ACG PRACTICE MANAGEMENT

Toolbox Highlights

Brought to you by the
ACG Practice Management Committee
The ACG Practice Management Committee’s mission is to equip College members with accessible tools to overcome management challenges, improve operations, enhance productivity, and support physician leadership in their private and physician-led clinical practices.

Learn from practicing colleagues through monthly articles on topics important to you. Articles include a topic overview, suggestions, examples, and a list of resources or references.

**Toolbox topics will include**

- Alternative Payment Models (APMs)
- Merit-Based Incentive Program Systems (MIPS)
- Medicare Compliance & Preparation for RAC Audits
- Reviewing & Maximizing Revenue Cycle Efforts
- Reviewing & Negotiating Insurance Contracts
- Patient Satisfaction Surveys & Engagement
- Reviewing & Updating Informed Consent
- Developing an Infection Control Plan
- Professional Society Opportunities & Involvement
- Quality Improvement Projects in Your Practice

"Pressures are high as gastroenterologists make important management decisions that profoundly affect their business future, their private lives, and their ability to provide care to patients." —Louis J. Wilson, MD, FACC

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Dear ACG Colleagues,

Welcome to ACG Magazine’s special issue on improving your GI practice. These articles were authored by fellow ACG colleagues and other contributors and have been published in ACG Magazine.

Please let us know if you have any ideas for future ACG Practice Management Committee articles and guidance. The ACG Practice Management Committee continues to strive to help you prepare for and succeed in this ever-changing environment of our profession, for all forms and sizes of the GI practice.

Accessible, relevant, and practical projects to improve your practice.

Gastroenterologists in private practice find themselves working in a time of unprecedented transformation. Pressures are high as they make important management decisions that profoundly affect their business future, their private lives, and their ability to provide care to patients. The ACG Practice Management Committee has a mission to bring practicing colleagues together to explore solutions to overcome management challenges, to improve operations, enhance productivity, and support physician leadership. It was in this spirit that the Practice Management Toolbox was created.

The Toolbox is a series of short articles, written by practicing gastroenterologists, that provide members with easily accessible information to improve their practices. Each article covers an issue important to private practice gastroenterologists and physician-led clinical practices. They include a brief introduction, a topic overview, specific suggestions, helpful examples and a list of resources or references. Each month, a new edition of the Toolbox is released, and remains available on the ACG website along with all previous editions. The Practice Management Committee is confident this series will provide a valuable resource for members striving to optimize their practices.

Louis J. Wilson, MD, FACG,
Chair, Practice Management Committee
In May 2019, the ACG Practice Management Committee gathered for a busy weekend of work in Dallas, TX to develop and deliver better educational material to ACG members and all types of GI practices nationwide. The members in attendance worked diligently, discussing and editing forthcoming Practice Management Committee Toolbox articles, reviewing plans for the 2019 and 2020 ACG Practice Management Courses—and most importantly—having fun socializing with colleagues.
PRIVATE PRACTICES IN GASTROENTEROLOGY ARE FACING INCREASING PRESSURE on many fronts. At a minimum, these pressures include decreasing reimbursements, higher practice personnel and equipment expenses, and increasing regulatory burdens. Many successful independent practices have found the revenue from ancillary service lines to be critical for financial success. Ancillary services which align best with gastroenterology are those which provide commonly necessary billable services while allowing practices to improve convenience for patients and improve care while adding supplemental revenue to the practice. Practices caring for a population of patients with inflammatory bowel disease should seriously consider the addition of outpatient infusion services.
Ambulatory infusion centers can be beneficial to patients and providers. Patients can expect to receive care in a familiar setting under the care of their usual physicians. Physicians might expect better compliance with therapy administered in office, and this also allows further opportunities to see patients and improve the therapeutic relationship. There is reason to expect that ambulatory infusion centers can continue to be a source of expanded revenue and value added for GI practices. Insurers that have to pay higher rates for hospital-based medical infusions services will likely continue to encourage outpatient infusion center utilization. This paper will briefly review the Centers for Medicare and Medicaid Services (CMS) rules and guidelines in the area of outpatient infusion. It will discuss practice and physical plan needs and requirements. It will review coding and billing, and lastly touch on reimbursement and financial risk.

**CMS Regulations**

The owners and operators of ambulatory infusion centers must be prepared to understand and follow CMS rules in this area. The rules for physician supervision of infusion are more stringent in the freestanding centers and physician offices than for hospital outpatient departments in this area. Ambulatory infusion centers must strictly adhere to CMS supervisor requirements. CMS requires direct supervision by physicians, and this explicitly means that the physician—and not an advanced provider—must be “immediately available” and “interruptible” to provide assistance and direction throughout performance of the infusion. However, the physician does not need to be in the infusion room when the infusion is given. Stated another way, the supervising physician must be present in the office suite or center during the entire infusion.

**Hiring the Right Staff**

Hiring the correct infusion nurse(s) or training an existing staff member(s) will likely be one of the most important determinants of the success of the infusion center. Centers should make every effort to hire a skilled, competent and knowledgeable nurse early in the process. This will likely spare many headaches which could arise later if the wrong person is selected. Owners must consider the expected total time spent giving infusions as well as whether this nurse will be involved in helping to obtain authorizations for the biologics, which can be a considerable time outlay. Salary, medical insurance and benefits for this provider need to be considered carefully when trying to assess the bottom line. Owners of ambulatory infusion centers need to be aware of the state licensing requirements and verify that these are met by the infusion nurse or other personnel involved with the infusion of medications to patients.

**Setting Up the Infusion Suite**

Equipment and staffing needs and costs will need to be carefully considered and budgeted for by each group prior to starting the infusion center within their GI practice. The physical space for the center is a fixed cost, and ideally the physician group would have the space available in their office and thus be “renting from themselves.” Infusion centers can, of course, vary considerably in their size and comfort structure. One center might be as simple as a single infusion chair with an IV pole compared with other units decked out with 20 high-tech leather recliners, each with its own TV and massage unit. A minimum financial outlay might likely include the costs of two infusion chairs, infusion pumps, blood pressure monitor(s), patient entertainment equipment, and general supplies (locking refrigerator, IV tubing, needles, gloves and medications to handle complications). An estimate of the costs for this equipment is modest and can be found elsewhere.

**Buying and Billing Medications**

Obtaining and billing for biologic medications is usually done by ambulatory infusion centers in one of two ways. There may be a “pass through”-type arrangement or “buy and bill.” In a pass-through situation, a specialty pharmacy delivers the drug (and possibly infusion equipment) to the ambulatory center, and then the pharmacy bills the insurer directly. The pharmacy would also be responsible for the authorization and collection of copays. Alternatively, in buy and bill, the outpatient infusion center establishes an account with a wholesaler and purchases the drug directly from a specialty pharmacy. The infusion center then bills the patient’s insurance plan or Medicare directly. The buy-and-bill method requires caution and diligence on the infusion center’s part in several areas. It will be the center’s responsibility to comply with insurance company and CMS rules in this area, to obtain the most competitive pricing for drugs, to ensure correction and necessary authorizations, and finally to collect patient co-pays, to name a few. It is important for any practice undertaking an infusion center to understand coding and billing for outpatient infusion services. As busy physicians, we may sometimes have a poor understanding of what appears to be a bizarre and confounding structure when it comes to the details of coding and billing. Having competent coders and billers and a clear understanding of the most recent current procedural terminology (CPT) codes is paramount to receiving the appropriate reimbursements. Each insurer may also have their own policies regarding infusion payment and reference should be made to the insurers’ individual websites.
There are specific rules regarding infusion coding that can be complex. It is very important to record the timing of the entire infusion. For example, CPT code 96413 for infusion of infliximab covers the “administration of drug, IV infusion techniques up to 1 hour,” whereas code 96415 covers each additional hour (listed separately in addition to the code for the primary procedure). The Healthcare Common Procedure Coding System (HCPCS) is used to supplement the CPT codes. In the case of infusions, this would be used to cover the drug, IV tubing, syringes and other supplies for the infusion that are not included in the CPT code. For infliximab, the HCPCS code is J1745 for 10 mg, and the code represents 1/10 of a 100 mg vial. Therefore, you would need to bill 10 units of J1745 on the claim form to indicate every 100 mg that was used. Coding coverage may vary by insurer or even between plans with the same insurer. Consult your payers for specific coding policies. Be aware that policies pertaining to reimbursement of biologic medication can be complex and are updated frequently.

