physicians achieve the highest level of integration with the Hospital and ensure stability but bear a significant amount of independence and autonomy
- Easy segue to clinical integration and Hospital’s accountable care era strategy

**Employment “Lite” PSA**
- Comprehensive alignment strategy requiring less integration than employment
- Multiple options (including hybrid models) which allow for a greater level of customization
- Practice entity retains structure
- Hospital strengthens its service line while the Practice realizes some financial benefits
- Practice physicians remain independent
- Easier segue to clinical integration and deployment of accountable care era strategy
PSA Takeaways

- The PSA model is exceptionally attractive to orthopedists desiring a strong hospital affiliation without the loss of independence and full autonomy.
- With reimbursement declining in orthopedic services, the PSA gives groups the ability to improve their financial situation and address issues relative to their ancillaries.
- Physicians can collect both production incentives and orthopedic quality care incentives.
- Much like the CCMA, the PSA can also pave the way toward a more integrated alignment strategy (i.e., employment) or toward clinical integration.

PSA Case Study

PSA Case Study: The Organization
PSA Case Study: The Impetus

• Due to volume, physicians at Organization A need to continue their relationship with both Hospital #1 and Hospital #2 while involving greater alignment without employment

• Organization A approached both Hospitals #1 and #2 with the potential for a GPPSA wherein the Hospitals would contract for the practice’s professional services in exchange for a global payment rate (inclusive of compensation and benefits)
  – Practice entity remains intact
  – Practice physicians and support staff remain employed by the Practice

Primary motivations for Organization A’s decision to pursue the PSA:

- Opportunity to significantly improve its bottom line without being employed
- Increased ability to fund operations through administrative and cost efficiencies by pooling revenue from both hospitals
- Ability to return to a more unified practice model

PSA Case Study: What Took Place?*

• Organization A presented the GPPSA model to both Hospitals #1 and #2, both of which expressed great interest
• Organization A negotiated similar terms under a GPPSA with each Hospital
  – Six physicians exclusively practice at Hospital #1
  – Five physicians exclusively practice at Hospital #2
• Hospitals #1 and #2 collect all professional fees from the services provided at their facilities by the respective physicians
• Each Hospital provides a global payment per wRVU, which is pooled by Organization A and distributed through their income distribution plan
• Resulted in an average of 12% increase in compensation for the physicians at Organization A

*Coker’s role was to serve as the lead transaction advisor to Organization A, which included structuring the deal(s), conducting due diligence and financial analyses related to the deal(s), negotiating the transaction, and overall management of the transaction’s process.
III. Future Directions

The Alignment and (Clinical) Integration Strategy

- Significant collaboration amongst many different stakeholders, and among competitors
- A go-forward alignment strategy is ultimately the best way to create a foundation suitable for successful integration and development of collaborative models, particularly between distinct private groups
- Whether amongst medical groups or with a hospital partner, without sufficient alignment, quality of care and population health management are likely to suffer

Clinically Integrating to Deliver Value

Clinical Integration (CI) is a term used to describe a collaborative and coordinated approach to healthcare delivery.

CI is especially important in the US healthcare industry, wherein the two recent major imperatives: (1) health reform efforts are also related to the variables in the value equation.

If value is defined as quality per unit cost (V = Q/C), then CI is equitably seen as a method of providing services that produce measuredly higher value (Q/C) and high quality to costs ratio.

The Future of Physician-Based Healthcare

- We are in the midst of a significant cultural shift.
- The engagement of physicians through alignment and integration will help lead the way to change:
  - Significant clinical buy-in will be necessary to re-tool a care delivery process.
  - Physicians are arguably the most equipped to influence change amongst medical staff, physician and non-physician caregivers.
- Whether physician-based or hospital-based, new delivery models necessitate HEAVY buy-in from participating providers.

Typical Physician-Based CIN Structure

Clinical Integration Takeaways

In Conclusion...

Accountable care is ushering in a wave of change, all of which prove unique challenges for private practice physicians.

While risks/challenges exist, doing nothing will have detrimental impacts for independent physicians. Traditional care delivery will prove to be more costly and unsustainable.

In general, private practices can lack the infrastructure/resources (IT, primary care, etc.) necessary to respond optimally to these changes.

Federal and commercial payers have begun supporting value-based payment programs with a particular focus on orthopedics.

**MUST DEVELOP STRATEGIC PLAN FOR RESPONDING TO ACCOUNTABLE CARE**

Alignment through PSAs can serve as viable short-term strategies (3-5 years) and can certainly set the foundation for the long-term strategy of clinical integration.
IV. Q & A