PINNACLE

Recruitment, Retention, Alignment Beyond SHOW ME THE MONEY

MRC GLOBAL

PINNACLE ENTERPRISE RISK CONSULTING SERVICES

PINNACLE HEALTHCARE CONSULTING

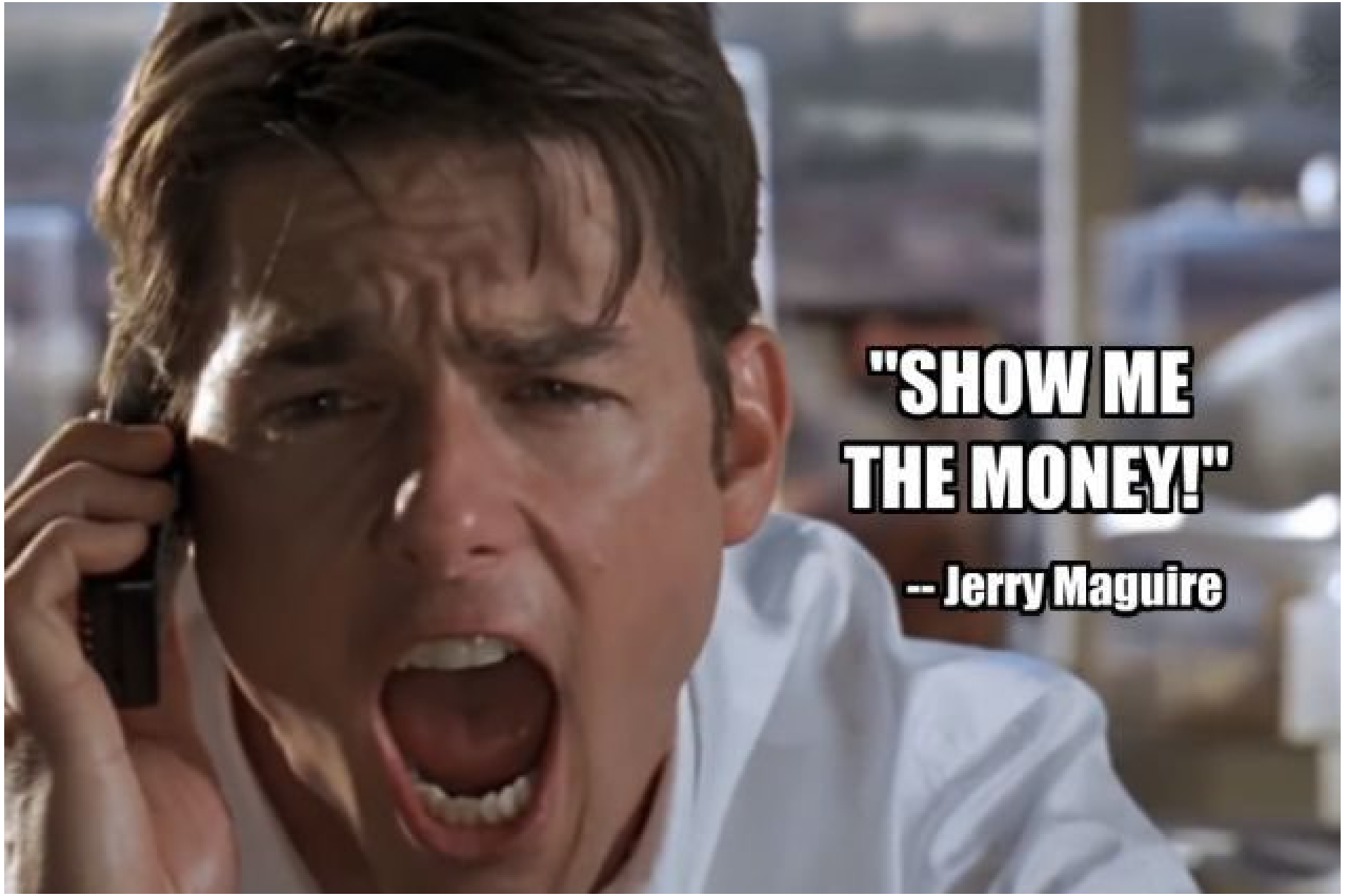
PINNACLE HEALTHCARE REVENUE SOLUTIONS

TeleNeph

Is the only thing that matters Start and End with… Show me the Money?