Adding outpatient infusion services to your physician practice can be a great benefit to your patients and a good opportunity to supplement practice income. As with any new service line, a business plan should be done and reviewed with an administrator or consultant who understands the risks and benefits of the endeavor. Centers will be infusing small amounts of very expensive drugs, and non-payment of even one patient can be detrimental financially, costing literally thousands of dollars. Understanding how to obtain proper authorization and payment is critical. Infusion can be profitable for physician practices if managed properly. There are several companies that provide infusion management services that are experienced in helping practices navigate the process from setup to operations.

PRACTICAL SUGGESTIONS AND EXAMPLES FOR YOUR PRACTICE

Reasons to Consider an Outpatient Infusion Suite for Your Practice

1. Continuity of patient care (better control of their disease). This in turn improves patient compliance, as you can monitor infusion appointments and appropriate dosing.
2. Improved patient care. Patients prefer in-office infusion suites over alternate sites due to lower cost share and time requirements.
3. Adding ancillary services to a GI practice is the best solution to compression of reimbursement.

Steps to Adding Outpatient Infusion Services

1. Create a list of patients currently receiving biologics as well as patients that may require biologics in the near future.
2. Contact drug manufacturer (Johnson & Johnson, UCB, Takeda) to get information on Contract Purchase programs, rebate programs and co-pay assistance programs.
3. Investigate contracted fee schedules with all payers for all biologics and CPT codes.
4. Compare purchase prices to contracted fee schedules. This step alone will determine infusion suite viability.
5. Identify appropriate space and purchase necessary equipment (infusion chair, blood pressure monitors, patient entertainment equipment and infusion supplies.)
6. Identify and hire experienced staff for verifications, billing and an infusion nurse. These are critical to the success of your infusion suite.
7. Identify and select a wholesaler medication vendor to begin purchasing. Be sure to compare several wholesalers and then negotiate payment terms.
8. Contact drug manufacturers to enroll in patient access support services, which will assist in verifications of benefits for infusion patients.

Practical Suggestions

1. Make your patients aware that by infusing GI-specific biologics (infliximab, vedolizumab, etc.), we are giving drugs with which GI physicians have intimate knowledge and experience. This gives an advantage to us over hospital infusion centers, where a wider variety of medications are being infused but with no such specialized experience.
2. Make your infusion facility patient friendly. Strive for convenience for the patient in both location and setting. Hire great infusion nurse(s) and, when possible, shorten time of patient infusions.
3. Anticipate time to get insurance contracts and reimbursements in place. Expect to operate in the red in the short run.
4. Consider iron infusions in addition to infusion of biologics for IBD.
5. Keep a close eye out for advances in biotech and infusion; biosimilars as an example.
6. Carefully review payer mix and payer contracts, as reimbursement from some may not be adequate to make office infusion worthwhile.
7. Get administrative help from a consultant group or outside agency if you are not able to do it yourself.

RESOURCES

- Infliximab Coding and Billing: bit.ly/InflixCB
- Versel, N. Build Your Own Infusion Clinic, Biotecnol Healthc 2005 Feb; 2(1), 35-36, 39-14. See bit.ly/VerselN
- Medicare Supervisory Requirements: bit.ly/MedSupReqs
BEYOND ITS OBVIOUS MEDICAL-LEGAL RAMIFICATIONS, INFORMED CONSENT (IC) IS A CRITICAL PART OF GOOD PATIENT COMMUNICATION AND DOCUMENTATION. The principles of IC can be applied to procedures, treatments and the prescription of high-risk medications. It is also more than a document. Informed consent is a process by which patients can accept or reject “health care treatments” in an informed and voluntary manner. Practices should periodically review the processes and the documents related to informed consent. This toolbox provides a useful framework to accomplish this important project.

OVERVIEW
Obtaining IC is a process that allows the provider to discuss risks and benefits of the proposed treatment. The “IC form” documents that discussion. As a rule, the consent process should not be delegated, and the performing provider should take full responsibility to provide the necessary information to the consenting patient. Simple and appropriate language is key. The provider should use words the patient understands to review the intervention being proposed, the indications for it, expected outcomes (including the possibility of incomplete or failed procedures), known risks and complications, and any additional risks specific to that patient. Alternative treatments should also be reviewed, especially if the patient declines consent. Consent for procedures should include discussions of the risks of sedation or additional interventions being provided. In all of this, a two-way conversation is optimal, always allowing time to hear and respond to questions from the patient and family. The documentation of the discussion should become a permanent part of the medical record.
INFORMED CONSENT REQUIREMENTS
Informed consent documents are typically developed in response to state and local regulatory requirements. In addition, CMS CoPs (conditions of participation for ASC) and hospitals have their own requirements. We recommend against the use of consent forms provided by pharmaceutical companies or device manufacturers. Significant state to state variations in the informed consent process exist. There are also institutional interpretations of those laws that need to be considered. Consult your legal team and malpractice provider to assist you in including all the required elements pertinent to your state. If handouts or videos are used in the process, one should document in the patient’s chart that the patient viewed/received them. Using a common format, develop a form for each procedure incorporating large font and simple language. The provider performing the test and the patient (or appropriate designee) should sign and date the form.

SPECIFIC ELEMENTS OF INFORMED CONSENT FOR GI PRACTICE:

1. What interventions should be consented?
   - Operative or invasive procedures
   - Percutaneous procedures traversing into an organ
   - High risk (risks that the patient would consider important) diagnostic or therapeutic interventions
   - Intravascular insertion of instruments (excluding peripheral IVs)
   - General, deep, or moderate sedation
   - Receipt of blood or blood products

2. What treatments or medications should be considered for a modified consent?
   - Drugs with black box warnings from the FDA (e.g., metoclopramide, obeticholic acid) or drugs with mandated consents (isotretinoin)
   - Drugs with potentially serious side effects (i.e., biologics)

3. Who must give consent?
   - Any person 18 years or older who is mentally competent
   - If a person is judged to be incompetent (unable to understand the risks, benefits, and alternatives to the proposed health care treatment), consent can be obtained from the following:
     a. Court appointed guardian
     b. Spouse
     c. Adult Child
     d. Parent
     e. Adult Sibling
     f. Next closest relative by blood or adoption
   - Utilize the services of an interpreter if the patient does not speak English and family member or friend accompanying the patient does not speak English and follow local policies and guidelines, regarding interpreters
   - In case of an emergency, and if none of the above persons is available, emergent consent may be obtained from two physicians, but this may vary from state to state and hospital/facility/health care system, depending on specific laws and regulations

4. Who can obtain informed consent?
   - The provider who is supervising or performing the Health Care Treatment
   - Physicians can obtain consent for all treatments requiring IC for which they are credentialed
   - APPs may obtain IC for procedures in which they have been trained and for which they are credentialed

5. What key elements are included in the consent?
   - The intervention or treatment being proposed
   - The expected outcomes (including incomplete or failed procedure if possible)
   - The known risks, benefits, standard alternatives, and risks specific to the patient
   - The type and options of sedation provided

KEY CONCEPTS
1. Remember simple and appropriate language
   a. Simple and clear wording is crucial.
   b. Use 12-point font or larger
   c. Use bullet points instead of paragraphs
   d. Place development date on your forms and review intermittently to keep up to date
2. Use educational language and keep legal jargon to minimum
3. Review all consents you are using now and update to include information and ideas in this kit
4. If trainees are performing the procedure, this should be included in the discussion and document
5. For medications, consider a modified consent as all elements will not be needed. Consider using the FDA medication guides and document they were given to the patient. (www.fda.gov/drugs/drugsafety/ucm594941.htm)
6. If treatment or procedure is not accepted, document refusal and discussion of alternatives and prognosis

