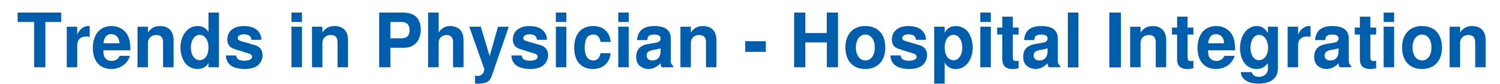


Trends in Physician - Hospital Integration

June 2010

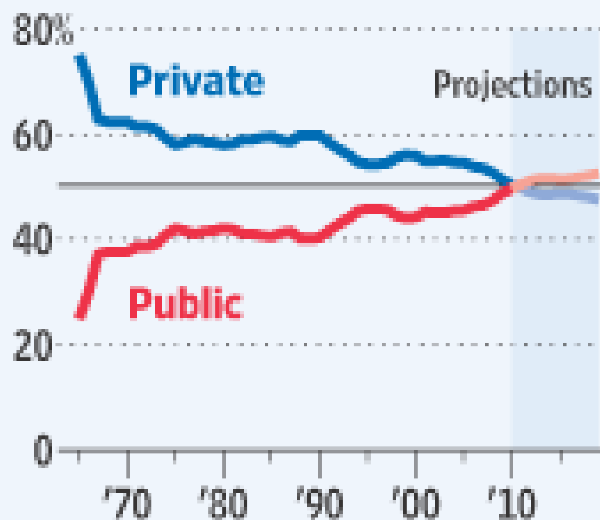
Boston • Cleveland • Dallas • Denver • Miami • San Francisco • Washington, D.C.

Today's Discussion

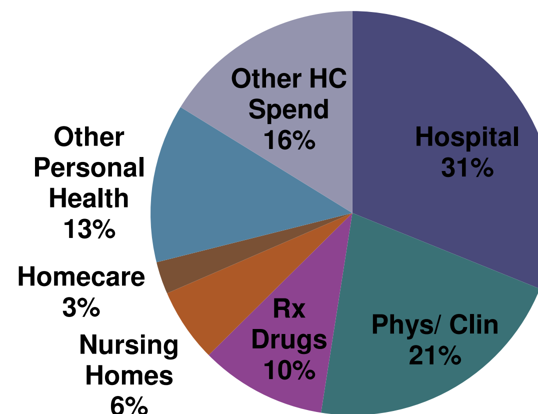
- Impact of Health Care Reform
  - Brief Review of Reform
- Hospital Strategic Options
  - Review Six Options
- Effective Actions
  - Enhance Physician Employment Capabilities
  - Organize Employed Physicians into a Multi-Specialty Group
  - Create a Clinically Integrated Network
  - Invest in Clinical Information Systems

The Growing Crisis – How Can Providers Help?

Healthcare expenditures projected to be ***17% of GDP in 2010***



- **$2.3 Trillion Health Care Expenditures '08**
- **$1.1 Trillion (47%) - Public Payments**
- **Public expenditures for healthcare projected to exceed 50% of total in 2010!**



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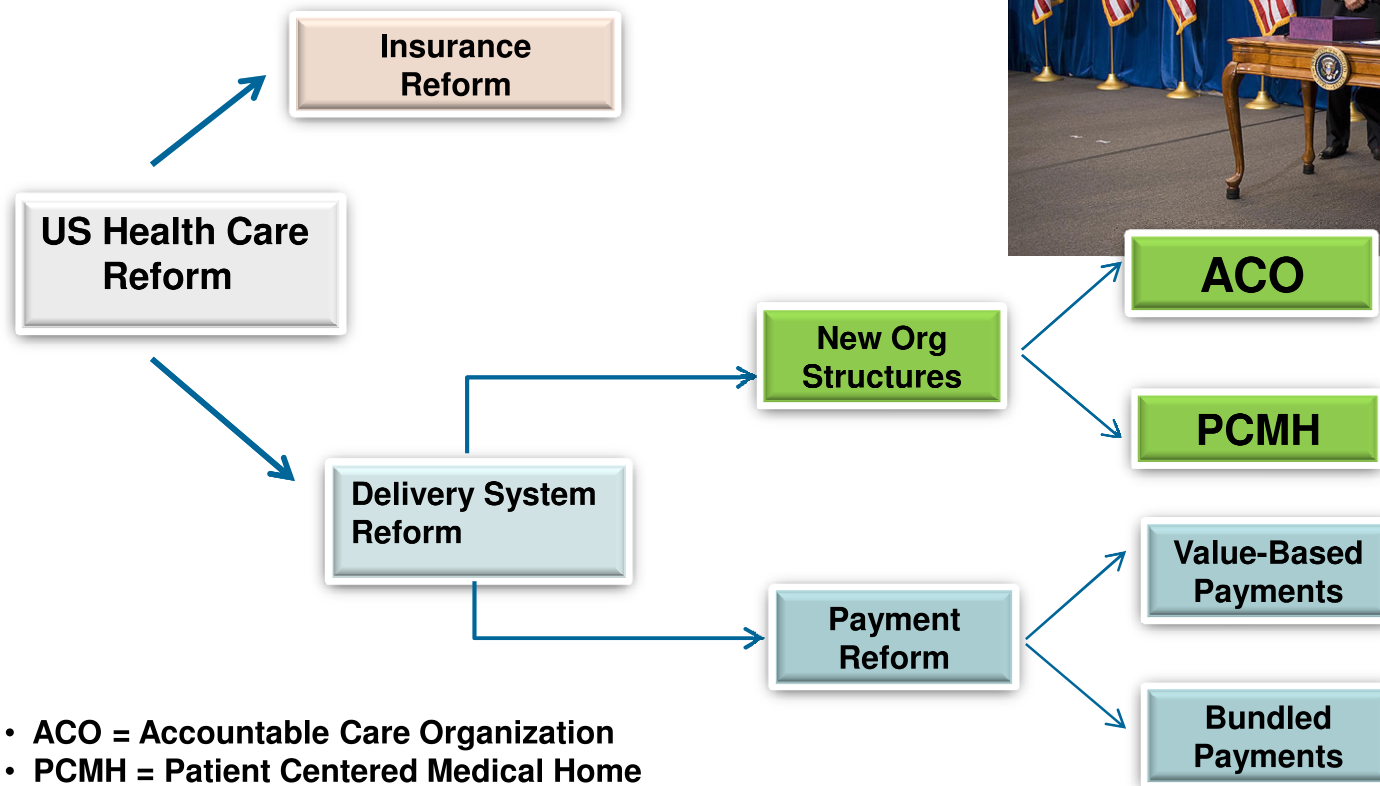
Patient Protection and Affordable Care Act - 2010

Two-Pronged approach to Redesign of the US Health Care System. Who will Lead "Delivery System Reform"???



