

Draft Report
UBMD Project Team (Revised 9/14/07)

The project team began its deliberations on April 4. Following is an outline of the committee's recommendations. The reasons for each recommendation are summarized; a more complete summary of points for and against each recommendation can be found in the Appendix.

1. The missions of the UBMD practice plan are to
 - a. Support the academic missions of the medical school
 - b. Provide excellent, timely and efficient integrated health care
 - c. Improve health care in the region
 - d. Increase market strength and influence of SMBS departments
 - e. Improve financial health of departments
2. Establishment of an integrated plan should occur in two phases
 - a. Implementation phase: The initial structure is established, including the Management Committee, UBMD officers etc (see 12 below) and joint contracting/marketing is begun.
 - i. A common billing system is established
 - ii. An EMR is chosen that can be integrated with the billing system
 - iii. Common benefit and personnel systems are developed
 - iv. Practice plans remain independent corporations with Management Committee as its MSO
 - v. Initial corporate structure permits group contracting and facilitates early economies of scale
 - vi. The nonprofit corporation instituted through the Management Committee can be modified to a fully integrated plan by a bylaws change to include all individual plans in a single entity
 1. Minimal additional cost of nonprofit integrated plan after initial reorganization is completed
 - b. Consolidation phase: separate practice plans are amalgamated into a single corporation via a change in bylaws and dissolution of individual plans
3. All practice plans should participate at startup
 - a. Partial membership would undercut marketing and contracting and undermine group confidence in plan
 - b. Membership in UBMD group should be primary over membership in other practice plans (RPCI) and IPAs
 - i. Clinical income of all RPCI faculty that comes from work at sites other than RPCI should go through the practice plan
 - ii. High level discussions are necessary to formulate a model for integration of UBMD and clinical activities of UB faculty at RPCI
 1. Fee for joint marketing and contracting
 2. Contract/MOU between plans
 3. Integration of plans since most RPCI practitioners are UB faculty
 - iii. Until a method of integrating RPCI and UB plans is devised, include full time faculty located at RPCI and other sites in UBMD governance to maintain collaboration despite issue of "representation without taxation"
4. All full time faculty clinicians should be members of UBMD beginning with initial reorganization
 - a. Includes physicians and other clinicians who are full time faculty who generate clinical income/revenue through fully independent practice (i.e., who practice without need for

- physician co-signing chart or collaborative agreement) via direct patient billing and/or contracted clinical services,
- i. GFT and “non-salaried” full time physician faculty
 - ii. Clinical psychologists
 - iii. Social workers in independent practice
 - iv. Podiatrists
- b. Clinicians in these fields who are not full time faculty (e.g., volunteer faculty) who do not practice independently, and who do not generate income through the practice plan, are not included
 - c. Non-MD members of the practice plan should be able to serve on the Management Committee and vote for Management Committee members (discussed below), but they cannot serve as or vote for members of the Governing Board
5. The Management Committee (MC) should serve as the implementation committee (see 8, below)
 - a. Considerable ongoing work will be necessary to establish the new corporate structure. Implementation will include convening relevant subcommittees, obtaining legal assistance and other consultation for the new corporate structure, and overseeing implementation of the initial organization
 - b. The Project Team IT subcommittee should continue as an IT subcommittee of the Management Committee
 - i. Two standing technical assistance groups should be recruited: one for implementation and then ongoing maintenance of billing system and one for initiation and maintenance of EMR
 1. Considerable ongoing work is necessary for upgrades, training new employees, etc
 - c. MC will need source of funds for implementation
 - i. Development of common billing/management system and EMR
 - ii. Legal costs
 - iii. Initial personnel costs
 - iv. Possible funding sources:
 1. CAO fund initial source
 2. Other funding sources may be appropriate (loan, grants, taxes etc)
 - v. Initial MC discussions should address balance of costs, timing and available funding sources
 6. Once new structure is operational, CAO tax should be used as academic enrichment fund
 - a. Operating costs paid from practice plan operating budget
 7. Plan for an operating budget, fund for new initiatives, space, loans, etc should be developed by Executive Director and Management Committee and approved by Governing Board
 8. Initial actions of the Management Committee
 - a. Oversee implementation
 - b. Group marketing and contracting
 - c. Initiate quality improvement and practice standards
 - i. For example, speed with which patients are seen after referral
 - d. Write bylaws for integrated plan
 - e. Develop plan for financing and timing of migration to common billing/practice management system