RESOURCES
1. Websites:
   - CMS.gov: [CMS Conditions of Participation for Hospitals: 42C>F>R> 482.24.C(2)(v)482.51(b)(2)482.13(B)(2)]
   - Your state Dept. of Health website
   - FDA: fda.gov/drugs/drugsafety/ucm594941.htm
2. Organizations:
   - Your state Department of Health
   - Your malpractice carrier: [for Mississippi we use Medical Assurance Company of Mississippi (MACM)]
3. The Joint Commission Accreditation Hospital Standards: [RL01.03.01] The honors the patient’s right to give or withhold informed consent, Elements of Performance 1-731-12
AN EVOLUTION OF THE PHYSICIAN TO HOSPITAL RELATIONSHIP IS ONGOING. Changes are being driven by the need to provide value and quality, the economic pressures on private practices, and the need for physicians to protect the valuable resource of time. Hospital employment is not the preferred option for many due to a desire for autonomy and personal stewardship. An alternative contractual vehicle, the professional services agreement (PSA), offers an avenue to advance alignment with your hospital system and remain independent while acquiring financial support for direct services provided. PSAs provide an option open to practices of any size.
BACKGROUND
Radically different reimbursement paradigms, rising expenses, and uncertainty of future revenue have pushed private practice physicians to consider new ways to economically relate to hospital systems. Full hospital employment can provide security and frees the physician of many of the burdens of private practice. However, the loss of autonomy experienced when moving from a private practice to a larger facility is significant. A PSA may be a more attractive option to foster alignment without employment. These agreements are typically fostered through an Internal Revenue Service (IRS) 1099 payment structure (rather than a W-2). Through a PSA, the physician is still employed at their practice corporation, but agrees to provide services at the hospital as an independent contractor. PSAs are fundamentally flexible and customizable. While there are a variety of different types of PSAs, the most common types are discussed below.

Entering into a PSA can confer several advantages—enhanced compensation, strategic planning, including joint development of clinical programs, installation of the electronic health record systems, data sharing, joint recruiting of new physicians, and bridging participation in clinically integrated networks (CINs) or accountable care organizations (ACOs). Through PSAs, physicians receive fair market value (FMV) compensation for any clinical or administrative services provided.

KEY BENEFITS OF A PSA VS. AN EMPLOYMENT AGREEMENT:
- Physician independence from hospital
- Greater flexibility
- Physicians can keep their existing benefits structures
- Stability for the physician-hospital relationship
- Easing implementation into a hospital CIN or ACO
- Easier to terminate
- Increased leverage to re-negotiate

WHAT ARE THE MOST COMMON PSA TYPES? WHAT ARE THE KEY COMPONENTS?

1. Global PSA
- Hospital pays all practice overhead, along with work relative value unit (RVU)-based compensation for the physicians. Support staff remain employees of the practice.
- A joint-management committee with hospital and physician representation manages the practice.
- Physicians remain directly involved in running their practice (practices must be capable of management and reporting to the hospital’s professional services and finance department).
- Hospital owns accounts receivable, establishes fee structures and contracts with payors.
- Ownership of ancillary revenue, real-estate, billing and collections are negotiable.
- As the practice infrastructure remains intact, at dissolution, physicians can return to their original practice format with minimal disruption.
- The duration of this type of agreement is typically short (1–2 years) and will likely need to be re-negotiated based on the outcome of the contract term.

2. Traditional PSA
- Hospital employs all support staff, assumes and manages the practice through their practice entity. This frees the physicians from the responsibility for the typical day-to-day practice management.
- Hospital contracts with the physicians through the existing practice entity.
- Physician compensation is based on a work RVU formula.
- Physicians remain employees of the practice entity.
- Hospital owns accounts receivable, establishes fee structures and contracts with payors as well as billing and collections.
- Ownership of ancillary revenue and real-estate are negotiable.
- Significant changes may be developed at your practice, depending on the nature of the work culture that the hospital establishes for its employees. Once the contract expires, re-entering private practice typically requires hiring an entirely new office staff.
- Hospital employment may prove advantageous to support staff.
- The productivity and financial data acquired during the PSA contract term can provide transparency to the process of negotiating to full-time employment at the end of the contract term.

3. Practice Management Arrangement (PMA)
- Hospital employs the physicians directly (W-2 type payment).
- Physician group-practice management and administrative structure is independently preserved, but contract with the hospital for these services.
- Hospital pays fair market value (FMV) for management services.
- Lacks flexibility of a typical PSA, but eases transition to employment and can simplify dissolution or transfer completely to hospital.
1. Carve-Out PSA

- Physician groups can agree to provide specific services or needs, such as call coverage, endoscopy services or various combinations of services.
- This is a limited provision for specific services provided, that is tailored to the needs of the hospital and the practice.
- Physician services are paid based on FMV and are typically work RVU-based.
- Related administrative costs would be carved out and reimbursed by the hospital separately.

2. “Wrap-around” to PSAs

- Can be a part of some aspects of PSAs to add focus on quality and value.
- This includes: cost saving initiatives, administrative duties, teaching functions, or medical directorships.
- Can be simple incentive payments, or up to and including, “at-risk” compensation for demonstrating quality of care and cost-efficiencies.
- Becoming more common, as the focus on quality and value for services increases.

**KEY CONCERNS FOR THE PRACTICE WHEN CONSIDERING A PSA:**

- Does the agreement fit into applicable Stark Law and anti-kickback statutes?
- Does the proposed agreement provide a fair compensation package based on FMV?
- Is the intended hospital partner or MSO capable of running your practice as efficiently as you or your current staff?
- Will the new management structure allow a sufficient degree of shared decision-making?
- Is the contract long enough to make it worthwhile? Ability to renegotiate over time?
- Will the hospital seek to push you to full employment?
- What happens to your practice with non-renewal?
- Are there hidden costs in the overhead which do not exist in your current practice?
- How are physician extenders factored into the FMV calculation?

Depending on how you answer these questions, one type of PSA may be a better fit for your practice’s specific needs.

**SUGGESTIONS AND COMMENTS:**

1. **Evaluate your practice’s current status** and review all available options. While the focus of this article is practice alignment and retaining independence through PSA arrangements with hospital partners, other options to consider include full independence, full employment by a hospital/system, or employment within a large group corporate model.

2. **Evaluate the PSA models** and choose which best suits your goals. Work with the proposed hospital partner to provide raw data that can be used to devise a compensation plan, and address operational issues and human resources concerns.

3. **Expert legal guidance** is recommended to ensure any agreement meets requirements for FMV, Stark, anti-kickback statutes, and state-specific laws.

4. **Work together as a group** to choose and devise the best long-term arrangement. Do not be afraid to get creative! Find ways to help your group and make it attractive to your partners, such as a cohesive approach to GI care and other possible value-added services.

5. Many of these structures are relatively new and have not yet been tested legally to the fullest degree. Thus, consult with an experienced healthcare attorney before entering into any arrangement.

6. **Ensure that the appraisal and valuation approaches are done by an experienced third-party valuation company.** The hospital system internal valuation will not be adequate or impartial.


7. **Use the Employment Checklist from the “White Paper: A contemporary option for alignment and integration” from The Coker Group** to review key discussion topics as you explore your options.


**RESOURCES:**


THE CONCEPT OF BUILDING A PRACTICE

In today’s era of medicine is vastly different than just a few years ago. Gone are the days of simply doing good work and building a grateful and faithful following of patients. The landscape of how patients find doctors, share their experiences, communicate their satisfaction, and the permanency of these perceptions is so quickly and constantly changing that it is a difficult concept to even understand. Many doctors don’t bother to develop a competitive website, market their practice electronically, engage in social media, or work towards reputation management at all. As these have been emerging technologies, and fall outside the realm of traditional medical training, it is easy to simply look the other way or wait and see what happens. But being overly cautious can be risky in itself. Rapid change does not just imply risk, however, but also opportunity.
TRADITIONAL METHODS OF MARKETING

Professional loyalty from referring doctors can be optimized by developing personal relationships, calling with important results, and helping doctors out with urgent issues. Periodic visits to referring providers’ offices are a helpful means by which to check in and provide updated clinical guidelines or to introduce a newly hired associate. Most importantly, periodic visits allow for providers to inquire about the quality of care they are providing. This provides your practice with invaluable feedback necessary to improve the service you provide, and allows the referring doctors know your practice cares about their patients.