I. Recruitment
II. Retention
III. Physician Alignment Models

Misunderstood Priorities


"SHOW ME
THE MONEY!"
-- Jerry Maguire

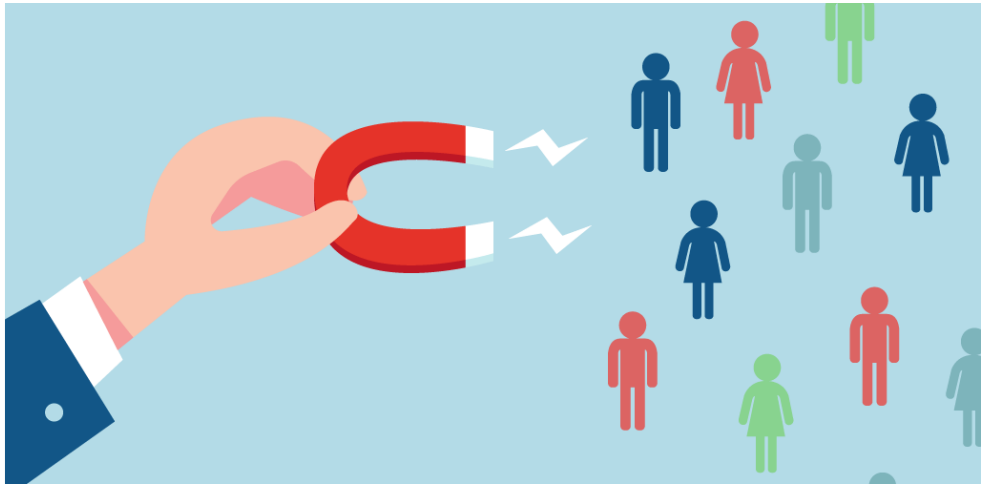
But…is it?

Recruitment

- Focused on the best time of the year – we **never** get hot days, or hurricanes, or tornados, or blizzards
- Upfront **CASH**
- We're Magical
- Whatever you want – we have it
- Sign-On – No problem
- Loan Repayment – No Problem
- Moving Expenses – No problem – just save those receipts
- We simply can't go higher because of FMV – Oh - Competing Offers – how much more do you need?

Retention

- Work-Life Balance
- Compensation
- Call Requirements
- Investment Opportunities
- Partnership Path
- Mentorship
- Program Reputation / Clinical Excellence
- APP Support
- Administrative Time



Recruitment versus Retention

1. Focus on retaining both new and current physicians
2. Continue to reinforce the promises you made during the recruitment visit
3. Be Concise and Clear about the Path

For Practice:

- How does my compensation plan work?
- Equity Buy-in?
- Years to Partnership
- How many others are being recruited at same time?
- What information will I receive?

For Hospital:

- How does my compensation plan work?
- What does life look like after guarantee?
- Will I owe money back if I fail to exceed my guarantee?
- How do I provide input / feedback on items that are important to me?

Compensation

- Explain the Plan
- Visualize the Plan
- Discuss:
  - Risks
  - Upside & Downside
  - Ability to Make More / Less
  - Impact of Decisions:
    - 4 day versus 5 day work week
    - Taking More / Less Call
    - Higher / Lower Patient Volumes
    - Coding / Documentation Education
- Opportunities to Invest in ASCs and other participation?
- Transparency of the Data

Mentoring

- How do you onboard physicians?
- Just spent 8-12 years in medical school but don’t know anything about being in a practice
- And what is this Value Based Care?
- Whether Hospital or Group – do you have a Physician and Administrator assigned to new Physicians?
- Engagement of Physicians - Drive Retention
- Hospitals want alignment with Physicians beyond compensation but frequently fail to discuss items beyond WRVUS, Call Coverage, and Expense Reductions
- Opportunities for Leadership Roles – Are you going to train / teach me how to do that?

Work Life Balance

- Can I work 4 Days / Week?
- How many weekdays and weekends of call?
- Can I pay someone else to do my call?
- Do APPs take Primary Call?
- How many patients am I expected to see a day?
- Who establishes my schedule?
- How many WRVUS am I expected to do?

Program Reputation – Examples

BEST AMBULATORY SURGERY CENTERS
U.S.News & WORLD REPORT

Accredited Awarded by
AAAHC
ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

AANEM
American Association of Neuromuscular & Electrodiagnostic Medicine

TOP WORK PLACES 2024

ABRET

A World Class Destination for Neurosurgery

Blue Distinction® Center+

AMERICAN COLLEGE OF RADIOLOGY
ACR
AMERICAN COLLEGE OF RADIOLOGY
ACCREDITED FACILITY

QOD SPINE SURGERY

ALS ASSOCIATION
CERTIFIED TREATMENT CENTER OF EXCELLENCE

American Heart Association
American Stroke Association
CERTIFICATION
Meets standards for
Primary Stroke Center