- i. Specific allocation of central and “back office” practice plan personnel for each plan
 - f. Develop plan for implementation of common EMR
 - g. Develop a business plan for contracting with reorganized hospital system
 - i. Including process for resolving differing benefit/loss balance in different departments from a large group contract
 - h. Improve internal referral mechanism
 - i. Begin plans for outpatient center
 - i. Best location is UB South Campus
 - 1. Close to basic science departments, VA and Metrorail
 - 2. Convenient to suburbs
 - 3. Independent of hospitals
 - ii. Explore joint venture with UB
 - iii. Include teaching and research space
 - j. Explore joint ventures with other groups
 - k. Determine whether corporate integration of plans should be phased in or should occur at same time
- 9. Migration to common billing system
 - a. IDX appears to be optimal choice at this time
 - b. Phased migration necessary because of cost, current lack of staff trained in IDX, need to overlap new and old billing systems and time for decisions about which personnel to retain in department and which functions to delegate to central billing
 - c. Begin by migrating plans with outsourced billing to common system
 - d. Demographic but not billing data can be transferred from other systems to IDX
 - e. MC should determine after careful review optimal balance of central and departmental location of staff and functions (authorizations, initial billing, denials, follow-up, etc)
 - i. Central office for basic authorization/billing/accounting operations
 - ii. Some personnel retained in departments for specialized operations
- 10. Gather further data on optimal EMR while implementing billing system
 - a. Several EMRs are compatible with IDX
 - b. Committee has been appointed to determine best choice
 - i. Should report recommendations to MC
 - c. Costs appear similar
 - d. Decision should be made by end of year to coincide with full implementation of IDX by Pediatrics
- 11. Billing and EMR committees should report to Management Committee during implementation. These or substitute committees could serve as standing subcommittee of MC IT subcommittee
- 12. Governance (Figure 1)
 - a. Governing Board unchanged per Article 16
 - b. Convert UBA to Management Committee, to be called UBMD Management Committee
 - i. Vote of UBA modifies bylaws
 - ii. Former UBA staff provides technical support to MC
 - iii. University President, VPHS and Dean become voting members of Management Committee
 - iv. Community members of UBA board form an advisory committee chaired by VPHS that makes recommendations to MC about business decisions, relationships with community, etc

- v. Department chairs who are UBA board members (or their designates) serve on MC as part of their role as chairs
- vi. MC chaired by elected UBMD president as in 11i below
- vii. The complex connotations of the term “UBA” to various faculty members is probably an indication for name change to UBMDMC
- c. MSO function performed by MC
- d. Gradually migrate toward fully integrated plan as outlined below
- e. Management Committee is operational group
 - i. Reports to Governing Board (GB)
 - ii. Governing Board maintains general oversight and direction of plan, while specific operational structures are managed by Management Committee in accordance with Governing Board priorities
 - iii. GB can eliminate or reorganize MC by majority vote of GB members consistent with current process for eliminating UBA:
 - 1. Must include majority (i.e., at least 4) of the 6 departments required for LCME accreditation
 - 2. Majorities must be sustained over two votes at least 2 months apart
 - iv. Membership
 - 1. Clinical chairs or designees
 - 2. One basic science chair or designee elected by basic science chairs
 - 3. 3 at large members elected or appointed from G B
 - a. GB president plus 2 at large GB members
 - b. Provides continuity and oversight of operations by Governing Board
 - 4. 6 at large members from general clinical faculty
 - a. Provides faculty input not dependent on departmental membership
 - b. No more than 2 members of Management Committee from any one department
 - v. Members of Management Committee cannot be members of Governing Board with exception of GB president and two GB members elected or appointed to Management Committee
 - vi. 3 year staggered terms for at large members
 - 1. Unlimited possible re-election
 - vii. Term of GB member on MC terminates with leaving the GB
 - 1. Replacement selected from GB
 - viii. Dean, VPHS and UB President are voting ex-officio members of Management Committee
 - 1. Cannot serve as officers
 - ix. Simple majority vote for most decisions
 - 1. Personnel issues (see below) require 3/4 majority
- f. Subcommittees of the Management Committee
 - i. Finance
 - ii. Contracting
 - iii. Marketing
 - iv. Operations
 - v. Compliance
 - vi. Credentialing