Sending holiday cards or gift baskets to referring offices is an excellent way to remind them of your practice and a means to simply say “thank you.” This can especially endear you to an unrecognized gatekeeper of referrals, the front office staff. Mailers, newsletters, or notices focusing on new technology or services in your practice can help to keep you ahead of competitors. Purchasing ad space in a local periodical is an option. Being interviewed regarding a newsworthy story highlights you as a local expert. Lectures and seminars are opportunities that showcase your practice and present your physicians as valuable resources. An example of this is organizing a course that offers CME credit, while showcasing the talents of the members of your practice.

Periodic visits to referring providers’ offices can help to keep you ahead of competitors. Purchasing ad space in a local periodical is an option. Being interviewed regarding a newsworthy story highlights you as a local expert. Lectures and seminars are opportunities that showcase your practice and present your physicians as valuable resources. An example of this is organizing a course that offers CME credit, while showcasing the talents of the members of your practice. The face-to-face contact at such events is tremendously beneficial. Knowing that “the gatekeeper of referrals, the front office staff” will believe nothing else, know that it will save you and your office staff countless hours of telephone time.

A good website will be easy to understand, easy to navigate, and provide valuable resources for patients. Beyond the basics, your website can include technology savvy patients who will want to see your picture, find your location on a mobile app, or simply gauge the professionalism of the practice. You can leverage this interest to engage in marketing, answer frequently asked questions, provide a map and listing of your hours, and have educational content available. If you believe nothing else, know that it will save you and your office staff countless hours of telephone time.

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WEBSITE DEVELOPMENT

There is essentially no practice that can get by in today’s age without a functioning website. A website that is easy to navigate can help patients locate a practice in their area that suits their needs. Search engine optimization can help improve the visibility of a practice among search results. Even a “mature practice” will include technology savvy patients who will want to see your picture, find your location on a mobile app, or simply gauge the professionalism of the practice. You can leverage this interest to engage in marketing, answer frequently asked questions, provide a map and listing of your hours, and have educational content available. If you believe nothing else, know that it will save you and your office staff countless hours of telephone time.

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SOFT MEDIA

The electronic age is here, social media is here to stay, and whether you know about it or not, people are talking about you online.

“One of the greatest risks of social media is ignoring social media,” said Don Sinko, chief integrity officer of Cleveland Clinic. “It’s out there, and people are using it whether you like it or not. You don’t know what you don’t know.” By embracing social media, physicians can increase their visibility among patients and colleagues, highlight accomplishments, and develop an online presence to reach the next generation of colleagues and prospective patients. Furthermore, education from trained professionals may help dispel misconceptions, combat inaccuracies, and preserve trust in the medical profession. This allows them to boost their local, regional, and national reputation as problem solvers and valuable resources to patients and colleagues.

Blogging

Writing a blog about health care issues, professional experiences, or disease states is a terrific way to deliver your thoughts to a larger audience. You can keep this strictly medical, you can delve into health care reform or other topical interests, or you can be personal and insightful. You should come up with a goal for your blog and keep that in mind whenever writing. Do you want the most number of readers, to augment your professional reputation, to bring in new patients, or to deliver medical news to a more select community?

Twitter

Twitter has seen an explosion of growth as a source for medical information and a forum for professional dialogue. There’s a tremendous amount of peer-to-peer networking that occurs via Twitter, a kind of connectivity that is hard to find anywhere else. Articles and abstracts are often released here first. In fact, published articles in the field of gastroenterology and hepatology that were discussed on Twitter were independently associated with higher citation rates compared with those that were not, as recently published in GIE3.

In 2016, a hashtag ontology was developed to create a standardized list of hashtags for academic discussion on social media as published in A/J/G. This list of hashtags was agreed upon by various GI societies including ACG, AGA, ASGE, AASLD, and colleagues.
Advertising is used, this is a mechanism whether organic readership or paid advertising is used, this is a mechanism to reach a vast numbers of patients. Targeted ads can be directed to certain age groups, demographics, and even ZIP Codes. Facebook groups can also be used to target specific audiences. Facebook has become a medium for the masses, and virtually every age group is extremely engaged in this social media platform. If you want to generate raw numbers of views, Facebook might still be the best digital place to market.

**Facebook**
Facebook is the prototype for social media engagement. In fact, it may be eclipsed by newer, and “purer” forms of communication. However, it is still a very powerful tool. Whether organic readership or paid advertising is used, this is a mechanism to grow their individual professional and personal networks. For example, as an example of how Twitter can be useful from the medical perspective, we discussed #MondayNightIBD with Aline Charabaty, MD. Dr. Charabaty, a national expert in IBD at Johns Hopkins, created this hashtag as a simple means for professionals to communicate with one another about interesting cases. Dr. Charabaty told us, “I am an educator; techs, fellows, anyone who will listen. But there are questions for which there may be no published answers. This is a realm where we can extend our usual clinical questions to a broader audience and ideas that are not addressed in the publications. We can ask clinical questions, take polls, and learn the nuances of others’ practices.” Additionally, Dr. Charabaty emphasizes, “it’s completely fluid. You can catch up anytime if you are busy and can’t be there, and just read through the discussions.” Dr. Charabaty’s initially small-group discussion recently hit over 200,000 impressions on Twitter. It has grown to become, as she says, “a little journal club.”

Twitter is also frequently used to amplify discourse at GI conferences through live tweeting. Communication and connections forged online can translate into real-life networks and collaborations, as apparent during in-person social gatherings that are a staple at many national conferences. This type of activity benefits everyone. All participants gain exposure. This allows for everyone to be heard, and expand and grow their individual professional and personal networks.

**Instagram**
Instagram is the fastest growing major social media platform, now exceeding over 1 billion active users. Each visual post is uniquely organized on one’s personal page in a “grid,” though new posts accounts followed by the user will show up in a similar news feed. The structure and visual nature of the platform typically requires posting with less frequency. Owned by Facebook, some of the advertising functionality translates across both platforms. Furthermore, other industries have capitalized on “influencers” on Instagram to promote a variety of products. The influencer phenomenon has coincided with a surge in medical professionals and trainees joining Instagram to promote their practices and share personal experiences. As a highly visual platform, many users find the platform engaging.

Without the character restrictions of Twitter, individuals can post longer captions and expound on their material. Instagram has adopted functionality seen on most other popular platforms, namely the temporary 24-hour video posts of Instagram stories. Within these stories, users can post polls, Q&A sessions, and livestreams. Similar to Twitter, hashtags are critical for amplification of material on Instagram, and likewise engagement with others on the platform. Searching these GI-related hashtags will reveal who is utilizing these hashtags and potentially identify a target audience or influencers in that topic.

**YouTube**
YouTube has been cited as the second largest search engine and is the fastest growing video sharing website in the world. Each month the site sees 5 billion views per day and 300 hours of video uploaded every minute. Video is an effective medium of conveying information, but requires a different skill set of filming and editing.

**ASSOCIATION FOR HEALTHCARE SOCIAL MEDIA**
The Association for Healthcare Social Media (ahsm.org) is the first 501(c) (3) professional society devoted to health professional social media use. The new organization aims to provide resources to help health professionals build a health-related social media presence and to define best practices to encourage responsible social media use. By doing so, physicians can avoid missteps and potential professional pitfalls, as well as inadvertent harm toward public health. Part of the resources will also be for patients to better interpret health-related social media posts for accuracy. These best practices are currently in development.

**REPUTATION MANAGEMENT**
It's wonderful when something meaningful and insightful you write becomes a sensation, but it's similarly tragic if something taken out of context or misconstrued goes viral.
You must keep this in mind whenever posting anything online. You should assume that anything you write anywhere online is visible to anyone, could be taken in the worst possible way, is not subject to separation of personal and professional, and is available permanently. These facts likely keep a lot of people off-line, but they should not dissuade you completely from engaging in social media. You should just do so cautiously.