Megatrends Affecting Physician Practices

1 Increasing Costs + Declining Reimbursement = Eroding Profit Margins

- Labor shortages
- Supply chain challenges
- Decreased reimbursement
- Regulatory difficulties causing increased documentation for same or less revenue

2 Strategic Partnerships

- Regional Supergroups
- Mega Healthcare Mergers
- Private Equity Investments

3 Primary Care Disruptors

- Focus on Consumerism
- Retail and Corporate Entrants

4 Value-Based Care

- Shift from FFS to VBC payments
- CMS still incentivizing even more by pushing for rural market adoption
- Significant increase in capital investments across the industry
- ACOs Incorporating specialists (no longer just about PCPs)

5 Advancements in Technology

- Telehealth offerings have increased 154% from COVID
- Artificial Intelligence
- Hospital at Home & at Home Monitoring

Options for Physician Practices

1 Remain Independent

- Determine your long-term economic viability
- Defining competition
- Develop strategies for success
- Renegotiate manage care contracts

2 Develop New Revenue Streams

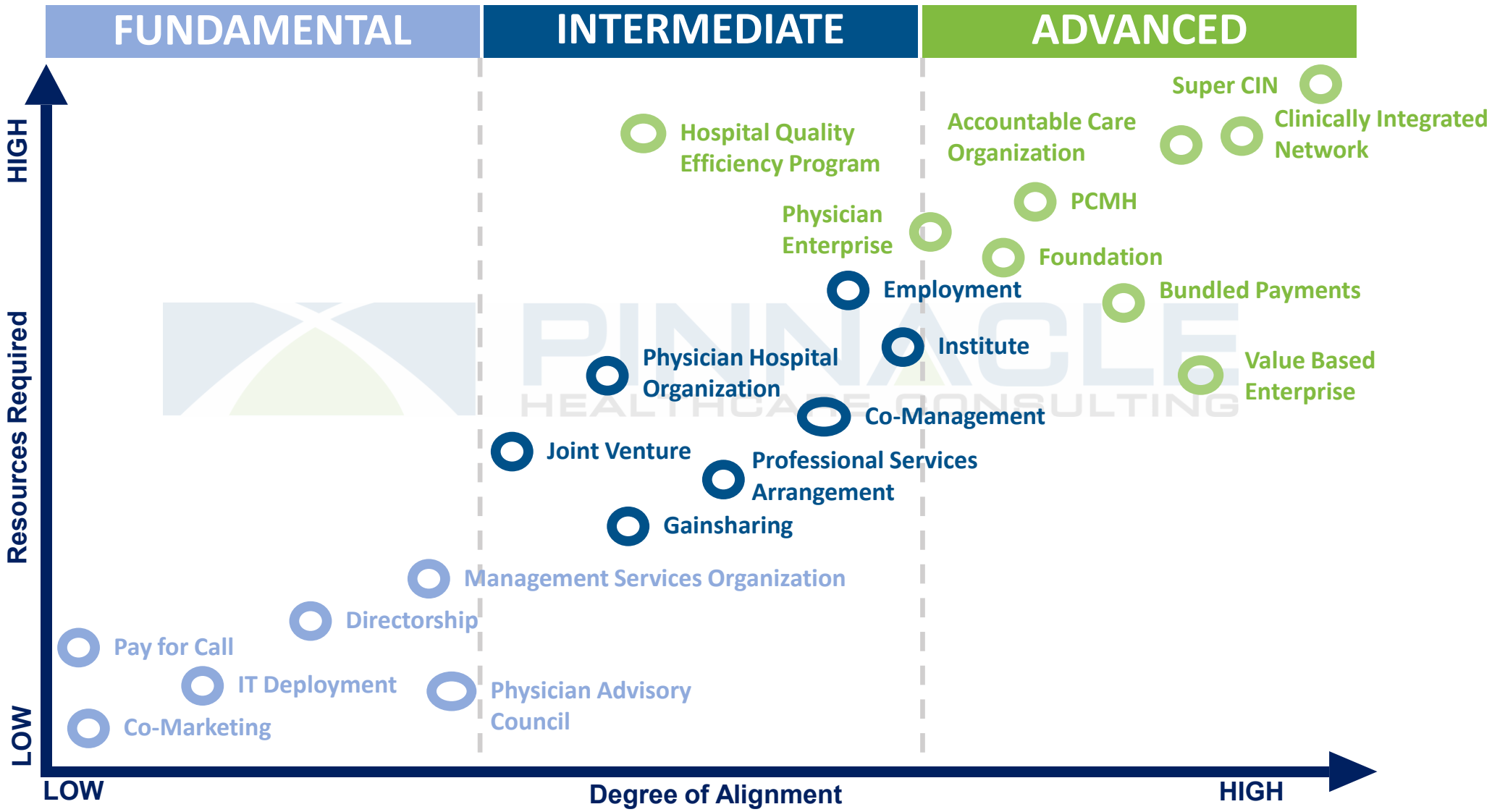
Partner / Own Equity

- New service offerings
  - Ancillaries/OBL's
- Equity in MSO company
- Explore real estate options
- Hospital Alignment Options
  - Gainsharing
  - Call
  - PSA / GPE / Employment
  - VBE
  - ASC ownership / Joint Venture

