GETTING IT TOGETHER: INTEGRATION OPTIONS FOR ORTHOPEDIC SURGEONS

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It has become evident to us in our law practice that the uncertainty brought on by healthcare reform, the continued consolidation of managed care companies, and the continuing trend toward hospital-based (foundation and outpatient department model) medical groups has created a great deal of uncertainty among California Orthopaedic Association ("COA") members. Some years ago, we developed a White Paper for the COA Board of Directors addressing a number of ways in which COA members could affiliate with one another. The purpose of this article is to provide an updated version of that strategic planning White Paper.

It goes without saying that each one of COA's member medical groups and solo practitioners practice in a relatively unique market. Some COA members may practice in medical markets where small groups and solo practice might still be the predominant model. We believe most of the COA members practice in highly populated areas wherein they must compete with Kaiser, hospital system foundation model groups, and freestanding multispecialty medical groups. This leads us to believe that COA members should at least understand the options available to them and thoroughly evaluate those options before deciding to make a change in their practice setting or stand pat. We hope this article will assist in that effort.

HYPOTHETICAL SITUATION

We believe it is best to analyze a hypothetical situation, and through that analysis provide an understanding of the medical group affiliation options. For purposes of this article, we will assume that there are 20-plus orthopedic surgeons interested in evaluating their affiliation options. Also assume that most of these orthopedists practice within one of three fully-integrated medical groups acting either as professional corporations or a partnership of professional corporations of five or more physicians. Lastly, consider that there may be five or more solo practices among this group of physicians.

As we discuss each of the issues below, we will change the facts accordingly to make them more relevant to the situation under analysis.

LEVELS OF INTEGRATION

These medical groups and solo practices have a number of options through which they could affiliate. There is what we characterize a "Continuum of Integration" available to them. At the beginning of the continuum (i.e., the least integrated situation), the medical groups may consider consolidating certain administrative functions. Let us assume that these practices have different practice management systems and perhaps even contract with an outside billing and collection company. There seems to be little question that what would likely be seven or eight medical practice business office's and as many information systems, is, inefficient. These practices would also have to decide what type of electronic medical record ("EMR") system would be best as well. It is, in fact, likely that while one practice may use a sophisticated practice management system, other medical groups, particularly the solo practices, may not have the same options available, and could very well be operating with much older, less sophisticated systems.

CONSOLIDATION OF BUSINESS SERVICES

These practices could consider consolidating their "business services." This may be done through the formation of a management services organization ("MSO") which would likely be structured as a California limited liability company ("LLC"). The practices could then decide how this entity would be governed, most likely based on the number of physicians in each entity that holds a membership interest in the MSO. The MSO could develop an orthopedic business office by consolidating both the systems and the individuals in the various practices who perform the business functions. This step is often more difficult for solo practices to accomplish because usually their staff members perform multiple functions, including business and medical tasks. Generally speaking, however, medical groups will likely have employees dedicated specifically to the business operations of a practice, and those individuals and their services could be consolidated.

The MSO could also own the information system(s), and any other tangible assets related to business services, that would be necessary. If, for example, a medical group that had recently acquired a sophisticated information system was amenable, that medical group could contribute the system to the MSO. This could become the practice management system for the other practices.

Without question, it is complicated to consolidate various information systems and business services into one office. Debates among the practices are likely to occur, such as whether to contract out for a turnkey practice management system and billing and collection functions, or whether to develop a business office that serves the client practices. These are all important issues to address, and it is impossible to anticipate the facts in every situation.

The MSO may also employ all the non-physician employees of the various practices so long as it is lawfully structured. Podiatrists, Chiropractors, Acupuncturists, Physician Assistants ("PAs"), Registered Physical Therapists ("RPTs"), and Nurse Practitioners ("NPs") could potentially all be a part of the practice, so long as they were employed by the professional entity, (e.g. the professional medical corporation), pursuant to California corporations law. Likewise, all of the other employees could lawfully be employed by the MSO. This consolidation of employees undoubtedly creates efficiency with respect to human resources issues. For instance, there could even be "floating" employees to substitute for employees on vacation. As the employees in this situation would all be well versed in the information system, they could seamlessly provide substitute services where needed.