Whether you have taken charge of your professional digital presence or not, you have one. You may as well own it and drive it in the direction you want. A good exercise is to Google yourself and check the various doctor rating sites to see what people write about you. But be prepared, there will be negative comments. Experience has shown that often times, despite the initial disappointment that might result from seeing negative reviews, you can get valuable feedback regarding your overall practice. If the comments always focus on the front office staff being rude, your waiting room is dirty, or that you seem dismissive, these can be tangible action points for meaningful and positive change.

Even a negative comment itself can be spun into something positive. A response along the lines of an apology for some misunderstanding or delay, and a reaffirmation of your practices commitment to provide the highest level of care, can win over readers. People will respond to, “I am as disappointed as you are to hear this. Thank you for bringing it to my attention, and I hope you return so we can start over after I have made some very necessary changes.” A negative review that goes unanswered, on the other hand, can be seen as an acknowledgment of the comments as fact or disinterest on your part. Whatever you do, do not be inflammatory or engage in any kind of hostile back and forth. The Internet loves for these David and Goliath type stories to go viral.

Most of the doctor rating sites have the option for you as the healthcare provider to take ownership of that account. This allows you to put your picture and a written introduction in place. You may be able to direct people to your website from there. This looks more professional and polished, and less anonymous—anonymity being a key driver of negativity online. There’s also the risk that if you do not take ownership, someone else may lay claim to it. Although most of the sites have some type of paid membership available, be wary of sites that suggest they can improve your ratings for pay.

CONCLUSION

How doctors communicate with the rest of the world, and how our own patients find and rate us, is a game that has entered a new season. We must play in the current field conditions. Websites, electronic advertising, and social media are all extremely useful tools to augment the time-honored and more traditional approaches. Define your goals clearly when using social media and stick to them. Be cautious in your approach, particularly if you venture outside of the strictly medical with social media. Remember that people can have a tremendous number of fickle followers, or a few very dedicated and professional followers. Take charge of your online reputation, because people are talking about you whether you know it or not. And remember, at the end of the day, maintain a human touch for your office and your own individual practice. People may find you and talk about you electronically, but it still all comes down to your face-to-face meeting.

FURTHER READING

For further information, there are a number of professional discussions on these topics that take place during the national society events such as the practice management conferences, regional conferences, or the Annual Meeting of the ACG.

2. Social media “likes” healthcare: From marketing to social business. PricewaterhouseCoopers Health Research Institute, April 2012.
3. Longitudinal relationship between social media activity and article citations in the journal Gastrointestinal Endoscopy, Smith, Zachary L. et al., Gastrointestinal Endoscopy, Volume 90, Issue 1, 77 - 83
4. https://journals.lww.com/ajg/Citation/2016/08000/Harnessing_the_Hashtag__A_Standard_Approach_to_GI.2.aspx

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DO I INVEST?
Legal Issues in Considering Endoscopy Center Investment

By Ann M. Bittinger, Esq., a health care attorney with physician group clients across the country.

Questions? Email ann@bittingerlaw.com

Most gastroenterologists are offered an opportunity to invest in an endoscopy or surgery center at some point in their careers. Along with practical and financial considerations that I touch on below, the federal Anti-Kickback Statute governs these investments at the time of buy-in and as long as the gastroenterologist owns shares. In today’s evolving health care environment, with less-complex procedures happening more frequently outside of the hospital environment, the time is right to consider investment. But proceed wisely.

The Federal One-Third Tests

The federal Anti-Kickback Statute makes it illegal for physicians to refer Medicare patients to facilities with which they have an investment interest. There’s a very complicated exception to that prohibition, however, to allow physicians to invest in ambulatory surgery or endoscopy centers where they perform procedures.

Generally speaking, to comply with the Statute, the physician’s work at the center has to be an extension of the physician’s office practice. The law intends to disallow passive investment in a center. For example, a primary care physician investor who refers patients to a gastroenterologist who performs services at the center would have a difficult time meeting the rule. The rule construes the dividends on the primary care physician’s investment as a kickback for a referral of patients to the gastroenterologist, who performed the surgery and helped the center make a profit. Instead, investors have to be actively engaged in the practice.

There are two “one-third tests” to meet the Statute safe harbor. At least one third of the investor’s medical practice income must be derived from performance of procedures that are reimbursable by Medicare when performed at a center. That means that the investor has to perform surgeries or endoscopies frequently enough that income therefore makes up one-third of his or her income.

There’s another one-third test applicable only to multi-specialty centers; endoscopy centers are typically not multi-specialty, as they are owned exclusively by gastroenterologists and perform only GI procedures. If the center has investors from different specialties, at least one third of the procedures that the investor performs have to be performed in this center. In other words, this center is where the investor has to be taking his or her cases. According to 1999 regulations, the purpose is to ensure that the center is “an extension of the physician’s office space and not a means to profit from referrals.”

If you don’t think you can meet these thresholds, don’t invest. Not only could you face prosecution under federal criminal law and have to repay Medicare, the surgery center could kick you out and not return your investment. If the feds get involved, you and the surgery center could be forced to repay three times the amount that Medicare paid for services you performed when you were not in compliance. Also, you could be excluded from Medicare participation.
INVESTMENT AMOUNT
Many clients have told me that the centers claim that the law requires the same buy-in price to all physician investors. That’s not entirely correct. While the center can’t loan you the investment amount or require you to pay for investment through work i.e., sweat equity, there’s nothing in the federal regulatory scheme that mandates one price for all. Generally speaking, when a person invests in any company, the price per share is based on the value of the company. A center cannot vary the buy-in price based on the expected or actual volume or value of referrals that the owner brought or would bring to the center. That doesn’t mean, however, that the dollar-per-share or buy-in price has to be the same for everyone for years. In fact, if patient volume or reimbursement is down or debt up, it makes sense from a compliance standpoint to argue that indeed the value of the company has fluctuated so the price to buy in should change.

EBIT—WHAT?
Often, the buy-in price is based on a formula called EBITDA. That stands for the company’s Earnings Before Interest, Tax Depreciation and Amortization. The company’s CPA determines that amount, typically each year. The center’s governing documents (usually called an operating agreement) may say that the price per share will be a multiple of EBITDA. The company’s directors may be able to change that multiple. Alternatively, the operating agreement may allow the directors to determine the value of the company, usually based on a definition other than EBITDA in the operating agreement.

You should be able to see that document prior to buying in. You will likely be asked to sign a non-disclosure agreement before receiving the operating agreement.

HOW MANY SHARES?
Endoscopy centers must pay dividends to their gastroenterologist investors in direct proportion to the gastroenterologist’s ownership percentage. If Dr. Jones owns 5%, and a dividend is issued for $500,000, Dr. Jones would be paid 5% of $500,000 or $25,000. This amount does not vary based on the number of cases Dr. Jones performs or the profits generated to the center from those cases.

When you are offered an investment opportunity, you might be presented with a range of percentage of shares you can buy. Keep in mind that if it is a small percentage (less than a majority), the investment brings with it no real rights to control the company (more on that below). Instead, you’re getting an opportunity to get a share of profits based on the percentage of shares you own—not based on how profitable you are to the center. You may buy in at 10% while other ACG members decide to buy-in at 5%. There’s nothing illegal about that.

DECISION-MAKING
One allure to investing in a surgery center is the voice that the physician investors have in how the center is operated (as opposed to having no ownership or control of the hospital’s operating rooms). Be sure to read the fine print in the operating agreement, however, so your expectations are on-point as to just how much control you have, or don’t have.

If there’s an outside management company, that management company may be the majority shareholder, thus having control of all decision-making—and dividend issuing. In other words, despite your percentage, if the management company can unilaterally decide whether to pay out profits as dividends to shareholders (it’s not automatic), and they decide not to pay, then you get nothing. Keep in mind that the management company is also being paid by the center to manage the center.

Likewise, who decides what is important? Even if there is no management company involved, a select group of investors on the board of directors may be the exclusive decision-makers. If you invest, do you get a seat on the board? The answer is in the operating agreement.

EXITING
Another key consideration is whether you get your money back if you leave, for whatever reason. In many cases, there is little or no return on your investment. Your health care attorney can help you understand your operating agreement terms about exiting.