- **ACO = Accountable Care Organization**
- **PCMH = Patient Centered Medical Home**

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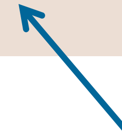
Cost Drivers – American Health Care

Six major factors *contributing to US high cost of care………….*

- Normal Inflation
- Worker Shortage - nurses, technicians, primary care providers…
- New technology – devices, treatments, drugs, science
- Inefficient, uncoordinated, unlinked care
- Perversely incented caregivers/ zero performance data
- Aging population

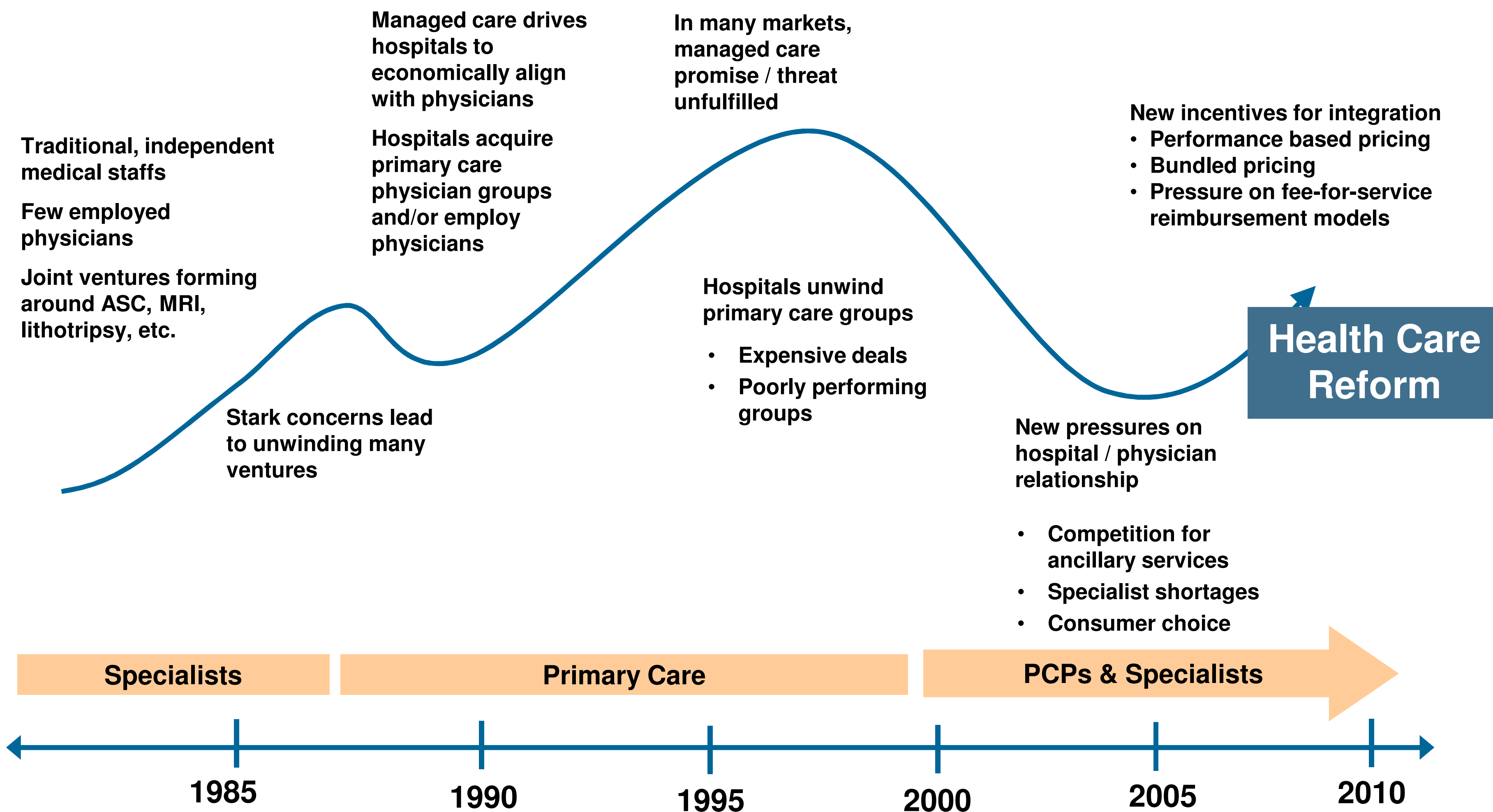


Delivery System Reform and Payment Reform can address these Drivers of Cost**……**

From ***Health Care Will Not Reform Itself*** – George Halverson 2009

Delivery System Reform

Yes, we've been here before, but things have changed…



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Bundled Payments offer Greatest Impact on Cost Trends

Estimated Cumulative Percentage Changes in National Health Care Expenditures, 2010 through 2019, Given Implementation of Possible Approaches to Spending Reform

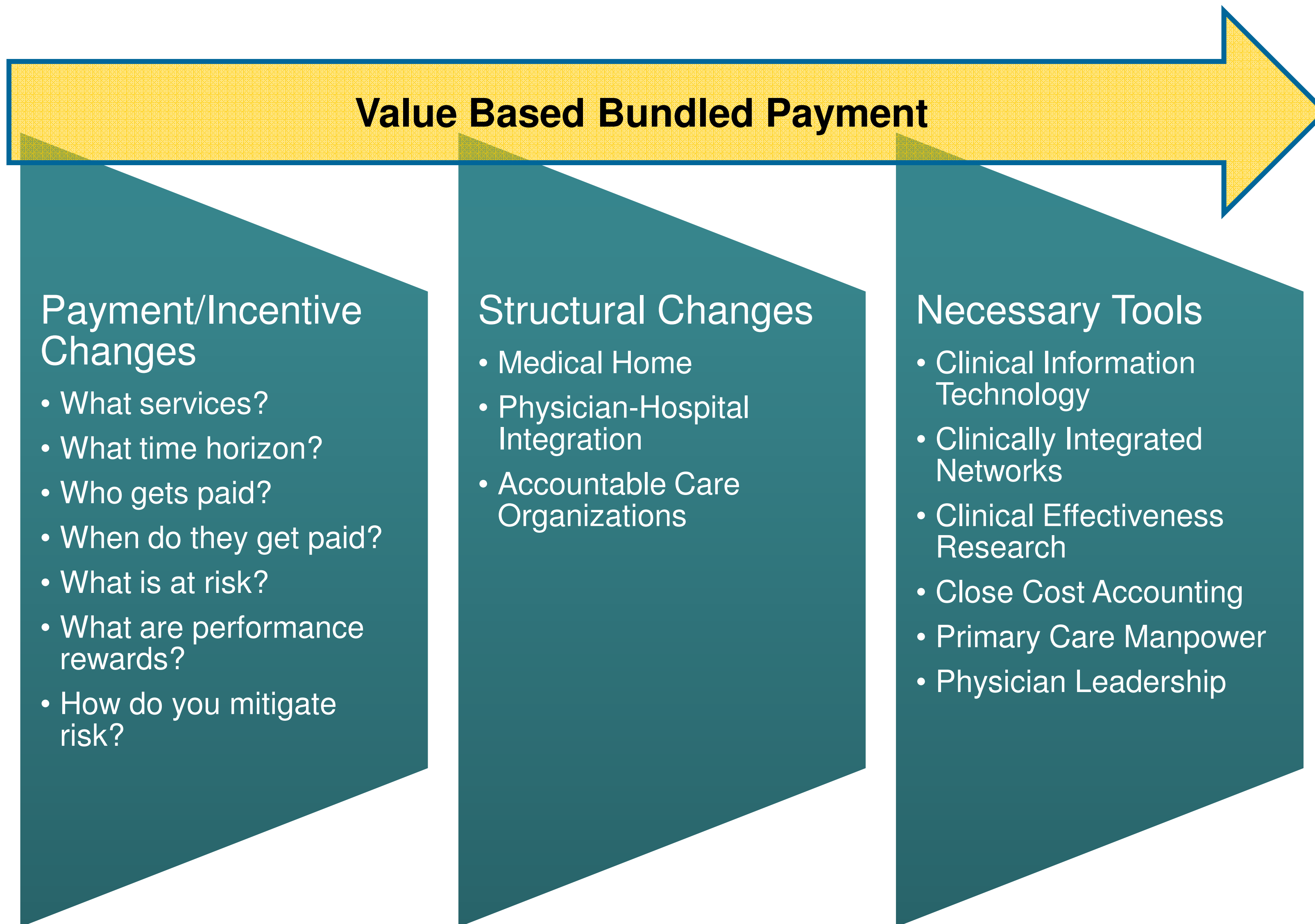
Approach	Low estimate	High estimate
Bundled payment	−5.4%	−0.1%
Hospital-rate regulation	−2.0%	0.0%
HIT	−1.5%	0.8%
Disease management	−1.3%	1.0%
Medical homes	−1.2%	0.4%
Retail clinics	−0.6%	0.0%
NP–PA scope of practice	−0.5%	−0.3%
Benefit design	−0.3%	0.2%

−6 −5 −4 −3 −2 −1 0 1

Change in National Health Spending (%)

Hussey P et al. New England J Med 2009;361:2109-2111

Shifting to Bundled or Value Based



Getting from Here to There

How to get from A to B?