The MSO could also seek out health insurance and other benefits and hopefully have more leverage than the individual practices would have available in their smaller entities. There could also be benefits for the physicians in the practice entities as well. The MSO would be responsible for, and would likely have, a human resources person, who would assure that all the practices were complying with the myriad of federal and state employment laws and regulations.

This model is certainly not unique. There are a number of employee leasing companies that provide this service. However, in this model, the MSO is owned and controlled by its client medical practices. The business office staff could be carefully selected to have specific expertise in critical areas such as workers' compensation billing, Medicare compliance, etc.

As particular to COA, it would be beneficial for this MSO to focus entirely on orthopedic practice issues and thus be able to bring more expertise to the table. There are MSOs which try to service multiple specialties, and, while these can be successful, due to the uniqueness of orthopedic practices, we believe it would be better to focus solely on orthopedic practices.

We assume that the practices that would consider this type of affiliation would likely be located in at least contiguous medical practice areas. It is not essential that the practices be located in the same medical community, but it would likely work best if they are contiguous medical communities. On the other hand, the MSO office could really be anywhere because it focuses on just business services. Obviously, the direct support employees would provide services in their existing medical practices, but they would all be employees of the MSO.

Such an MSO would be able to analyze any number of managed care contracts with respect to the contracts' non economic terms. It would also be necessary for the MSO to have a system through which the client medical practices do not have access to the other client medical practices' contract fee schedule.

We do not discount the difficulty of changing this important function in each of the medical practices considering consolidation. Once again, it is much more difficult for solo practices to consider such an affiliation than it is for medical groups. Nevertheless, we believe an MSO model could include solo practitioners who might eventually decide to become part of one or more of the medical groups.

At this point in the continuum, all of our hypothetical practices continue to bill and collect through their practice entities. All of their revenues go into bank accounts owned by the entities. Each practice, though, would pay a fee to the MSO, which could essentially be an expense-sharing arrangement, similar to the system that many solo orthopedic surgeons utilize now where they share space and staff with other solo orthopedic surgeons.

It is possible that the MSO could be set up in a way that it could generate a profit. It could also serve non-owner client orthopedic practices. We believe though, that it is best that all the client orthopedic practices be offered the opportunity to have ownership, as this will more closely bind those practices to the MSO. We also believe that the lay administration should have the opportunity to hold equity in the MSO. Although this is something that medical group managers are not able to do in professional entities in California - in fact, it is unlawful.

It is important to understand that the MSO model does not allow any significant negotiation of fee-for-service contracts among the participating practices. Without going into a great deal of detail, the practices could consider implementing a "Clinical Integration" model, which could allow a certain amount of fee-for-service negotiations, as referenced below.

ANCILLARY SERVICE JOINT VENTURES

We will assume for the moment that the orthopedic practices with five or more members have x-ray and possibly physical therapy. It is even possible that they might have an extremity MRI, or even a full-body MRI - although this would actually be unlikely with a small number of physicians. If there were, for example, a larger group of ten or more orthopedic surgeons who had a full-body MRI, some of the ancillary joint venture models could be utilized.

As most orthopedic surgeons know, there are significant federal and state laws which govern an ancillary services joint venture. Over the last two or three years, the federal regulators in the form of CMS and the Office of the Inspector General ("OIG") have

been vocal in attempting to further limit ancillary service joint ventures. However, at this time, it is still possible for orthopedic practices to share in ancillary services without a full merger.

Our hypothetical practices could consider developing an imaging center and a physical therapy operation to be located in a single building. It would be necessary for all the participating practices to have an office located in the same building as the ancillary services department, and also for members of the medical groups to see patients regularly in that facility (e.g., at least four days a week). A medical group of five or more physicians could rotate a physician through this office and comply with the necessary federal and state regulations. However, at this stage in the hypothetical, the solo practices would be much more limited. A solo practitioner would actually have to move his or her entire practice into the building to comply.

Let's assume that the MSO is used as the entity that owns and operates the ancillary services department. In this manner, the participating practices would be the owners of the ancillary services department. Non owners could perhaps receive ancillary services on a very limited basis, but the focus would be to provide a shared ancillary services capacity for all the medical groups and, if located in the same building, the solo practices.