In summary, endoscopy center investment can be quite lucrative and professionally fulfilling. Be sure to evaluate all offers, though, with the help of experienced health care counsel.

KEY ISSUES IN INVESTING IN A CENTER
• Is 33% of your practice made up of surgery/endoscopy center procedures?
• Is the center single- or multi-specialty?
• Is there a management company and, if so, what percentage does it own?
• What percentage interest would you own?
• What decision-making rights come with that percentage?
• Who determines if dividends are paid to investors?
• Do you get your investment back if you leave?
Pursuing Clinical Research for Ancillary Income

By Ann M. Bittinger, Esq., a health care attorney with physician group clients across the country.

Questions? Email ann@bittingerlaw.com

IT’S QUITE COMMON FOR GASTROENTEROLOGY GROUPS TO PURSUE CLINICAL RESEARCH TRIALS not only to generate ancillary income for their practices but also to stay abreast of new developments in the specialty. Research offers patients state-of-the-art treatment approaches that might not otherwise be available. And sponsors generally pay well for participation.

Scientific inquiry can be professionally fulfilling. But physicians should not perform trials without understanding the associated tribulations.

I have represented a few highly-regarded physicians who hired me after their state licensing boards received word that they failed to conduct research properly. Physicians jeopardize their ability to maintain a clear license and their general practice of medicine if things go awry in their clinical trials.

LOOK BEFORE YOU LEAP
Physicians should not leap into research without looking at clinical research laws. Clinical trials are governed by complex and layered federal law, with different agencies in the Department of Health & Human Services (HHS) regulating the research dependent on its subject matter. If your trial involves a pharmaceutical, the U.S. Food and Drug Administration rules apply. The HHS Office of Human Research Protections oversees all research involving human subjects under what is generally referred to as the Common Rule. The Office of Research Integrity and Office of Inspector General may also be involved.

Your practice was likely first involved in research when a pharmaceutical company or other company—called a Sponsor in the research field—asked one of your physicians to be a principal or sub investigator. You may be asked to participate in a pre-study site visit (PSSV), in which the sponsor or a contractor interviews you and assesses your site.

MODELS FOR RESEARCH IN PRIVATE GI PRACTICES
Generally speaking, there are two business models for research in private practices: original research and contract research. Original research is organic from the physicians in the practice. They develop the protocols.

Contract research involves agreeing to be a principal or sub investigator in a trial that was developed by a third party (usually for-profit) company, such as a pharmaceutical company. Most research in private GI practices is contract research.

Within the contract research model, you can take one of two routes. The first is to deal directly with the sponsor and to retain your own staff to handle the administrative portion. Practices are increasingly following the second route though, by contracting with a Contract Research Organization ("CRO"). They feed studies to practices and help practices with compliance and data management. They are a middle man, so to speak, between the sponsors and the investigators and most provide assistance to the investigators.

TIPS IF YOU GO IT ALONE
• Don’t sign a principal investigator agreement without implementing some level of a Research Compliance Plan in your office and retaining someone to oversee it on site for you.
• Take it upon yourself to attend a seminar in basic research administration requirements. Remember that your site, as principal investigator, will be ultimately responsible for the research it performs and for data and adverse incident reporting. You can’t supervise what you don’t understand.
• The main component of research compliance is administration of the informed consent to patients. The content of the informed consent document and the process for obtaining...
signatures and retaining the signed forms is important for compliance with federal law. Who in your office is going to be trained to carry this out?

- The FDA requires the disclosure of certain financial information—potential conflicts of interest—relating to studies.
- Institutional Review Boards (IRBs) must approve the protocols and research methods.
- In addition to compliance with the above, you need to make sure you don’t bill payers—particularly Medicare—inappropriately for your research patients. Data management and reporting requirements within the protocol requirements are substantial. A physician can’t do it alone.
- Monitors will visit your site and audit the research.
- Have a clinical trials health law specialist develop a Research Compliance Program for you—and implement it.

**TIPS IF YOU CONTRACT WITH A CRO**

- If you lack the magnitude of trials or the time and resources to develop your own Compliance Plan and train your own clinical trials director, contract with a third-party research management company or CRO. They usually take a portion of the payments from the sponsor to the researcher in exchange for performing compliance activities.
- Have a lawyer with specialized training in clinical trials review the contract and interpret for you what exactly your expectations should be about what the CRO will do for you. A lot of times, CRO contracts say they will assist with compliance and reporting, but they don’t take responsibility for taking the initiative and completing the proper documents.

**STRUCTURING YOUR PRACTICE FOR CLINICAL RESEARCH ANCILLARY SERVICES**

I am often asked if practices should form a separate research company to perform research initially or later spin-off the research component from their practices into a separate company. Certainly, normal asset protection and personal liability analysis should be performed by a health law specialist on your specific situation. To protect the practice from regulatory fines (and perhaps malpractice claims) from the research operations, the two service lines (clinical practice and research) would have to be in separate companies; however, if the patient is a normal practice patient (as most are), it may be difficult in a malpractice claim to separate what was done in the research company versus what was done in the practice.

Generally speaking, two companies are safer than one if the scale is appropriate. Separate companies need to be truly separate though, with appropriate documentation and reporting. A medical assistant who works for both the research and practice service lines would have to become a part-time employee of both companies instead of a full-time practice employee. The research company would have to file employment taxes, pay rent, and so forth. This may be more trouble than it is worth. And in a group practice, issues of which physician practice shareholders also become shareholders of the research company, and how they make decisions and earn profit distributions, can be difficult to address.

Like any business, your research component is perhaps best grown if you start out small as a sub investigator or principal investigator, work out the kinks, and see if the research work complements your practice. As things grow, consider setting up your own separate, legal research clinic company. Be mindful of the need to keep EMR and other data separate also.

Another issue is physical space. Should the research service line have its own dedicated space? It’s a good idea to maintain research records separate from general practice records. Having a separate room where research contracts and data are analyzed and stored is important. Dedicated administrative space for the principal investigator is important. You may want to dedicate a separate exam room within your normal practice just for research patients. The coordinator likely needs an office space. Monitors will visit and it’s good to have a guest office in which you can meet with them and they can perform their work without seeing practice data or other study data.

Following these steps should help you avoid tribulations. Don’t let your excitement about contributing to science and adding ancillary income jeopardize your medical license and existing livelihood.

**HOW TO GROW YOUR CLINICAL RESEARCH SERVICE LINE**

- Start small and grow with expert guidance
- Invest in infrastructure: implement a business plan and don’t be cheap with coordinators
- Educate yourself on clinical research compliance—attend a seminar
- Implement a Research Compliance Plan
- Make your practice attractive to sponsors by implementing effective enrollment processes
- Reward practice physicians (legally) who meet enrollment quotas and comply with the Research Compliance Plan

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**CULTIVATING LONG-TERM RELATIONSHIPS WITH RESEARCH SPONSORS**

Once you have the compliance infrastructure in place, how do you grow this service line? Make your practice attractive to sponsors. Here’s how to cultivate a long-term relationship with sponsors:

- When you enter into principal investigator agreements, meet your enrollment quotas. Enroll patients in the study. Believe it or not, this is one of the major challenges for sponsors—to hit proper enrollment numbers so that data is statistically reliable. Your research contract will likely include the number of subjects that you are expected to enroll as well as the timeline for enrollment. You will be asked to participate in more studies if you hit enrollment numbers.
- Hiring an experienced coordinator to serve as a liaison with the sponsors is important not only for compliance and management purposes, but for marketing purposes as well.
- Invest in your infrastructure. Physicians get in trouble when they think they can make six figures being a principal investigator and doing very little work by simply hiring a few nurses and a coordinator to do the research. And you will burn bridges with the sponsors if you fail to meet contractual requirements or breach the law due to your failure to invest in staff and other infrastructure.
APPROACHING A PRIVATE EQUITY SALE

without a clear understanding of your legal rights and liabilities post-sale is like Sandra Bullock’s character in the movie Bird Box trying to survive, blindfolded to avoid deadly eye contact with ambivalent forces: you might survive in the short term, but in the end it’s best to find a safe place where you can see.

It’s important to consider any sale—particularly with a private equity firm—with eyes wide open. Make sure that you are in a good place with proper financial, legal, and operational advisors who help you see through the private equity mystique.