Paralyzed by the Crevasse

FEE FOR SERVICE

- A system we know - all about "heads in beds"
- Low margin, but it works
- Contribution margin analysis always puts hospital at center
- Need only to provide a great operating environment for MDs – not true integration

Whither Margins?

BUNDLED PAYMENT

- Seems so "90s"
- Got burned on this 15 years ago
- How much of this business will there be?
- Will our system really get the upside of keeping patients out of the hospital?

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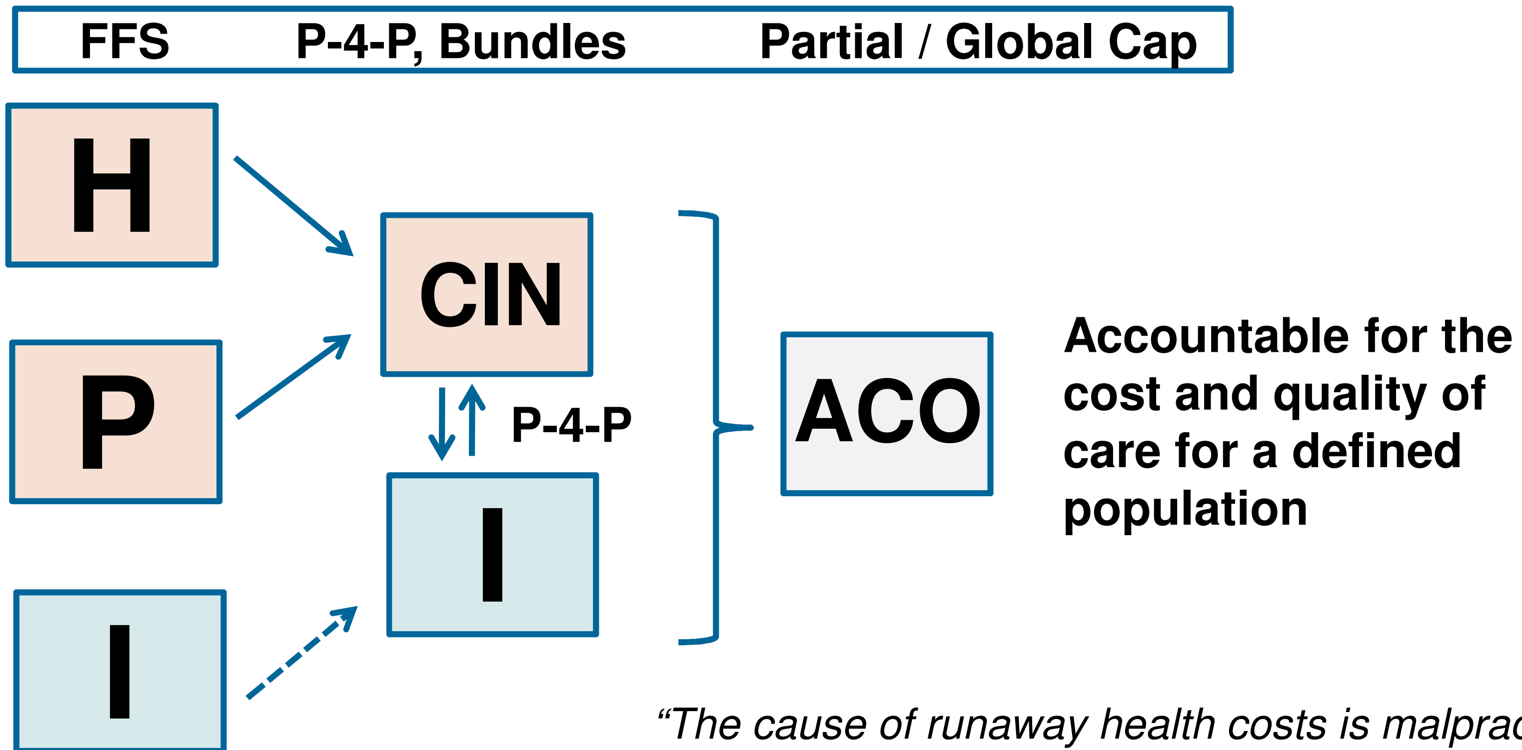
The Path to the ACO - Delivery System Reform

Integrating the three components of the delivery system into a single entity



Accountable for the cost and quality of care for a defined population

*"The cause of runaway health costs is malpractice, but not the medical kind. Rather, we're guilty of **business model malpractice** on a grand scale."*

Clayton Christensen – BusinessWeek March 2010

H = Hospital

P = Physicians

I = Insurers

CI = Clinical Integrated Network

ACO = Accountable Care Organization

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Health System Strategic Approach to Reform

CEO and Board to set a Direction – Lead time for Change is Significant

Option #1 - ***Defend the Current Model***

- *Actively strengthen the hospital position in the market through acquisitions, pricing, contracting to prevent the incursion of managed care, employer or physician initiatives to change the market*

Option #2 - ***Wait for a Mandate***

- *Maintain and continue to invest in current hospital volume-based model (beds and towers) waiting for payment reform to be adopted before announcing or acting on the need for a business transformation*

Option #3 - ***Hedge your Bet***

- *Maintain and invest in the current hospital volume-based model but (quietly) begin investing some profits in building infrastructure and capabilities that will support a business transformation if so required in the future.*

Option #4 - ***Begin the Transformation***

- *Decide to fundamentally change the organizations relationship with both physicians and payers, and begin restructuring the leadership and decision-making processes of the organization to manage care across the continuum. Major commitment to primary care through investment in a primary care network.*

Option #5 – ***Lead the Transformation***

- *Announce the current model "dead" and set a new direction by aggressively building the new organization capable of offering bundled pricing of services, managing chronic disease in the ambulatory setting, and contracting with payers for quality premiums, a share of savings, and risk contracts. Embrace the opportunity (strategic).*

Option #6 - ***Find a Niche (or Join another System)***

- *Recognize that transformation into an ACO is too great a change for the organization to achieve, and pursue a niche that can provide a unique service to the market.*

The "Hedging" Strategy

Physician Alignment Strategy Critical to Pursue an ACO Strategy

#1 - Defend the Current Model

#2 - Wait for a Mandate

#3 - Hedge Your Bet

#4 - Begin the Transformation

#5 - Lead the Transformation

#6 - Find a Niche

Four Key Strategies:

1.) Strengthen Physician Employment Capabilities

2.) Organize Employed Physicians into a MS Group

3.) Create a Clinically Integrated Network (Independents)

4.) Invest in Clinical Information Technologies (EMR, etc.)

Getting from Here to There

No Longer Paralyzed

FEE FOR SERVICE

▪A system we kn[...]
"heads in beds"
▪Low margin, but it wo[...]
▪Contribution margin analysis always puts hospital at center
▪Need only to provide a great operating environment for MDs – not true integration

Whither Margins?

BU[...]DLED PAYMENT

[...]'90s"
[...]ned on this 15 years ago
▪H[...] much of this business will there be?
▪Will our system really get the upside of keeping patients out of the hospital?