Each of the practices could bill and collect a global fee. Each practice could also contract with a radiologist or radiology group to provide a re-read of the MRI. We have found that the great majority of orthopedic surgeons actually read their own MRI and diagnose and treat based upon that reading. However, professional liability guidelines usually require that a re-read be obtained from a radiologist. Because orthopedic surgeons essentially provide the professional read of the film, they may bill the global fee. Each of the practices would then pay the MSO their share of the expenses.

We believe that this structure would be very much like two solo orthopedic surgeons practicing in the same office and sharing plain-view x-ray. Each of the solo practitioners would bill and collect a global fee for the service. They would then calculate the amount that is owed for their share of all the expenses of the plain-view x-ray operation (e.g., equipment, maintenance, x-ray tech, etc.). Although much more sophisticated, the MSO would serve the same purpose, through which each of the owner practices would pay a share of the costs of the imaging and physical therapy operations.

We would emphasize that CMS and the OIG seem determined to greatly limit the in-office ancillary exception under the Stark laws that permit such a joint venture. We would not be surprised if at some point in the future, the in-office ancillary exception was greatly modified such that only a fully-integrated medical group could use this exception.

We believe one of the advantages that would accrue to the owner groups of an MSO would be the ability to hire a high-level and well-trained and credentialed orthopedic practice manager. It may even be that the practice manager or managers of one of the owner groups could become the CEO of the MSO. In some cases, other managers could focus on the financial operations or human resource operations. The CEO of the MSO could operate as a high-level administrator for all the owner practices.

CLINICAL INTEGRATION

The clinical integration model has evolved over the last five or six years through pronouncements and opinion letters issued by the Federal Trade Commission ("FTC"). The Clinical Integration model has mostly been pursued by multispecialty independent practice associations ("IPAs"). However, we believe the model is adoptable to the creation of a "Musculoskeletal Home" model through which orthopedic practices could create sufficient clinical integration to allow limited negotiation of fee-for-service contracts. We would encourage any interested physicians to contact us, and we are happy to provide a copy of an excellent AMA publication entitled, "Competing in the Marketplace: How Physicians Can Improve Quality and Increase their Value in the Healthcare Market Through Medical Practice Integration." This article provides significant detail on this model.

This model is not as well developed as the MSO model, or affiliation models discussed below. However, we think it falls on the continuum of integration just after the MSO model. Clinical integration requires a significant sharing of both patient treatment data and financial data to create a compliant program. The MSO model, if completed, and if it includes a consolidated EMR system, should provide the kinds of data needed to create a clinical integration model.

ORTHOPEDIC IPA

It does appear that there are still opportunities for orthopedic surgeons to come together for purposes of accepting a risk-based compensation from multispecialty IPAs. In addition, we believe an orthopedic IPA could be utilized to negotiate emergency and orthopedic trauma coverage contracts with multiple hospitals. For purposes of our hypothetical groups, let us assume that the groups have consolidated into an MSO.

Although HMO enrollment and particularly capitated arrangements between HMOs and large multispecialty medical groups and multispecialty IPAs have not grown in number, they still exist. There is an opportunity for the hypothetical medical practices to combine into a 20-plus orthopedic professional corporation. The individual participating orthopedic surgeons would be the shareholders in the professional corporation. (Multiple shareholder professional corporations may not own shares in another

multiple shareholder professional corporation or corporations in California.) This new orthopedic professional corporation would have a board of directors that would be representative of the owner practices.

This orthopedic professional corporation could then negotiate for capitation (per member per month) rates to be paid to the entity for providing services to HMO patients. These contracts would be between the new professional corporation and the multispecialty IPA (which contracts directly with the HMOs). We believe there are a number of these orthopedic specialty IPAs that continue to exist and do fairly well.

These IPAs would need to meet the same FTC guidelines that multispecialty IPAs meet. They must be at substantial financial risk for that portion of the practice for which they contract. In other words, for purposes of the HMO patients, the participating medical practices are financially integrated.

Assuming the MSO has been created and, therefore, all the participating practices are on the same information system, there could be a significant savings in the administrative burden of an IPA. Whereas, the member medical groups may submit paper claims, or possibly electronic submissions, to their respective IPAs to be paid on a fee-for-service basis, the new orthopedic professional corporation would already be able to produce summary reports (e.g., encounter reports) necessary to manage the capitation and to provide the multispecialty IPA with the necessary data. This type of entity would require discussion of how compensation should be made to the member practices. However, these decisions would be controlled by the physicians who are the shareholders, and potentially the board members, of the new professional corporation.