PRIVATE EQUITY BASICS

Private equity investments are purchases by firms, owned by individuals or other companies, that provide funding to companies in exchange for equity. Equity means ownership. Put simply, private equity firms provide physician organizations or surgical center companies funding in exchange for ownership in the company.

WHAT YOU GIVE UP BY SELLING TO PRIVATE EQUITY

Many physicians fail to appreciate the importance of giving another company ownership of the physician practice until it is too late. When a private equity firm takes over the majority of shares in your physician practice, it gains the controlling interest in the practice. The majority owner usually calls the shots in an organization. If that owner is not a physician or lacks healthcare experience, the physicians sometimes find themselves in opposition with the new owners.

Legally speaking, the opposite of a funding by ownership is funding by loan. Loans are paid back with interest. With ownership, you sell shares in your company and get funding in exchange. You don’t pay anything back, and there’s no interest, but you give up certain rights in your company.

Private equity does not provide physician groups with funds without wanting something in return. What they usually want is the right to make financial and operational decisions about the company so that the private equity firm can make more money and, accordingly, get a return on their investment. Private equity firms don’t invest in GI groups because they are interested in the developing science of gastroenterology. They invest in GI groups for the same reason they invest in any other company—to get a return on their investment.

PRIVATE EQUITY PRACTICE PRICE

I am often asked, “What’s the difference between selling to a private equity group versus selling to a hospital?” The differences are many. First and foremost in importance to the seller is the selling price. Hospital systems are bound by the federal Anti-Kickback Statute and the Stark Law and perhaps similar state laws. The amount that hospitals pay physician groups for their practices generally must be at fair market value. There is an exception for one-time sales of practices, but, generally, counsel for hospitals advise against paying more than the value of the physician group’s assets when buying groups consisting of physicians who refer to the hospital. Any amount over fair market value (usually low-balled at the value of the hard assets of the company—not good-will or going-concern value) can be construed as a one-time mega-kickback for past or future referrals from the selling physician to the buying hospital.

Private equity firms don’t have to worry that their purchase prices will be construed as kickbacks because they don’t have hospitals to which the sellers will refer. The kickback and self-referral laws don’t usually apply to them. As such, private equity firms can often pay much more for ownership in a physician group than hospitals can or will.

THE CATCH

So, what’s the catch? If you are hesitant to sell to a hospital system because hospital administrators generally don’t know how to run physician groups (much less, endoscopy centers and GI groups specifically), how do you think a firm that doesn’t deal day-in and day-out in healthcare will operate your practice after you sell? To be fair, a
number of private equity firms are dedicating a lot of time and money to retention of advisors and managers who are experienced in healthcare. If the representative from the private equity firm does not know what a wRVU is, that might be a good sign that the firm is not completely dedicated to understanding how your practice operates.

Another con about private equity I hear from clients and others is that the new owners treat physicians like they are the furniture in the room—an asset to be moved and replaced on a whim. Perspective is important. Culture change is important. If your GI group was founded as a mom-and-pop shop, totally physician-owned, with board meetings attended by all shareholders who all get an opportunity to provide input on the management and direction of the practice, you should probably brace yourself for a bumpy culture change ride if you decide to sell to a private equity firm. Although “being treated like furniture” may be a bit exaggerated and dramatic, the fact is that you will likely no longer be an owner of the company at which you work. You’ll just be an employee. Employees generally have no say over the direction of their employer company.

That being said, physicians may retain some ownership rights post-sale. Read the fine print about what rights are attached to that stock. Are you in a new, separate class of stock from the private equity firm, and your class has no say on any decisions? Read the fine print of the proposed sale and ownership documents to understand your rights, if any.

NOT OFF THE HOOK
And read the fine print as to ongoing liabilities. Many practices find themselves considering private equity like a football offensive coordinator would consider calling for a Hail Mary pass—they are down on their luck and hope that this move will save them. Just how down on your luck are you? Chances are that the private equity company will know and will not take responsibility for any liabilities that may be actual or lurking at the time of sale. Private equity firms often make you integrate into their existing corporate structure. That means that your practice corporation or limited liability company will remain in existence after the sale, and the private equity buyer will have absolutely no responsibility. Even if they do take over your company and your corporation or LLC continues under their control, there will be language in the purchase documents that say that the buyer has absolutely no liability for anything that occurred prior to the purchase.

What that means is that if a letter arrives from Medicare asking for a refund of overpayment due to prior billing and coding improprieties, or a letter arrives from the state saying your medical assistants filed a wage-and-hour claim for unpaid overtime, liability rests on the seller. That may mean that the former practice corporation or LLC will have to pay the money. Worse, it could mean that the individual physicians might have to pay out-of-pocket. Sometimes, the private equity seller puts a somewhat large amount of its purchase price on reserve to cover liabilities like that. For example, if they would buy a practice for $10 million, they may require that $3 million of that be held in reserve for three years to cover exposure like this. Imagine the price dropping by 33% with the receipt of just one letter.

Who pays the lawyers in these situations? Often the private equity firm will have its own lawyers, the selling physician group will have theirs, and then individual physicians will seek their own counsel. I strongly encourage individual physicians to hire their own counsel and not rely on group counsel. Although the continuing liabilities situation could arise when selling to any buyer (including a hospital), it can be particularly dicey in private equity because they usually have well-heeled counsel whose interest is to protect the private entity firm, not to protect the physicians or seller group.

"Private equity firms don’t invest in GI groups because they are interested in the developing science of gastroenterology. They invest in GI groups for the same reason they invest in any other company—to get a return on their investment."

ALWAYS BE PREPARED
It is imperative that your group get its house in order, so to speak, before approaching a private equity investor. Not only does it minimize future liabilities, it makes you a more attractive target. Private equity investors usually begin their target assessment with a due diligence process, where an executive asks to review your financials, your compliance plans, etc. While this is normal in any acquisition in any industry, it’s particularly interesting in healthcare private equity because the executive asking the questions may not be experienced in healthcare, your specialty, or your market. The seller physician group might have to work a little harder in explaining nuances to the potential buyer. This is less-so the case in medical specialties that have frequented the private equity arena in the last decade, such as dermatology, emergency, and radiology. Gastroenterology is just now getting looks from private equity.

In closing, let’s return to the reason a private equity group would buy a GI practice in the first place—to get a return on its investment. I tell clients to expect a simple fact; some things (perhaps a lot of things) are going to have to change post-sale if the firm is going to get a return on its investment. Your addition to their portfolio is going to have to produce some sort of synergy or result that benefits the firm financially. To do that, things will change. For example, you might have to start doing endoscopies only at surgery centers that are in their portfolio. You might have to purchase supplies only from a supplier that is in its portfolio. This might have an indirect but important impact on how you practice medicine.

Face this fact with eyes wide open.
The College commissioned Ann Bittinger, Esq., to draft a white paper on Professional Services Agreements (PSA) as a resource for our members. In addition to guidance and perspective, Ms. Bittinger also provides template legal contract language that will be helpful to ACG members negotiating a PSA with a health system.

As you read the white paper, the legal template language can be viewed online by scanning this QR code with your smartphone.

View and download the template language: bit.ly/ACG-PSA-Legal-Templates

The rainstorm that started around 2010 in favor of consolidation in the healthcare industry continues to flood the market, with creative, mutually-beneficial arrangements between hospitals and physicians taking the form of every color of the post-storm rainbow. One form, Professional Services Agreements (“PSAs”), continue to be quite common among hospitals and gastroenterology groups where the system has not yet employed the gastroenterologists.

Background. A PSA is simply a contract by which physicians in a physician group provide services to a hospital or health system. They take many shapes and sizes. One physician can enter into a PSA with a system for a few hours of defined work. Or, on the other end of the spectrum, a GI group with dozens of gastroenterologists can contract through a PSA to manage the GI service line at a system, much like what we used to call a co-management agreement. There is no one-size-fits-all PSA, but there are key terms that should appear in any PSA, and those terms should be tailored to the specific facts and circumstances following negotiation of a robust letter of intent.