- vii. Quality improvement
 - viii. Bylaws/governance
 - ix. IT
 - 1. Billing system oversight subcommittee
 - 2. EMR oversight subcommittee
 - x. Dispute resolution
 - xi. Benefits
 - xii. Facilities/space
 - xiii. Nominations
 - g. Subcommittee members may be selected from the general membership and from CFOs of individual plans
 - h. UBMD officers
 - i. Elected from Management Committee
 - ii. Two year term for each officer
 - iii. President chairs MC and Executive Committee and works directly with Executive Director
 - 1. Will require salary support from operational budget
 - a. Portion of salary corresponding to effort as MC President
 - iv. President-elect
 - v. Secretary/treasurer
 - vi. Past president
 - vii. New secretary-treasurer elected each year
 - viii. Officer who rotates off Management Committee completes term as officer
 - i. Executive Committee
 - i. Sets agenda for Management Committee
 - ii. Rapid response to new initiatives to be presented to Management Committee
 - iii. Membership
 - 1. Officers
 - 2. Executive Director
 - j. Administration
 - i. Executive Director
 - ii. CFO reports to Executive Director
 - iii. COO or Medical Director reports to Executive Director
 - iv. Executive Director works with MC President and is hired by and reports to GB
 - k. GME funds go through MC as they do now through UBA
13. Advantages
 - a. UBA corporate structure can be modified to form MC
 - b. Maintains 501(c)3 status and eliminates cost and time necessary to form a new not-for-profit corporation
 - c. Keeps financial management currently performed by UBA within purview of faculty
 - d. Cheaper and simpler to move to final corporate structure
 - e. Portion of administrative infrastructure already in place
14. During implementation phase, corporate independence of practice plans is retained
 - a. MOUs with UBMD permit MC to conduct group contracting under corporate structure
15. When implementation is complete, individual practice plan corporations are merged into a single corporation
 - a. Vote of each practice plan to dissolve and join new entity

- b. Vote of GB to implement new corporate structure and expand corporation to include entire practice plan
 - c. Cost of reorganization supported by implementation financing arrangement discussed in 7c, above
16. Impairment or poor performance by ED, MC member or officer
- a. President appoints *ad hoc* committee to review
 - b. If president is subject of concern, immediate past president appoints *ad hoc* committee
 - c. *Ad hoc* committee reports to Management Committee
 - d. Removal by $\frac{3}{4}$ vote of MC must be ratified by GB
17. Operating principles
- a. Equitable assignment of costs
 - b. Surplus from high earning departments not used to subsidize underperforming departments
 - c. All departments make proportionate contributions to reserve and other funds
 - d. Meaningful practice incentives
 - e. All departments must be self-supporting
 - f. Group decisions about levels of unfunded care
 - g. Mechanism for addressing contracting in which some departments may benefit at expense of others in manner that does not harm "losing" departments
18. Financial monitoring of practices
- a. Regular review of all plans
 - b. Plans approaching deficit or with weak financial plan
 - i. ED reviews monthly financial statements
 - ii. ED helps plan to develop viable business plan
 - 1. Approved by Management Committee and GB
 - iii. ED reports on monthly basis to Management Committee
 - c. Plans in deficit
 - i. Report deficit immediately to Management Committee and Governing Board
 - ii. Plan of correction developed by ED and Management Committee and approved by Governing Board
 - iii. Monthly monitoring by ED of practice plan's finances with reports to MC

Figure 1. UBMD Governance