This entity could also contract for comprehensive orthopedic emergency room and orthopedic trauma coverage. We believe that because an entity could provide redundant and reliable coverage to hospitals, it would make sense to negotiate rates together. In many hospitals, the orthopedic department itself is the vehicle through which orthopedic surgeons participate in the call coverage panel and are compensated for such coverage. An orthopedic department of a medical staff may not negotiate these rates. However, the orthopedic specialty IPA would have the ability, we believe, to negotiate such rates. As referenced above, the new entity would be able to provide redundant and reliable coverage, which is not possible where a hospital contracts with multiple physicians.

Assuming that all of the hypothetical practices have moved along the continuum, and now include a professional medical entity (i.e., the specialty IPA) and an orthopedic MSO, it is possible that one or more of the practices could decide not to move further along the continuum. We believe the continuum is flexible in that some of the members could decide to fully integrate their practices, while others might want to remain just in the MSO model, or hypothetically in the MSO and the specialty IPA model. The economies of scale and efficiencies described in the MSO section would still occur.

FULLY-INTEGRATED MEDICAL GROUP

Because the specialty IPA, and even a clinically integrated specialty IPA with an orthopedic MSO, cannot freely negotiate fee-for-service rates, the participating practices could consider a full merger. This, of course, is a significant step and is essentially the last step on the continuum of integration. There are a number of different merger models that have been utilized over the years, particularly in the orthopedic arena. The most common model we see now is one which we will characterize as a "Division model merger."

Let's say that our hypothetical medical groups have decided that things are working well in the MSO and the specialty IPA. They may decide, however, that they would like to investigate a fully-integrated model through which they would be able to freely negotiate fee-for-service rates. We believe this will become more important as health reform evolves, and as the "Musculoskeletal Home" concept grows. As referenced above in the Clinical Integration section, the participating practices would be in a good position to effectively create such a Musculoskeletal Home; however, they would still not be able to negotiate fee-for-service rates.

It is also important to realize that the continuum that we describe is not one that necessarily requires a linear progression. In fact, the orthopedic practices could decide to move directly to the divisional merger model. As a consequence, they would likely consider developing an MSO, but they would have to consolidate their business services, information systems, and in fact bill and collect through a single entity.

For the moment, let us assume that our hypothetical practices have progressed along the continuum. The practices already have a professional corporation with the shareholders representing the various medical groups. Because the shareholders can only be the individual shareholders, the professional corporation is likely to be set up in a way that has a representative governance. In other words, a six or seven-physician owner group would have six or seven shareholders, while solo practitioners would represent only one member. Thus, it is very important that the governance structure of the professional corporation create a balance between the power of the board of directors and of the shareholders.

The most common way for a professional corporation to make critical decisions is through a supermajority vote by the shareholders. These critical decisions would include adding other medical groups or shareholders to the corporation, terminating a physician shareholder, or making any modifications to the Income Distribution and Expense-Allocation Formula (the "Formula"). For an organization to be classified as a single-integrated entity for proposes of antitrust law, the board of directors of the professional corporation must have substantial power. However, it is very possible to reserve a number of the important decisions to the shareholders.

We recognize that for many orthopedic groups, the shareholder members are the same individuals as the members on the board of directors. However, we believe that when a medical group approaches ten or more shareholders, it should consider creating a board of directors that does not have every shareholder as a member.

Under the divisional merger model, the professional corporation would have a board of directors, using our hypothetical breakdown, of perhaps five members. One member would be elected from each of the three fully-integrated medical groups, totaling three members. Let's assume that these three hypothetical medical groups are set up as professional corporations. The specialty IPA professional corporation, or a newly formed professional corporation, could have classes of stock. For example, the five-member board of directors could have one member elected from each of the three fully integrated medical groups. Each of the physician owners of these three medical groups would hold a class of stock that allows them a vote in that one individual.

If there were less than five solo practitioners, a class of stock could be set up that would comprise all the solo practitioners. Although we referenced a five-member board of directors, in this discussion there could be a four-member board of directors, with the solo practitioners electing one member.

It would also be possible to simply have a five-member board of directors through which each member is elected by a vote of all the shareholders. In that manner, the shareholders of one of the integrated medical groups would vote on all the board members. We believe that initially utilizing the class of stock structure is best. Over time, the difference between the former independent medical groups and practices might disappear and, therefore, a single class of stock could be utilized.