Clinical Integration **is a way for physicians and health systems to <u>bridge</u> the gap between FFS reimbursement world and tomorrow's value-based payment world.**

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Physician Employment

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A National Trend

Denver Business Journal - by Bob Mook

Docs flock to hospitals, larger group practices

Kathleen Lavine | Business Journal

January 15, 2010

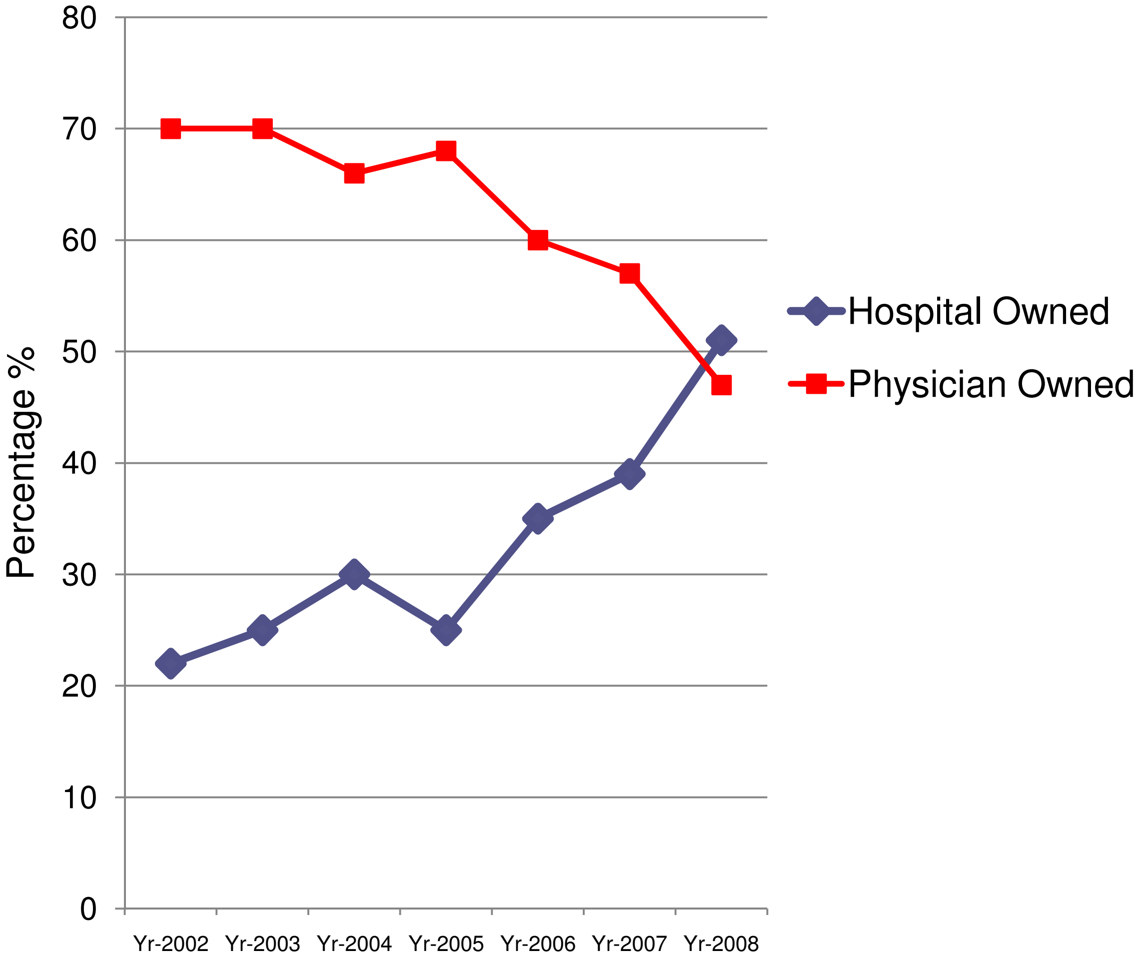
Overwhelmed by bureaucratic red tape, financial realities and the looming prospect of health care reform, more doctors in Colorado and nationwide are giving up their private practices to join hospital systems or larger group practices.

They're selling their small businesses in favor of a steady paycheck and benefits. But hospital systems also take away many of the administrative hassles that bog down private practices, while also giving doctors access to capital and technology for a competitive advantage over smaller private and group-owned practices.

The trend, which is evident in nationwide from Englewood-based Medical Group Management Association (MGMA), has accelerated in recent years with the downturn of the economy. MGMA's hospital membership increased 20 percent between 2003 and 2008. Meanwhile, the number of physicians overall who own their practices dropped 2 percent annually for the past 25 years.

Medical Practice Ownership in the USA

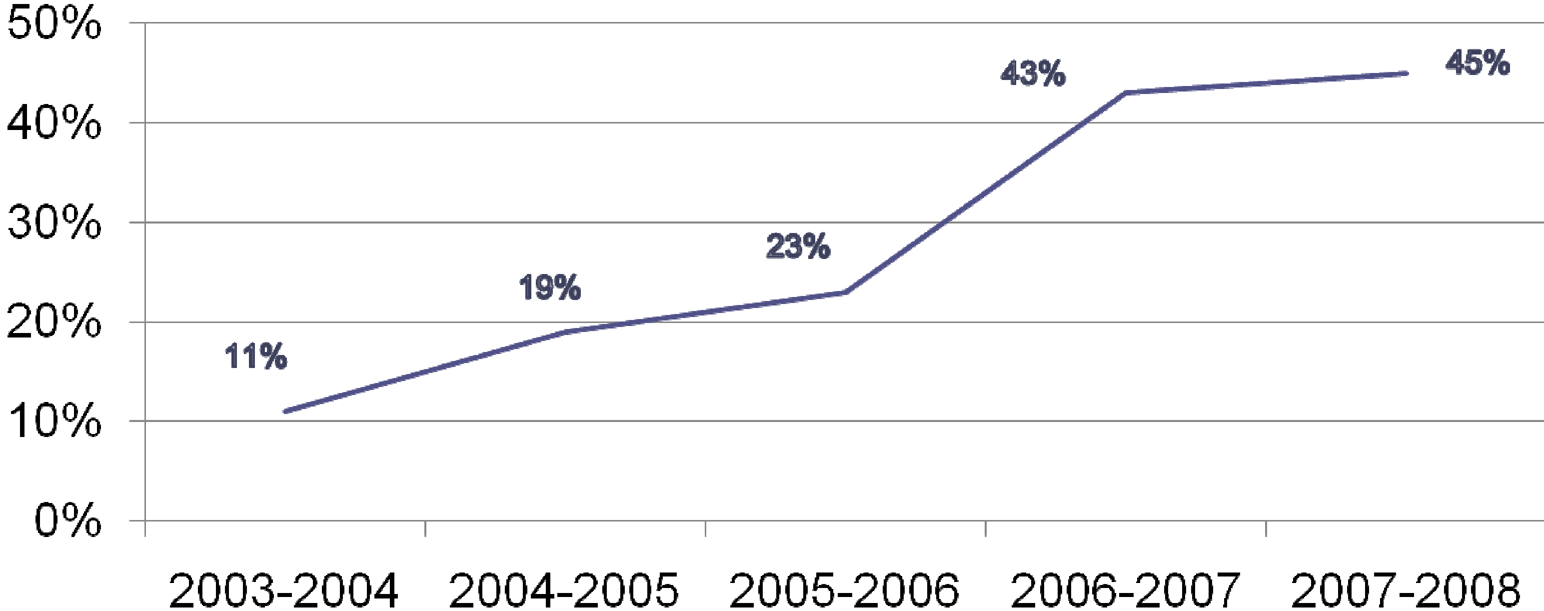
Trend in Hospital Ownership of Medical Practices is Compelling…….



Source: MGMA Physician Compensation and Production Survey

Current Trends in Physician Practice: Nationally (Cont.)

Demand for employment opportunities is growing quickly amongst physicians as a new generation enters practice and hospitals seek to meet new growth targets and performance objectives.