When a group sells its practice to a system, the group’s company is usually dissolved. The physicians no longer own the company for which they work, and they become W-2 employees of the hospital system, usually of its physician enterprise subsidiary. The closeness of the affiliation in a PSA, however, is one or more steps shy of full employment; how close is up to the terms of the PSA.

For most PSAs, the gastroenterologists typically still bill and collect for clinical services. As such, the health system is paying the group for administrative and management services only. In other PSAs, however, all of...
the gastroenterologists work under the tax ID number and payer contracts of the health system. (In other words, the GI group still employs all the physicians and assigns all of them via a PSA to work under the hospital system’s payer contracts). In those situations, the payment to the group compensates it not only for administrative services but also for the costs of salaries the group incurs in providing a full spectrum of gastroenterologists to provide services to the hospital. Because the hospital bills and collects for physician services, the hospital pays the group to pay the physicians’ salaries and benefits.

The Law. It is illegal for a hospital to pay a physician group other than fair market value. The hospital can only pay physicians rates that do not vary based on the volume or value of referrals, for commercially reasonable services. Payments above fair market value or for work that is not commercially reasonable can be construed by prosecutors as kickbacks that violate the Federal Anti-Kickback Statute. This is a criminal law, so if violated, the physicians and system executives who offered, solicited, paid, or received payment can face prison time.

Fair market value is a range, not a number. And the range should not be based solely on third-party data. To use third-party data properly, the facts surrounding the proposed relationship have to be shared with the consultant. That way, the consultant can ensure that he or she is comparing the industry information correctly to the facts at hand. Although it’s not advisable to blatantly negotiate what is considered fair market value, there is absolutely nothing wrong with providing supporting documentation about the facts at hand in response to a draft report from a valuation consultant. Typically, in a fair process, the consultant will interview both the physician group and the hospital and ask for non-biased, fair information relating to the valuation job. A consultant may share the draft report with both parties, soliciting feedback, before finalizing it, to ensure the integrity of the assumptions and conclusions the consultant makes.

Sample Agreement Terms. Although every PSA must be tailored to the specific facts and circumstances, groups should pay particular attention to these terms:

1. Duties
2. Term
3. Exclusivity
4. Non-compete (Confidentiality)

DUTIES

What are you doing? Because the most important compliance issue in a PSA is to demonstrate commercial reasonableness and fair market value, it is essential that the contract accurately and robustly describe the work that is being performed by the physician group for the benefit of the system. Is it specifically for call coverage, for example, or only for endoscopy coverage for the hospital? Valuation consultants, not lawyers, opine on fair market value, but before you call a valuation consultant you need an accurate description of services that will be provided. Sometimes PSAs are casually referred to as “medical director agreements on steroids.” Some level of medical direction or administrative oversight is part of all PSAs (other than agreements for call coverage only), but what else are you doing?

Need more help? View and download examples of contract language when negotiating duties related to your PSA: bit.ly/ACG-PSA-Legal-Templates

As to the schedule containing the metrics and targets, a model is beyond the scope of this paper, but be sure that the targets and metrics are tailored to your service. Do they make sense from a cooperative standpoint as items that both the hospital and group want to improve upon? Is there a fair way to track and document progress on those targets? Does the group get to review the documentation before it is finalized? Metrics should be flexible or provide multiple options. The practice will change over time, so the effectiveness of the measures needs to change in tandem.

As to physician recruitment, consider including in the PSA that if the staffing of the group falls below X number of physicians, then the hospital will agree to subsidize the income of a new hire subject to a recruiting agreement that complies with the Stark Law and Anti-Kickback Statute. This agreement typically mandates that the recruit stay in the community for 2–3 years in addition to a subsidy paid to the group to allow the group to pay him regardless of his collections or productivity. The recruiting agreement is separate from the PSA, but a provision in the PSA that would mandate a subsidy, under-to-be-determined terms, is helpful to physician groups. Another option is to mandate a needs assessment periodically, so that at a minimum a discussion about recruiting is built in to the PSA.

As to call coverage obligations, be wary of how heavy the beeper is. By this, I mean incorporate a cap or some other limit on the extend of your call obligations per shift. It’s not reasonable for a gastroenterologist to have to manage 30 inpatient and emergency department patients a night. Also, as to call obligations, explore the medical staff bylaws and PSA terms to ascertain whether an extender can be used in addition to, or in lieu of, a physician on call. For example, a call coverage provision might say that the group will provide call coverage 10 nights a month for $1000 a night, but in the event that the census for patients seen by the group on call in the hospital (inpatient and ED)
in the last six weeks exceeds 20, then the fee will increase going forward to $1750 a night to support a second provider on the shift or an extender. The heaviness of the beeper should definitely be considered by the valuation consultant to determine the fair market value of the pay for call coverage.

**TERM**

One of the pros of a PSA as opposed to an acquisition/employment model is that PSAs are easy to unwind, as the physician group entity remains in place. (That being said, an unwind can be difficult if the PSA includes the hospital hiring the non-physician staff and administration. In those cases, the PSA should allow for the re-hire of staff upon an unwind.) But easy termination can also be one of the cons. It is not uncommon for a PSA to have a longer-than-normal term, of three to five years for example, with no without-cause termination provision by either party. They are, in a way, a short-term marriage between group and hospital. Locking in a longer term may be more valuable than negotiating higher compensation. It’s hard to get things done if you know the agreement is subject to expire in year term. If you negotiate favorable control rights and exclusivity, you want to lock that in for a while. Additionally, PSAs usually have minimal for-cause termination provisions.

**Need more help?** View and download contract language examples related to terminations:


**EXCLUSIVITY**

When negotiating PSAs with hospitals, groups sometimes focus on the compensation and duties without paying attention to the value of intangibles, like exclusivity. An exclusive agreement means that you are the only entity or person providing the services defined in the agreement. If your group has an exclusive contract to handle call coverage, then only your group can take call (so long as there’s no conflict with the medical staff bylaws). If your group has an exclusive contract to manage the GI service line at the hospital and to oversee GI quality assurance and utilization review, then your group and your group alone maintains control of that. Having this intangible in your pocket prevents other groups from taking control of the department. An exclusivity term also makes clear the line of demarcation between what the hospital’s administrators do and what the physician group does.

**Need more help?** View and download sample contract provisions related to exclusivity:


**NON-COMPETE (CONFIDENTIALITY)**

One remnant topic from employment agreement drafting that hospital systems like to make a part of a PSA is a non-compete. Hospital counsel argues that if the hospital is going to associate so closely with the GI Group, sharing information and collaborating so closely and perhaps exclusively, then the group has to agree not to take that information and use it competitively. Non-competes lock groups in, preventing them from leaving and associating with a system that competes with the system. Agreeing to a non-compete sacrifices significant leverage. The point of pursuing a PSA rather than an employment model is to allow for an easy out if the Group is not happy. That easy out isn’t much of an out if the PSA includes a non-compete.

If the hospital system is sincerely worried about a group taking the system’s confidential information and using it elsewhere, then the group should argue that a Non-Disclosure or Confidentiality Agreement (not a non-compete) is the more appropriate contractual tool to protect the hospital’s interests. After all, the physician group has its own intellectual property and experience that it is bringing to the PSA. Any restrictions on use of information should be mutual. It’s not like the group is an employee who is being trained to work for an employer and who should, therefore, be subject to a non-compete post-termination.

**Need more help?** If the system suggests a non-compete in its letter of intent or PSA, view and download suggested language that you can counter with during your negotiation:


When negotiating your letter of intent before entering into the PSA, don’t focus on compensation to the detriment of other important provisions. Be sure to keep in mind topics that could carry great intangible value: termination and term, confidentiality-versus-non-compete, and exclusivity. Doing so could help your group more strategically align its future course and help it survive well into the 2020s. Spend significant time outlining exactly what duties the group will provide, as there’s no better way to assure a group’s demise than to come under the scrutiny of a United States Attorney who things a hospital is paying a group a kickback for referrals.

Careful counsel and detail-oriented executives for the group and hospital system should negotiate at arm’s length a PSA that reflects the true nature of services and protects what is important to each side.

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**By Ann M. Bittinger, Esq.,**

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