Adhering to our hypothetical, however, let's assume that there is a four-member board of directors. In fact, the board of directors might have already been established if the practices had created the specialty IPA discussed above. Let's assume that there is a four-member board of directors that has certain powers, while some important powers referenced above are reserved to a supermajority vote of the shareholders. The governance structure could also allow the shareholders in a certain class of stock—let's say each of the former independent medical groups—to vote on the admission of a shareholder within their class of stock.

For the most part, the day-to-day lives of the practitioners would likely not change. Assuming that there was a consolidation of the business services through the MSO model, and even a consolidation of ancillary services through that model, the actual day-to-day practices of the physicians would continue in their existing medical offices. All the non-physician employees would be employed by the MSO. There is a need in a divisional merger to allow the newly merged professional corporation to utilize the space and furniture and equipment of all the practices. These tangible assets could remain in the former practice entities, and these entities could continue to have the shareholders that they had before when the entities functioned as a medical group. Each of the former medical groups, now tangible asset companies, could contract with the new merged professional corporation to provide the space and use of equipment under some reasonable lease arrangement. We think it best to have the professional corporation, or the MSO, hold the medical office leases.

The predominant body of law related to the divisional merger is federal antitrust law. The FTC has issued some enforcement actions which have provided healthcare lawyers with an idea of the level of integration the FTC would require for a medical group to operate as a single entity for purposes of negotiating fee-for-service rates. The law is too complicated to address in this article. However, suffice it to say that the more integration the FTC sees, the more likely the entity will be found compliant with the law.

Many of our readers may be aware of such divisional merger groups that exist throughout the country. There are a number that have been formed, or are being formed, in California as well. Thus, the FTC has had the opportunity to evaluate such groups, and it would appear that the FTC is satisfied with the level of integration in these divisional merger models.

We strongly believe that within this continuum, it is critical for medical groups and solo practices to accept that all of the revenue that is generated for professional fees and ancillary services belong to the professional corporation. It is for this reason that the Formula must be carefully crafted. Most surgical groups utilizing the divisional model prefer to allocate all the professional fee revenue to the physician who generates it. If all other elements within the divisional merger are as integrated as possible, then we believe the allocation of these fees to the physician who generates them is an acceptable method under antitrust law.

The new medical group entity would, therefore, collect all the revenues for all professional and ancillary services. The first level of the Formula would be to allocate the medical group-level expenses. These expenses would include the MSO expenses described above. It is likely that a group this size would have an administrator, as well as the consolidated information systems

and business office described in the MSO model. Most medical groups decide to allocate these costs on a pro-rata basis. It is sometimes necessary to define what a full-time equivalent ("FTE") orthopedic surgeon does. There are permutations of this allocation, but let's say that the hypothetical owners of the new medical group entity have decided to allocate all these expenses based on the number of physicians in the division.

These expenses would also include legal, consulting, accounting, etc., expenses. It is also likely that the MSO would develop a general accounting system to serve multiple medical group clients. A general accounting system would be very important in the divisional merger model, as the model depends upon the accurate allocation of revenue and expenses.

Therefore, the first stage of the Formula would be to fully cover all of the corporate-level expenses. The general accounting system would then be able to segregate the revenues allocable to each of the "operating divisions" of the new medical group. These operating divisions would consist of the former medical practices. In other words, the three fully-integrated medical groups would operate as a division, while the solo practitioners would each operate as a separate division.

The next level of expenses to be paid would include all of the personnel expenses for the staff that provide services at each of the operating divisions. This would include the receptionists and clinical support staff in each office. This model allows the separate offices or divisions to continue to utilize whatever staffing levels they had before. Medical Group A would not really be concerned if Medical Group C was staffed at a higher level. This would simply reflect the staffing level that has likely evolved over many years. There would be an exchange of information about these staffing levels, and hopefully it would be possible to appreciate the efficiencies in the other operating divisions.

There would also be an ancillary services operating division, or perhaps multiple ancillary services operating divisions. Say that all the ancillary services (e.g., imaging, PT, DME, pharmacy) are operated as a single division. This division would also have a share of the corporate-level expenses allocated to it. As there are no physicians providing services within this division, there would be a need to allocate a fair share of the corporate-level expenses. It is possible that a share of these expenses could be allocated in accordance with the amount of revenue generated by the ancillary services division. The ancillary services division would pay its share of the corporate-level expenses.