Source: SG2 Healthcare Intelligence, "Building a Successful Employed Medical Group", 2009; Merritt Hawkins & Associates, 2008.

Current Drivers of Physician Employment

- **Declining physician incomes.**
  - ➔ Employment models offer physicians the safety of guaranteed income in an environment where average physician income adjusted for inflation fell 7 percent between 1995 and 2003, and where recent CMS decisions have reduced payments to freestanding centers, which are often owned by physicians.
  - ➔ Aligns physician practice with “deeper pockets” that can fund growth and technology
- **Private practice financial / regulatory stress**
  - ➔ Practices struggling to recruit/ grow because of new graduates expectations and requirements for salary guarantees
  - ➔ Complexity of managing work force and meeting regulations
- **Changing practice preferences (demographics)**
  - ➔ Young Physicians Seeking work/ life balance – not attracted to the private practice model
  - ➔ Start-up costs and “buy-ins” prohibitive in lieu of medical training debts
  - ➔ Future of private practice uncertain – young physicians are avoiding the
- **Projected physician shortages.**
  - ➔ Projected shortages of key specialties are causing hospitals to “employ” in order to assure services
  - ➔ Hospitals are locking in their referring primary care base to prevent defection.
  - ➔ Hospitals are faced with the decision between employing physicians and not having enough physicians on staff, particularly in certain specialties.
  - ➔ Physicians understand their importance to hospitals and are “selling” at peak value
- **Increasing acceptance by hospitals and physicians.**
  - ➔ Significant growth of the hospitalist model, inpatient medicine and
  - ➔ Employment of leading specialty groups creating increasing acceptance of model (no longer a haven for failing practitioners)
  - ➔ physicians actively seeking employment has collectively created an environment where physician employment is a common practice model.
- **Physician-hospital alignment – the cost/ quality imperative**
  - ➔ Consumer and governmental demand for “value” is causing hospitals and physicians to collaborate in order to meet expectations/ regulations.
  - ➔ Removes conflict with hospital management over ancillary ownership

Mutual Dependency of Physicians and Hospitals

Moving forward, there will be a important symbiotic relationship between Hospitals and Doctors in which both groups must have an understanding of each other's needs.

What Hospitals Need from Physicians…	What Physicians Need from Hospitals…
▪ Stable Professional Staff	▪ Quality Facilities and State-of-the- Art Technology
▪ Loyal and Engaged Physicians	▪ Support (capital) for Practices
▪ Safe High Quality Care	▪ Professional Physician Leaders and Practice Managers
▪ Cost Effective Practices	▪ Support for Clinical Care Redesign
• Adoption of New Technology / EBM	▪ Access to Information Technology
▪ Leadership in Care Re-design and Planning	▪ Fair Processes and Shared Decision Making

Recipe for "How to take a good practice and make it look bad!"

Health systems often wonder why previously profitable physician practices lose their luster when they become hospital owned

- Take away the office ancillaries (no credit)
- Provide office staff with hospital benefits
- Use inappropriate benchmarking of practice
- Open practice to self-pay, uninsured
- Put billing under the hospital CBO
- Treat group as a "loss leader" in MC contracts
- Require upgrade of office to hospital standards
- Move practices to hospital available space
- Focus practice managers on "referrals" and "losses" not on growth or throughput
- Lean staff to "reduce losses"
- Allocate Corporate "overhead" (like hosp dept)
- Fail to track and report downstream benefits
- Put practice capital at the bottom of the list (paint, carpet, etc.)
- Fail to invest / focus on measures of ambulatory quality and safety – position for P4

Health Care Environment "Then" and "Now"

Category	1990's	2010
• ***Physician Preferences***	*Employment choice < 10%*	*New graduates > 60%*
• ***Physician Executives***	*Few trained or experience*	*Larger Physician Executive Work Force* *Two decades of Training (ACPE, etc.)*
• ***Hospital Practice Ownership***	*Hospital owned < 15%*	*Hospital owned > 50%*
• ***Practice Management***	*Manage as "hospital department"* *(failed)*	*Manage as a "different business"* *(practice management specialists)*
• ***Quality of Care***	*Delegate to the Medical Staff*	*Board Accountability*
• ***Patient Safety***	*Not on the Radar* *To Err is Human (IOM) published in 1999*	*Board Accountability* *IHI 5,000 and 100,000 Lives Campaigns*
• ***Primary Care***	*Employ for "referrals" and "Capitation Contracts"*	*Employ to position for "Accountable Care" and Chronic Disease Mgmt*
• ***Hospitalist Program***	*Few Hospitalists in practice* *Term "hospitalist" coined in 1996*	*> 28,000 hospitalists nationally – majority employed*

A Different Approach in 2010

- **Purchase price.**
  - ➔ Hospitals purchasing “hard assets” only (using signing bonuses to recognize additional value)
  - ➔ Compensation guarantees “rate-based” and tied to market information
  - ➔ Third-party FMV requirements used to assure appropriate prices
  - ➔ Contracts require physicians to continue practice to receive full benefit
- **Productivity management**
  - ➔ Standardized contracts with compensation related to work effort
  - ➔ Adoption of Market-based Productivity Plans with Quality Bonuses
  - ➔ Practice performance monitored using Key Performance Indicators (not “losses”)
- **Goal Alignment**
  - ➔ Clinical Quality and Patient Safety
  - ➔ Patient/ Customer Satisfaction
  - ➔ Focus on Practice Growth (not “practice losses”)
  - ➔ Clinical information System development
- **Physician integration**
  - ➔ Physician Engagement Structures (at all levels)
  - ➔ Commitment to Physician Input in Decision-Making
  - ➔ Physician Leadership Recruitment/ Development
  - ➔ Adoption of Medical Group practice professionals and “Best Practices”