3 Consolidate/ Identify New Ownership

- Large Supergroup
  - Part Owner
  - Fully acquired
- Health System
- Payor
- Primary Care Market Disruptor
- Private Equity

Physician Alignment Alternatives



Physician Alignment

- What if you started by asking for physician input FIRST?
- Does Shared Governance Scare you?
- If you were transparent with data (including financials) – are you worried the Physician will want to take over Practice or Hospital?
  - Or simply want > portion of the revenue?
- Value Based Enterprise

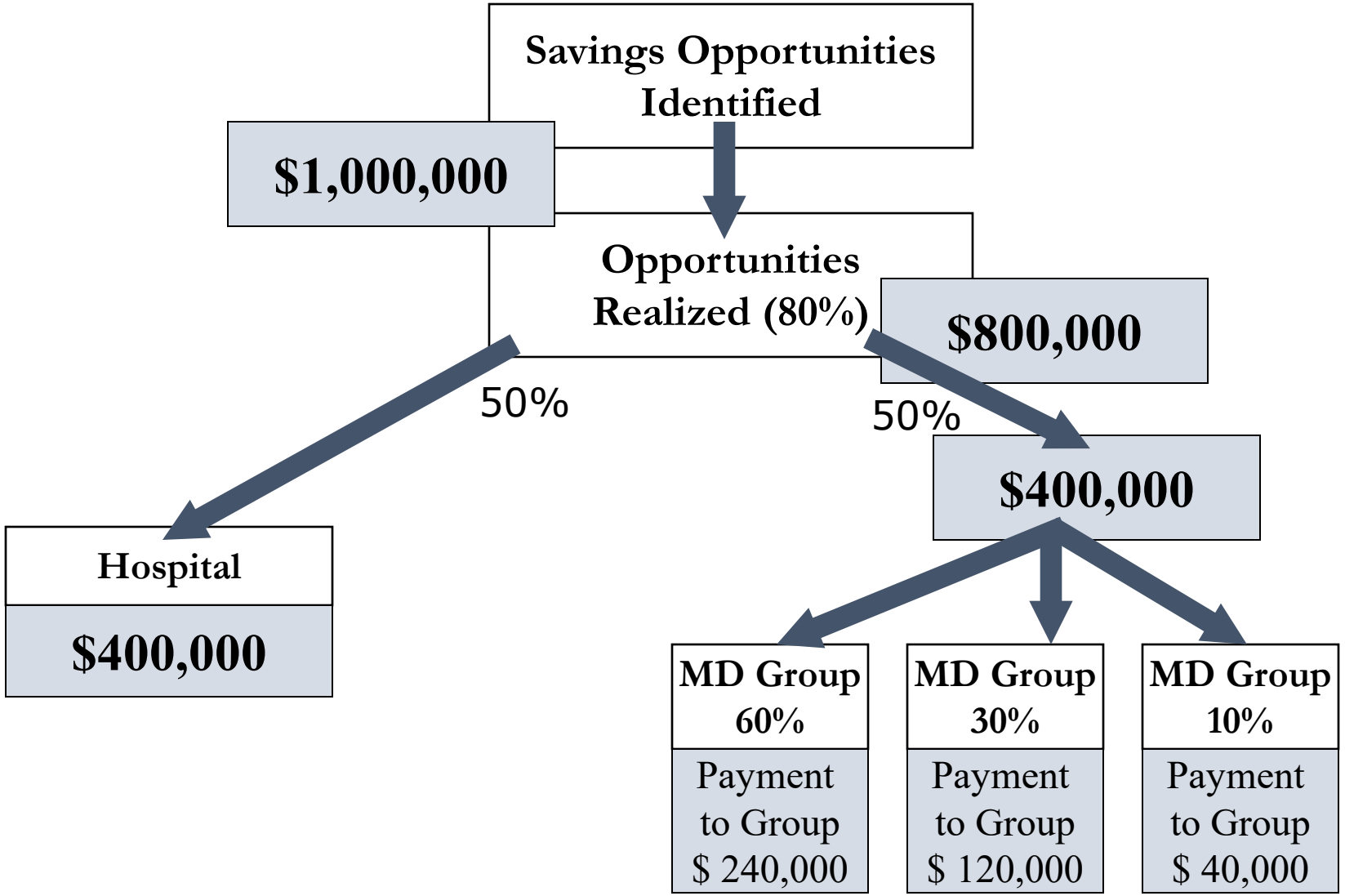
Models

- Are there opportunities to drive alignment in 2025?
- Begin by clarifying Goals
- Follow-up with Consistent Communication
- Create Ideas
- Implement!
- Leading Models:
  - Gainsharing
  - Value Based Enterprise
  - Professional Services Agreement / Employment