Each of the operating divisions then, including the ancillary services division, would be allocated all of their direct expenses. Once again, these are the expenses of the staff, space, equipment, etc., that exist at each of the offices. As referenced above, the payment for use of tangible assets would be made to the former medical practice entities, and that amount would be fully allocated to the what is now an operating division of the new medical group.

The next step in the Formula would be to determine a physician distributable earnings ("PDE") amount for each of the operating divisions. Of course, for the solo practitioners, the Formula would stop here. Whatever amount of PDE was allocated to his or her division would belong entirely to that division. However, with respect to the three multiple physician medical groups, the PDE would then be distributed to the physicians in accordance with whatever Formula they chose. In most cases, whatever Formula the former medical group used would likely be used again by the same physicians within an operating division of the new medical group. There may be an equal share, a 100% "eat what you kill" Formula, or whatever other kind of Formula chosen to be appropriate. Further, Medical Group A could do it one way, while Medical Group B could do it another way.

Each of the owner physicians could be reimbursed for legitimate individual business expenses. We recommend that the new medical group's CPA develop a policy for reimbursement. This policy would likely be more conservative than the former policy of the independent medical groups or solo practitioners. However, it is important not to risk an audit of the entire entity wherein a physician is too aggressive with expense reimbursement. Once each of the shareholder physician's PDE is calculated, these expenses would be deducted from that amount.

If an operating division has an employed physician who practices just in that division, the full cost of that employed physician's employment (e.g., salary, payroll taxes, benefits, etc.) would be allocated to that division, and it would reduce PDE. If an employed physician operated at multiple sites, an allocation could be made based on the percentage of the employed physician's practice that it generated in one of these operating divisions.

As we hope our readers will see, the shareholder physicians of the new entity have given up some significant autonomy. However, they would likely achieve a higher level of income based primarily upon the generation of some economies of scale, possible higher fee-for-service rates negotiated as a single entity, and also significant profit from the ancillary services divisions. Medical Group Management Association surveys have shown that orthopedic medical groups of more than eight physicians are likely to have one-half of their take-home income generated by other means than their professional fees. In other words, the ancillary services—and we would include ambulatory surgery centers here—comprise half their income. It should be noted that many such orthopedic medical groups develop wholly-owned orthopedic-only ASCs. However, because ASCs do not fall under the Stark law, preexisting ownership by medical group physicians of multispecialty ASCs could remain separate. This ownership can be entirely individual.

We certainly do not represent that the process of integrating medical group practices along the continuum of integration is easy. However, it has been accomplished and can be done in a way that accommodates the needs of the shareholder physicians. It is likely that some physicians would decide not to move along in the continuum. In our hypothetical, it could be possible that two of the medical groups and two or three of the solo practitioners decide to practice as a fully-integrated group. The other medical group and other solo practitioners could continue to be a member of the medical group for purposes of the specialty contracting IPA, and could continue to contract for services, and own shares in, the MSO. We think, therefore, that the continuum of integration is very flexible for the participating practices.

1206(l) OR MEDICAL FOUNDATION MODEL

Many COA members are faced with a multispecialty foundation model medical group in their area. This structure allows, under California law, a professional corporation to be formed with physician shareholders. This multispecialty corporation then contracts with a 1206(l) foundation entity. This foundation entity is most commonly controlled by a nonprofit hospital entity. The foundation entity essentially receives all the revenue for physician professional services and ancillary services. The foundation entity then pays the contracted medical group under a Professional Services Agreement ("PSA") compensation for all services. Therefore the foundation model medical group has no operating expenses as all the non-physician overhead is with the foundation. Where we described an MSO above, the foundation operates as an MSO. The difference is that the foundation collects all the revenue and then pays just for the professional services of the medical group physicians.