Local Trends in Physician Practice

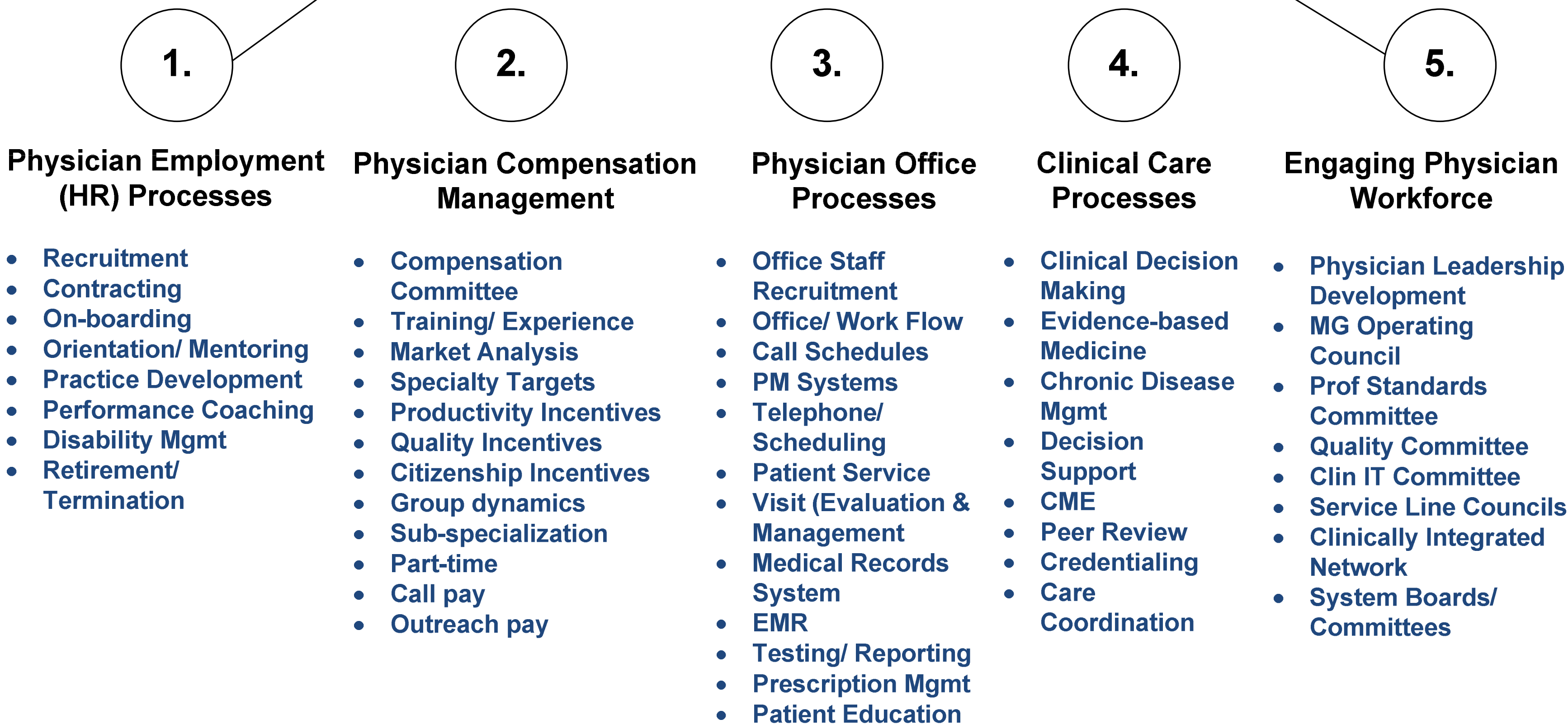
- In many markets the economics practice appear to be bimodal
  - ➔ Larger organized physician practices are doing very well.
  - ➔ Small practices, particularly in primary care disciplines, are struggling
- There is a strong aggregation trend among procedural specialists
  - ➔ Urology
  - ➔ GI
  - ➔ Neurology
  - ➔ Anesthesiology
  - ➔ Cardiology
  - ➔ Pulmonary
  - ➔ OB-Gyn
  - ➔ Radiology
- Large single specialty groups rates 130-170% of Medicare
- Unaffiliated physicians rates at or below Medicare
- In some markets physicians are dropping health plan participation; in others dropping Medicare
- Some physicians “going bare” with respect to malpractice coverage

Employment Can Solve a Variety of Hospital Challenges

System Business Goal	Tactic	MSO	Professional Service Agreement	Co-Mgmt Agreement	Joint Venture	Specialty Employ	Multi-Spec Employ	Clinically Integrated Network
Support independent practices (align closer but stay independent)	*Get Closer*	X	X	X	X			X
Provide ED/ Hospital Coverage	*Coverage*		X			X	X	
Provide services in an underserved market	*Support Mission*		X		X	X	X	
Prevent a critical specialty group from disintegrating	*Life Line*				X	X	X	
Staff a new specialty service (not in the community)	*New Service*					X	X	
Protect loss of critical practice up for sale in the market	*Defend*					X	X	
Prevent specialty group from opening competing facility (e.g. ASU)	*Respond (to Blackmail?)*			X	X	X	X	
Drive improvement in clinical quality and service	*Improve*		X	X	X	X	X	X
Re-direct referrals by acquiring a competitor's primary care	*Attack*					X	X	
Increase hospital volume by re-aligning a competitor's specialists	*Poach*				X	X	X	X
Create a Center of Excellence	*Super Specialize*			X	X	X	X	

The "Doctor Business" is Different

Traditional Hospital Management Lacks the Experience/ Skills to Employ Physicians and Manage Practices…….



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Two Different Cultures

Strengthen the Identities of each Group and Recognize the Contributions of both Cultures

The Physician Professional Culture………

"Expert Culture"

- Autonomy
- Need for rapid decision-making
- Individualistic behavior
- Flat structures (resists hierarchy)
- Consensus in group decisions
- Training: Biomedical Science
- Trained to work independently

The Hospital Administration Culture……….

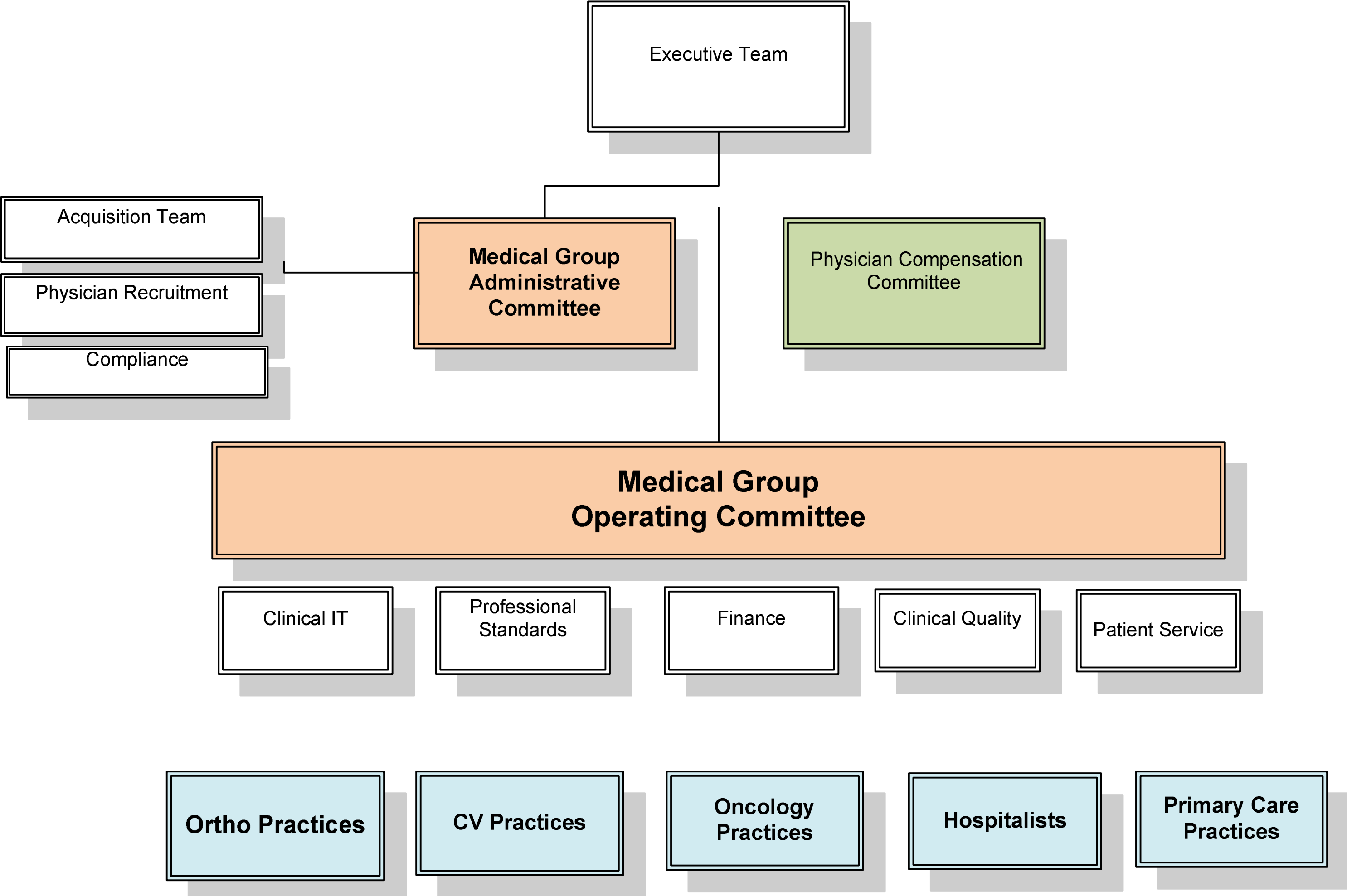
"Collective Culture"

- Embraces organizational mission, values, vision
- Avoids conflict
- Unlikely to take risk
- Respects hierarchy
- Training: Social and Management Science
- Trained to delegate and work in groups

"Separately Together" – Fiol and O'Connors (2009)

Create a Separate Medical Group Division

Generic *Employed Medical Group Division Structure with Specialized Management*



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Barriers to Physician Employment?