  - Group Practice Enterprise

Gainsharing

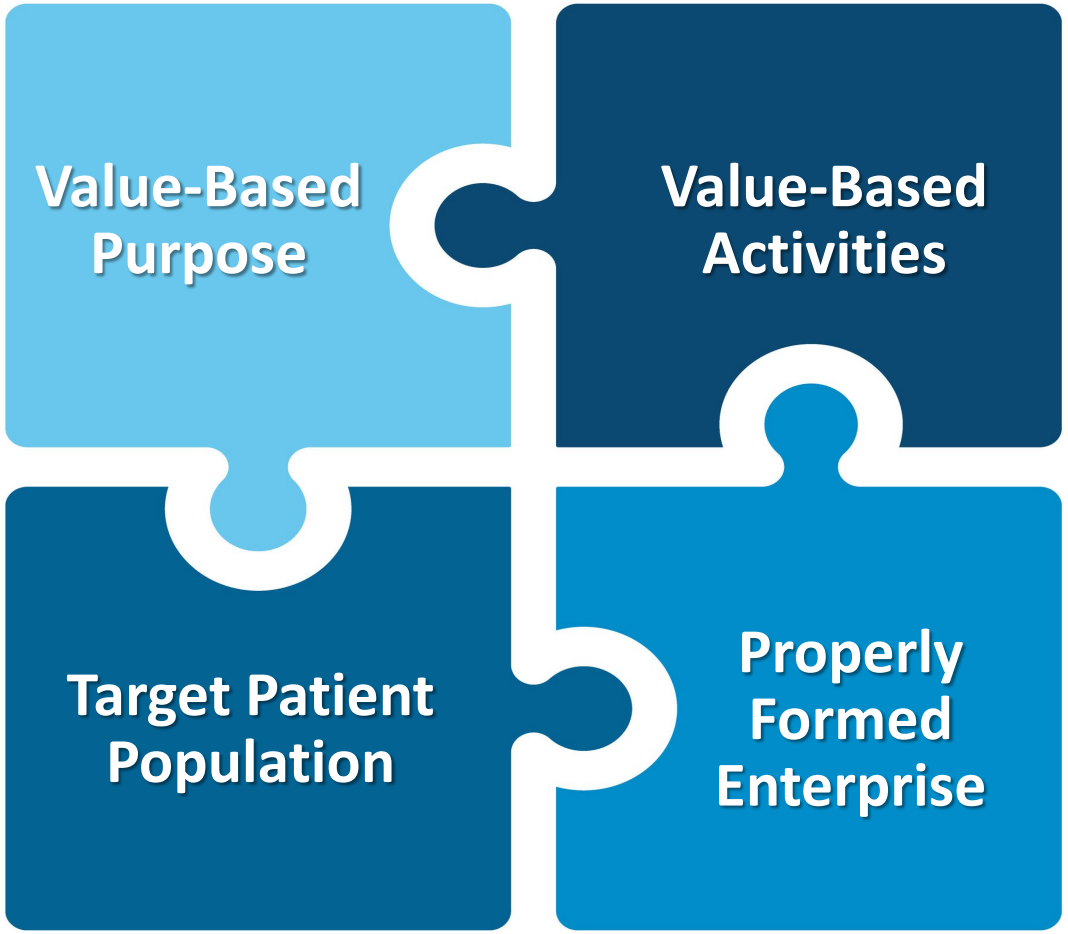
Steps in Gainsharing

Example


Savings Opportunities Identified
$1,000,000
Opportunities Realized (80%)
$800,000
50%
50%
$400,000
Hospital
$400,000
MD Group 60%
Payment to Group $ 240,000
MD Group 30%
Payment to Group $ 120,000
MD Group 10%
Payment to Group $ 40,000

Value Based Enterprise

Foundational Components of a VBE



VBE Risk Models

Stark Law Exception

1. FULL FINANCIAL RISK

The VBE as a whole must assume full financial responsibility for the cost of care for a defined patient population. This typically involves taking on capitated payments or global budgets where the VBE is responsible for managing both costs and care quality.
Physicians participating in the VBE do not need to be individually at risk, as the VBE itself shoulders the risk.