Most often, primary care physicians consider joining the foundation model. As most primary care physician specialties do not have the ability to generate significant ancillary revenue, and certainly not the ability to participate in an ASC, they are more likely to join these medical groups. In our hypothetical model, a significant portion of the patients referred to the orthopedic practices could now come from physicians who are part of this medical group. Many of these foundation model medical groups are large enough to have multiple orthopedic surgeons on staff. We have found, however, that orthopedic surgeons hired by such entities are likely to want to eventually be part of an orthopedic-only medical group. However, there are many orthopedic surgeons who are happy to practice as full-time members of these medical groups. In this case, there may be no opportunity for our hypothetical medical group to capture the patient referrals from the primary care physicians within these foundation model groups, particularly, when these groups consist of hundreds of physicians.

However, where the foundation model group is not so large, it would be possible for the new orthopedic group to offer to become the orthopedic department of that medical group. In this model, the foundation medical group would contract to utilize the physicians, and often the facilities, of the orthopedic group. There would need to be an interface between information systems so that patients of the foundation model group present at the offices of the orthopedic group would be treated as already-registered patients. This may be done with the technology available now. It is likely that the ancillary services referrals might have to go to ancillary services operations owned by the foundation and/or its affiliate hospitals. However, it is possible for the new orthopedic medical group to negotiate a fee for these services as well.

We believe that, without question, orthopedic surgeons would be better off in a fully-merged medical group with respect to competing with, or affiliating with, a multispecialty foundation model medical group.

OUTPATIENT DEPARTMENT MODEL

Some orthopedic groups have decided to affiliate with hospitals through the outpatient department model. This is a model similar to the 1206(l) foundation, and in fact it is permitted under 1206(d) of the Health & Safety Code. In this model, a hospital or hospital system essentially acquires all the tangible assets and non-physician employees of the orthopedic group. The orthopedic group facilitates, and then operates as an outpatient facility of the hospital. There are some significant logistical issues in this model because the offices of the orthopedic group have to comply with stricter building requirements. We have seen this model work, particularly where the hospital builds a new orthopedic clinic office for the orthopedic surgeon or surgeons.

Under this model, the hypothetical medical group that we discussed above would now consist of only the physicians as shareholders. The difference from the foundation model is that the medical group would continue to bill and collect for the professional fees, particularly the surgical fees. In some cases, the ancillary services revenue would be lost. However, if the PSA relationship then allowed the orthopedic group to have no office overhead, the eventual incomes of the participating orthopedic surgeons could be significantly increased. This model provides more autonomy than would be possible for physicians to have under a full 1206(l) model. The professional corporation then collects surgical fees, and the incomes of the physicians consist of those fees minus some direct overhead, such as malpractice, billing and collection costs for professional fees, etc. The hospital outpatient department bills the patient a facility fee. This is less convenient for the patients, as they receive a bill for professional services as well as a bill for the outpatient department services. However, we understand that many orthopedic surgeons consider this model to be a good one.

MISCELLANEOUS ISSUES

There are a number of additional important legal and financial issues related to the above discussion. These issues include tax and pension issues. For the most part, the pension issue is relatively straightforward. We believe the IRS will consider all the medical groups participating in an MSO model to be "affiliated groups." Therefore, the groups and the MSO have to meet certain tests. We have found, however, that unless a solo practitioner has a defined benefit plan, it is likely that compliance would be difficult. Where a new fully-integrated medical group is formed, the medical group most often establishes a 401(k) profit-sharing plan through which participating physicians are able to shelter $45-$50,000, or whatever amount is now permitted based upon the physicians' ages.

With respect to tax issues, many of these division model medical groups will elect "S" corporation status under federal and state tax law. This would allow the distribution of the profits from the ancillary services division to be paid out as "S" corporation distributions. We always recommend an experienced CPA take the lead on advising physician practices looking at affiliation model tax issues.

SUMMARY

It is our hope that this article will help COA members understand what options are available. As we have emphasized above, it is by no means an easy process to move along this continuum of integration. However, it is viable, and thus we think it important that each COA member, or COA member medical group, consider its options. In almost every medical community, orthopedic surgeons and orthopedic medical groups compete. We see no reason for this to occur. We think that, at a minimum, orthopedic groups should consider the first few steps along the continuum of integration. We believe the flexibility of the model, allowing orthopedic groups and individual orthopedic surgeons to move along the continuum as far as they want, is critical.

We often will provide an initial consultation to medical groups considering such affiliations. We are able to go into significantly more detail than is provided in this article. And, of course, the discussion will be very specific to the actual orthopedic groups and orthopedic practices that choose to participate.

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