Market forces and Physician Preferences are Accelerating Employment as the preferred Integration Strategy – Can Hospitals Respond?

Challenges

- **Board resistance – past experience**
- **Capital investment requirements**
- **Concerns over ability to afford future expansion**
- **Physician concerns about being employed**
- **Reaction of independent physicians to physician employment**
- **Competition for employment with other hospital systems**
- **Capability of system to manage physicians and practices**

Trends Predict………

Integrated Hospital-Physician Organizations will Outperform the Tradition Hospital - Independent Practice Model on Cost/ Quality and Access to Care!

Hospital Systems that fail to invest in developing physician employment capabilities will be in a precarious position going into the future…………….

- Physician Preference
- Evidence of Superior Performance
- Stability of Model
- Integration of Physician Leaders
- Single Contracting Capability
- Alignment of Physician Incentives
- Group Practice Culture

Some Examples of Integrated Models of Care

- Mayo Clinic
- Cleveland Clinic
- Kaiser Permanente
- Academic Medical Centers
- Geisinger Health
- Virginia Mason
- Aurora Health Care
- Allina Health Care
- Scott and White
- Dean Hospitals and Clinics
- St Johns Health System
- Advocate
- Sutter/ Palo Alto
- Sharp Rees-Stealy

Qualified Clinically Integrated H-P Network

A Strategy to Engage Independent Physicians

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Create a Clinically Integrated Network