2. MEANINGFUL DOWNSIDE RISK

The focus here is on the physician taking on meaningful downside risk, which is defined as at least 10% of the total value of the remuneration they receive. The VBE itself is not required to be at risk in this model. This allows flexibility for VBEs to structure physician compensation based on value-based outcomes without having the enterprises as a whole bear significant financial responsibility.

3. NO FINANCIAL RISK

The VBE can operate under value-based care arrangements without assuming financial risk. This is a lower-risk model where the focus is on improving care through defined value-based activities (e.g. care coordination or quality improvement).
In this model, physicians do not assume any financial risk, as there are no downside penalties. However, financial incentives can be tied to performance metrics.

AKS Safe Harbor

1. FULL FINANCIAL RISK

The VBE as a whole must assume full financial responsibility for the cost of care for a defined patient population. This typically involves taking on capitated payments or global budgets where the VBE is responsible for managing both costs and care quality. Physicians participating in the VBE do not need to be individually at risk, as the VBE itself shoulders the risk.

2. SUBSTANTIAL DOWNSIDE RISK

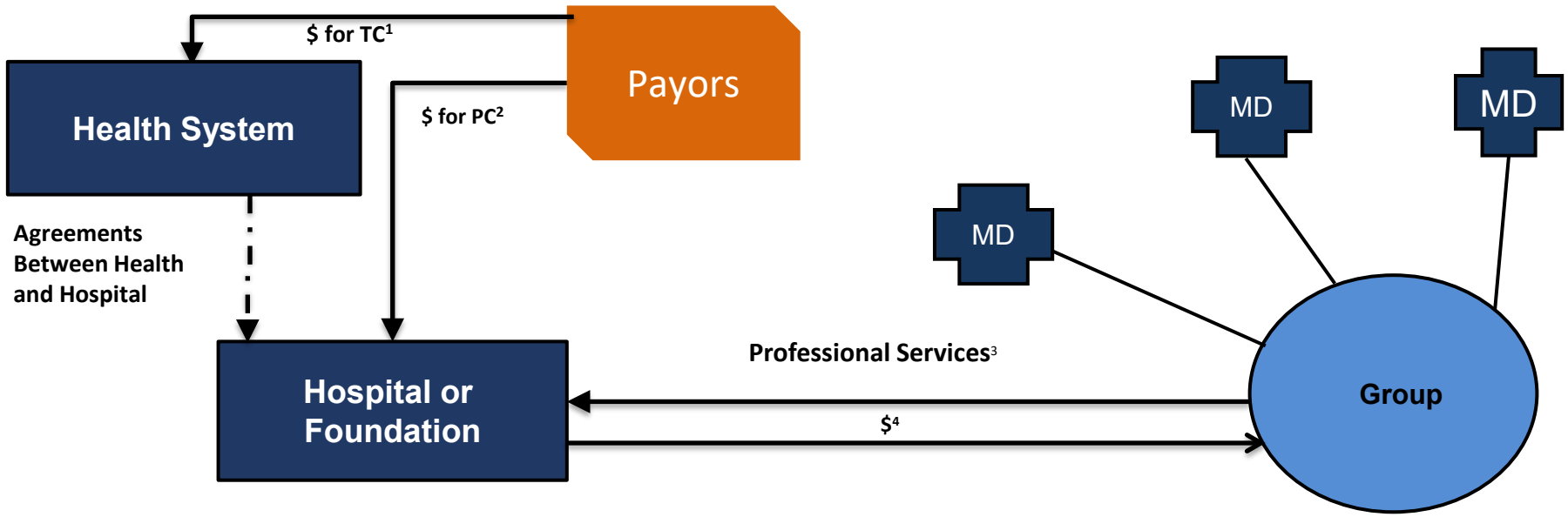
In this model, the VBE must bear a significant share of financial losses if it fails to meet predefined performance metrics.
Physicians participating in the VBE are also required to accept a share of this financial risk, aligning their compensation with their VBE's financial outcomes.

3. NO FINANCIAL RISK

Under this safe harbor, the VBE can focus on improving care coordination without assuming financial risk. This is often used for VBEs that are still developing their value-based strategies or are more focused on patient care processes.
Physicians are not individually at risk but are incentivized to improve care coordination and achieve quality outcomes.