Hospital-Physician Joint Contracting – FTC Qualified

1.) New Structure to Engage Independent Practices

2.) Focus across the Care Continuum

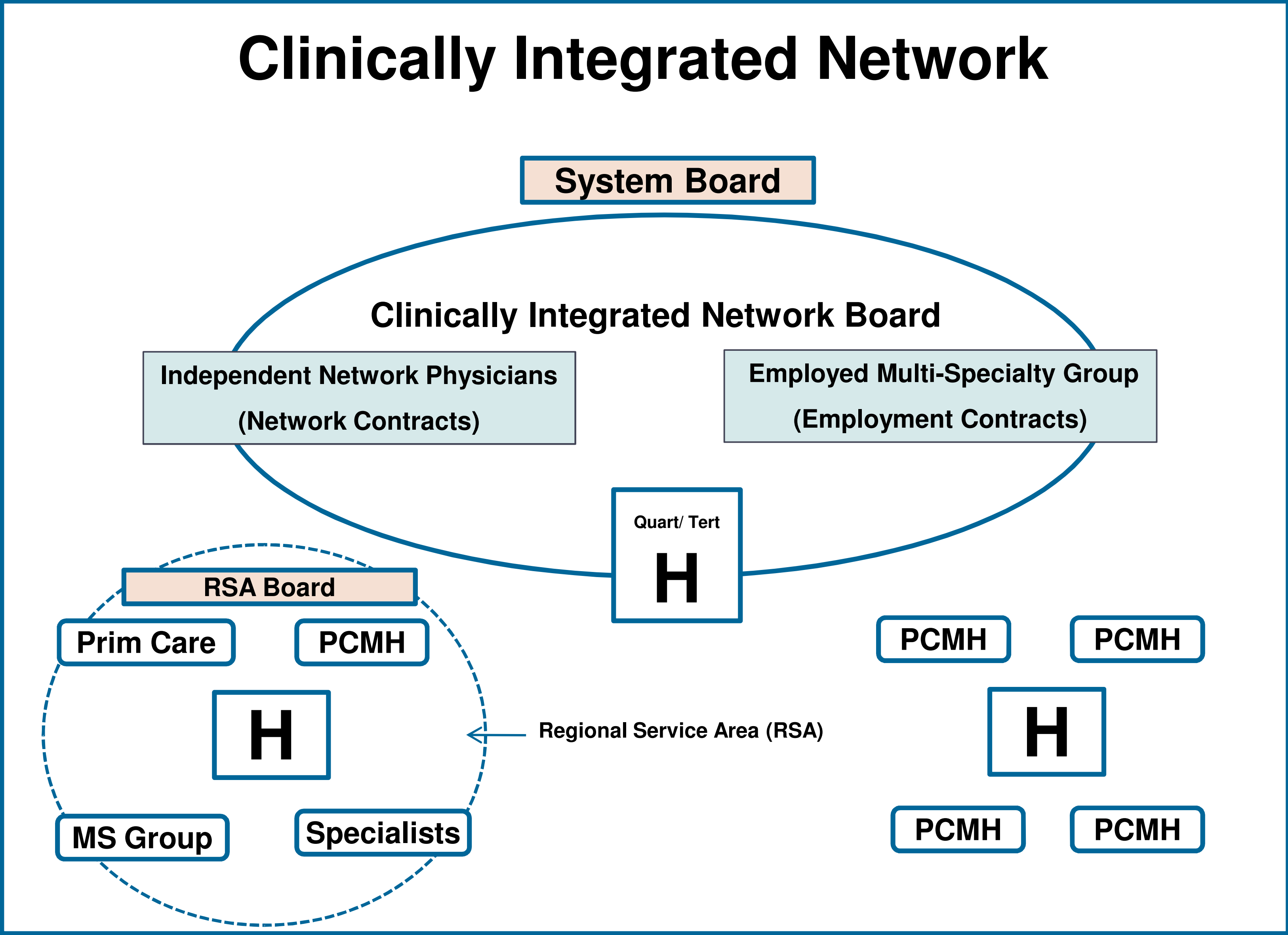
3.) Reconnect with Primary Care

4.) Leverage Hospital Quality Improvement Capabilities

5.) Engage Payers in Value-Based Contracts

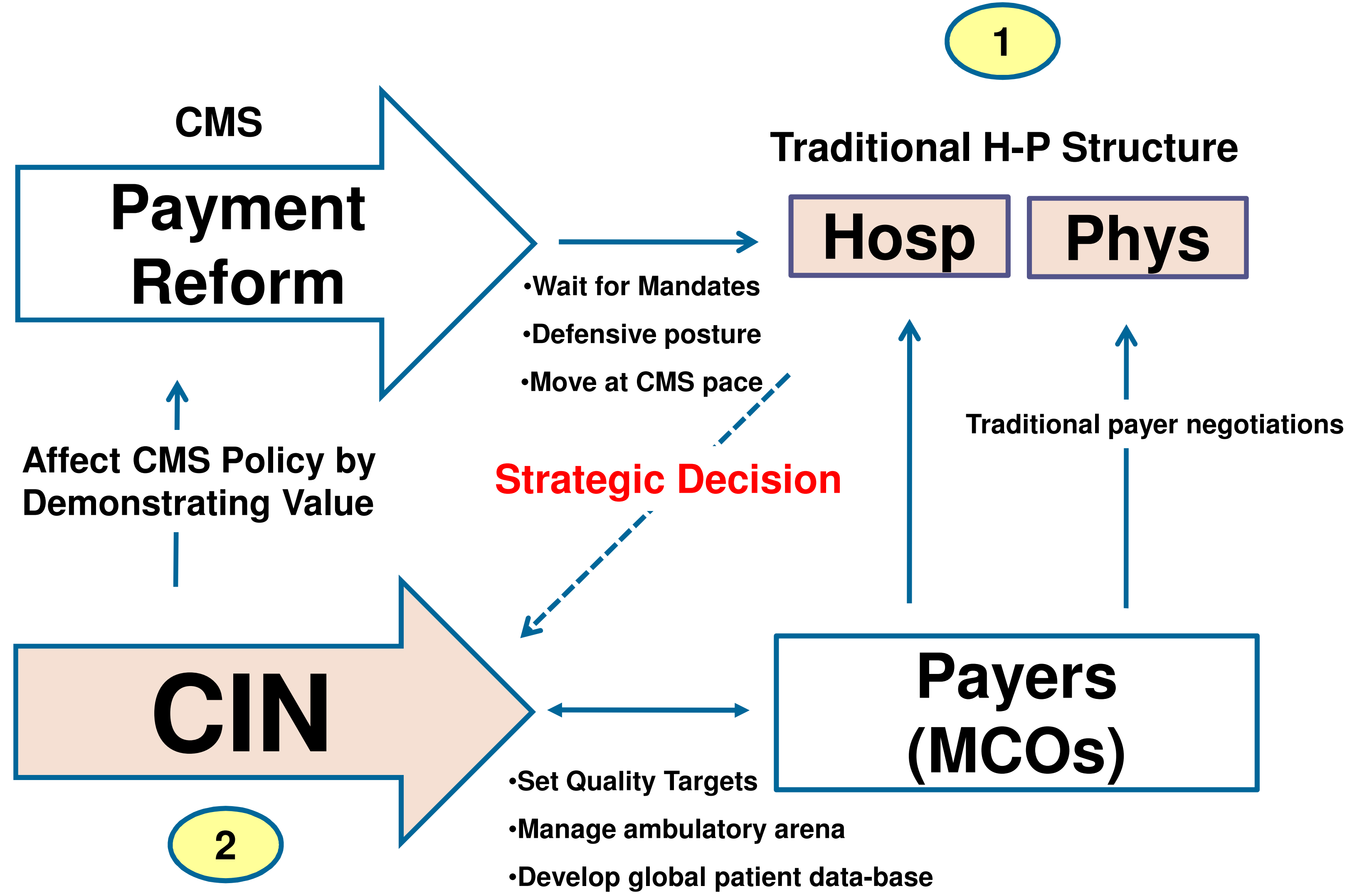
6.) Create Shared Quality Goals

Clinical Integration Diagram



Drivers of Healthcare Reform

Which position would you rather play from?



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CIN – Value for Market

Community Benefit

- Focus on Clinical Outcomes
- Demonstration of Efficiencies
- Focus Resources on Community Health Priorities
- Stable/ Cohesive Network
- Measures and Displays Results to the Community
- Led by Physicians

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CIN – Value for Physicians

- Leadership Opportunity for Physicians
- Better Alignment with Hospital
- Marketplace Recognition
- Focus on Clinical Outcomes
- Incentives Compensate for Additional Work
- Common Interface with Multiple Health Plans

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CIN – Value for Hospitals

- Creates Business Partnership with Key Physicians
- Focuses Physicians on Important Hospital Goals
  - ➔ Patient Safety
  - ➔ Costs
- Strengthens Loyalty
- Reconnects with Primary Care
- Physicians Drive Clinical Outcomes
- Positions for Health Care Reform
  - ➔ Bundled Payments
  - ➔ Payment Denials

Clinically Integrated Network

Critical Success Factors

- Physician Driven
- Same Metrics Across All Payers
- Minimize Additional Administrative Costs
- Additional Funds Recognize Extra Work by Physicians and Staff
- Infrastructure Necessary to Support Improvement
- Physician/ Hospital Alignment

Organizational Direction…

Has Your Leadership and Board set a Course of Action??

#1 - Defend the Current Model

#2 - Wait for a Mandate

#3 - Hedge Your Bet

#4 - Begin the Transformation

#5 - Lead the Transformation

#6 - Find a Niche

HOSPITAL SYSTEM

When to Decide?

"HEALTH" SYSTEM

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A Defining Question For Your Health Care System

Is an Emergency Hospital Admission a…

Good Thing!?……
Fill a bed, take x-rays, do a procedure

OR

..an Ambulatory Sentinel Event?

$$$$$

- **Missed appointment?**
- **Unable to get into clinic?**
- **Failed to fill prescription?**
- **Unable to get Rx refill?**
- **PC / specialty miscommunication?**
- **Patient misunderstanding**
- **Failure to listen to patient?**
- **Missed lab or x-ray report?**

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APPENDIX

Health Care Reform – PPACA Demonstration Projects

Schedule of Demonstration (Pilot) Projects approved under health reform

Senate Bill H.R. 3590	Funding	Dem Project	Description	2010	2011	2012	2013	2014	2015	2016	2017
Sec. 2704	Not Spec	**Inpatient Bundled Payments**	Bundled H-P payments for inpatient care								
Sec. 2705	Not Spec	**Medicaid Global Payment**	Global Capitation for Medicaid (5 states)								
Sec. 2706	Not Spec	**Pediatric ACO**	Payments to Pediatric Providers forming an ACO								
Sec. 3022	$4.9 B (est)	**Medicare Shared Savings**	Payment to Providers forming an ACO						???		
Sec. 3023	Not Spec	**Episodes of Care**	EOC - 3/30 days around hospitalization								
Sec. 3024	$5M	**Independence at Home**	Payments Promoting Home-Based Primary Care								
Sec. 3025	$7.1 B (est.)	**Readmission Reduction**	Payt adjustment for 3 conditions			1-Oct			1-Oct		
Sec. 3026	$500M	**Community-Based Care Transitions Program**	Transition services to high-risk Medicare beneficiaries								
Sec. 3027	$1.6 M	**Gainsharing**	Extends current gainsharing projects		30-Sep						
Sec. 3504	$24M	**Regionalized Emergency Care**	Supports iinovative regionalized emergency care								

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Physician Employment “Failures” (1990s – to date)

- **Purchase price.**
  - ➔ Physician employment driven by hospital fear of capitation - when capitation declined, reason disappeared
  - ➔ Hospital competition for primary care practices pushed up price
  - ➔ Hospital sophistication in valuation of practices missing – paid “goodwill” and guaranteed high incomes
- **Productivity management.**
  - ➔ Salary guarantees without performance metrics created opportunity for physicians to “retire on the job”.
  - ➔ Absence of productivity goals or practice expectations created a decline in practice performance
  - ➔ Cash from practice sales allowed senior practitioners to trade work time for family time
- **Hospital practice management**
  - ➔ Hospital attempts to lead practice management with hospital leaders failed (different business)
  - ➔ Hospital “accounting” of practices deeply flawed by cost/ revenue allocation
  - ➔ Hospital focus on “practice losses” rather than new patient growth contributed to failure
  - ➔ Skilled practice managers left after reporting relationship switched to hospital personnel
- **Physician Integration**
  - ➔ Philosophy of keeping acquired practice separate (“no change”) added rather than reduced practice management cost
  - ➔ Failure to recognize the value of physician input into organizational decisions created a disengaged workforce
  - ➔ Fear of the independent medical staff “backlash” kept system from marketing acquired practices
- **Goal alignment**
  - ➔ Failure to engage physicians in system issues/ decision-making a strong negative signal to providers
  - ➔ Singular focus on cost-cutting initiatives created cynicism regarding leaderships commitment to “health care”
  - ➔ Hospital leadership lack of medical practice management knowledge created loss of respect
  - ➔ Physicians just “punched the clock”

New Model Definitions

Clinically Integrated H-P Network (FTC Qualified)

A "qualified clinically integrated arrangement" is an arrangement to provide physician services in which:

1. *all physicians who participate in the arrangement participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of physicians and create a high degree of interdependence and cooperation among these physicians, in order to control costs and ensure the quality of services provided through the arrangement; and*
2. *any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.*

(*Statements of Antitrust Enforcement Policy in Health Care by the FTC and the U.S. Department of Justice, Statement 8,* http://www.ftc.gov/reports/hlth3s.htm#8.)

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