Professional Services Agreement

Professional Services Agreement



1. Health System contracts with Payors for Practice Based Rates
2. MDs reassign right to bill for the professional services under Health System TIN (could also be billed / collected by health system)
3. MDs provide professional services to Hospital
4. Hospital or Foundation pays MDs an FMV fee for professional services
5. Acquisition of all non-provider expense items (other than advertising, legal, accounting, etc…of group) can be acquired or pay a $ / WRVU for overhead or a Flat Rate

Roles / Responsibilities Example

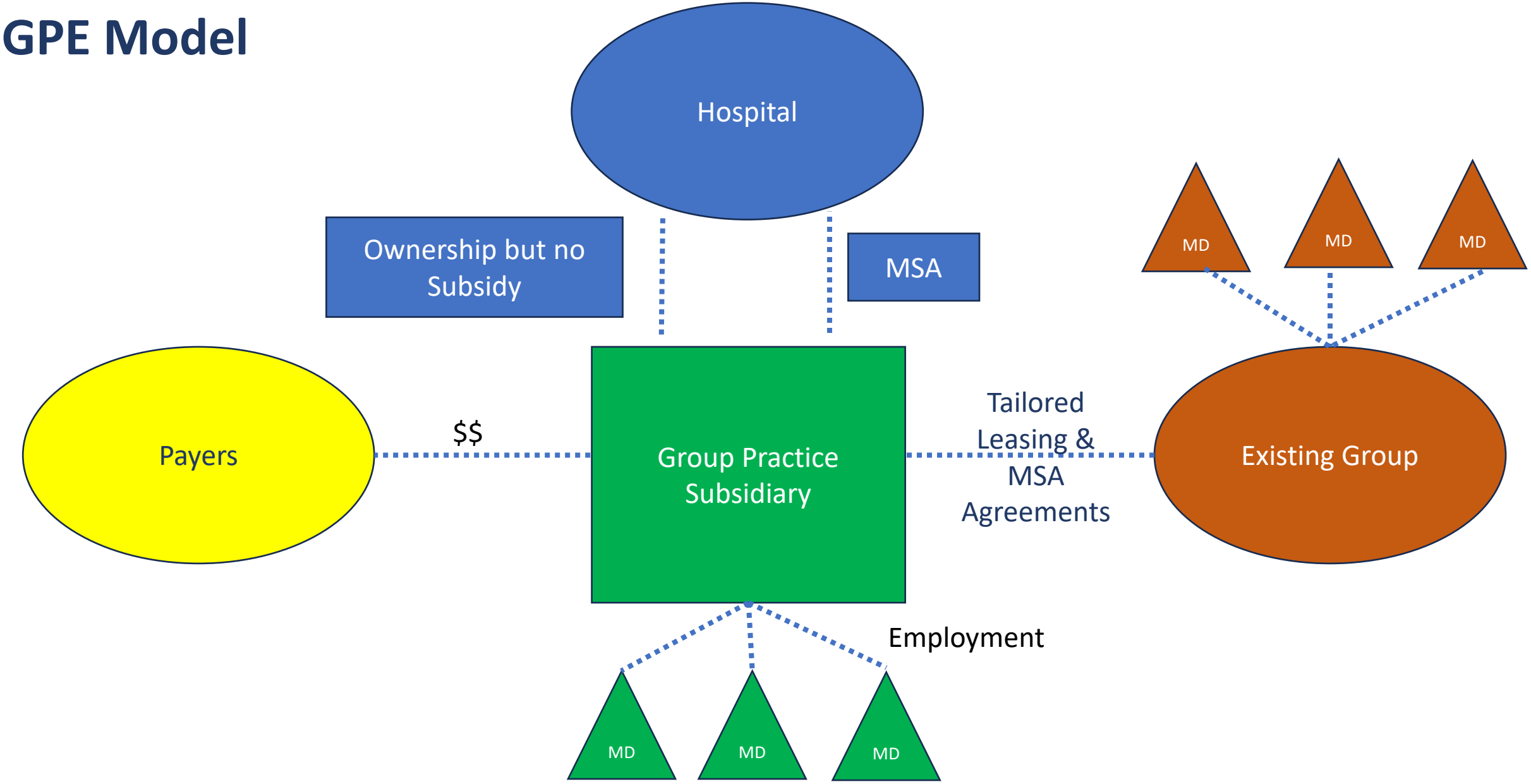
	Practice(s)	Hospital
Employment of MDs / APPS	X	
Payment of Professional Comp – MD / APP	X	Paid to Group
Revenue - Clinic		X
Revenue - Ancillaries		X
Employment of Clinical / Non-Clinical Staff (related to Clinic Ops)	X	X
Billing / Coding Clinic Services	X	X
Acquisition of Practice Assets		X
Acquisition of ASC or Joint Venture		X
Rental Payments - Clinic		X
Co-Management / VBE / Administrative / Performance Payments		X

Group Practice Enterprise

Group Practice Enterprise (GPE) Model

- A new entity would be created under a separate Tax ID
- Physicians are the majority of the governance board
- “Black box” analysis to be completed / confirmed if GPE is selected model
- Physician salaries NOT restricted by FMV
- Ancillaries remain within the GPE
- Physicians maintain control of day-to-day operations
- System will have control through reserve powers
- Private Group entity still exists to own / lease assets and space to GPE (with exist strategic if needed)

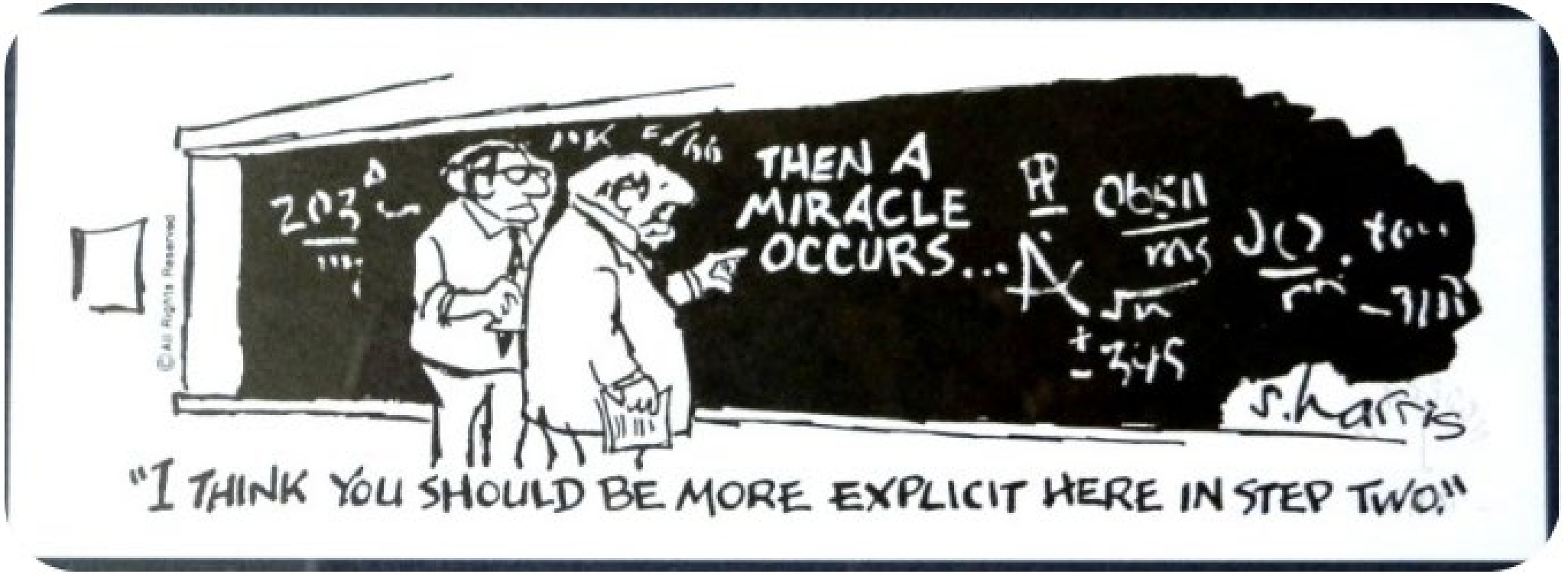
GPE Model


Hospital
Ownership but no Subsidy
MSA
MD
MD
MD
Payers
$$
Group Practice Subsidiary
Tailored Leasing & MSA Agreements
Existing Group
Employment
MD
MD
MD

Lessons Learned

- Practices (both private and hospital-based) are going through changes not previously experienced
- Senior versus Junior Partner Realities
- Revenue impacts associated with higher costs (Labor, RCM, Cyber, EHR, Provider Transitions) and changing reimbursements
- Call burdens are increasing during a time when more physicians value their time greater than the groups time
- Growth of Gainsharing, VBE, and Call Structures / Support
- Greater need (or at least application) of Transparency
- Traditional approaches (Comp, Alignment, Markets) simply not enough
- Shift from Volume to Value is happening (Merit Based Incentive Plans, Medicare Goals of 2030)
- Need to Define STRATEGY

Use an Inclusive Disciplined Process



Don't rely on miracles!

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