Building a Sustainable Physician Strategy

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Introductions

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Session Outline

• Physician trends
• Objectives of physician integration
• Six strategies to achieve sustainable integration
• Closing comments
The Context – Physician Trends: Reform Is Already Underway for Most Physician Practices

- Pre-reform practice economics and physician income have already dramatically changed
- Physician practices are struggling in an era of declining reimbursement and increasing costs
  - Professional reimbursement has fallen slightly or stayed essentially flat in most markets across the country; technical reimbursement has and is declining rapidly
  - Commercial insurers have been driving reimbursement down, in an effort to reduce costs and forestall reform
  - Medicare reimbursement has fallen substantially for certain specialties
The Context – Physician Trends: Reform Is Already Underway for Most Physician Practices (continued)

• Many state Medicaid programs run out of money partially through their fiscal year and have not paid claims for months at a time

• Increasing costs have led many practices to:
  – Drop their malpractice insurance
  – Drop their participation in Medicare and Medicaid
  – Convert to concierge practices, impacting admissions and shifting hospitals’ payor mixes, while exacerbating the primary care shortage in many local markets
  – Defer consideration of an electronic medical record

• Many physicians are proactively seeking employment due to:
  – Current economic pressures and concern about the future
  – Lifestyle shifts in practice preferences
The Context – Hospital and Health System Trends: Hospitals/Health Systems Are Focusing on Improving Physician Integration

• Most organizations recognize that their physician strategy is the key driver to achieving one or all of the following:
  – Improvements in quality
  – Growing/maintaining current volumes
  – Reducing costs and competing on value
  – Improving culture

• A new era of alignment that requires a significant level of physician integration is required
  – A value-driven care delivery and payment system requires hospitals to manage care more efficiently, with a close focus on outcomes
  – Clinical integration programs, ACO’s and other value-based programs may/will allow health systems to share performance-based incentives with physicians
The Context – Hospital and Health System Trends: Hospitals/ Health Systems Are Focusing on Improving Physician Integration (continued)

• The medical staff models currently in place in many hospitals are unlikely to achieve the level of alignment required to successfully improve quality and efficiency

• Employing and integrating physicians is challenging:
  – The physician shortage is real, particularly impacting primary care, rural healthcare, and selected specialties in certain regions
  – Today’s physicians have different professional and personal goals, changing the dynamics for physician recruitment and retention
    ✓ A generational difference in physicians impacts their desired level of work effort and call coverage versus compensation
  – The financial impact of physician integration represents a growing challenge for hospital budgets as employment losses mount
  – Many organizations have tried, most have failed, and many are trying again
Anticipated Changes in Regulatory Requirements and Reimbursement Will Further Exacerbate the Financial Challenges Being Faced by Health Systems Who Employ Physicians

- MedPac proposed eliminating provider based reimbursement in the ambulatory setting which has fueled the acquisition of specialty practices and helped to make them accretive

- MedPac has indicated that full implementation of the SGR cuts are built into the baseline projections and, therefore, if the SGR cuts are not implemented a corresponding level of savings would need to be generated from other sources

- Non-governmental payers have slowed the rate of growth of reimbursement or have sought to reduce the level of current reimbursement

- Non-governmental payers have sought out high performing networks to leverage as “narrow networks” and market shifts are occurring
Hospitals/ Health Systems Are Focusing on Improving Physician Integration

- Physician organizations already affiliated with hospitals and health systems are experiencing the same challenges as independent physician practices
  - Declining reimbursement
  - Increasing expenses
  - Increasing levels of financial losses
  - Need for sophisticated technology
  - Shortage of primary care physicians and selected specialists

The bottom line: The current system isn’t sustainable for independent physicians or for hospitals/health system employed physicians
Objectives of Physician Integration

- Support overall hospital/health system strategy
- Help physicians prepare for continued shifts in practice dynamics
- Provide access and coverage for an expanded population of newly insured patients
- Ensure shared goals related to quality, cost, and outcomes

Six Strategies to Achieve Sustainable Integration

1. Develop a physician-hospital alignment plan that supports the health system’s strategic goals and uses pluralistic approach to integration and alignment
2. Ensure sufficient capital for physician initiatives
3. Use a disciplined approach to practice acquisitions
4. Structure effective physician compensation programs
5. Create effective clinical integration programs
6. Proactively manage physician integration initiatives to achieve goals
Strategy 1. Develop a Plan that Supports the Organization’s Strategic Goals and Uses Multiple Approaches to Integration and Alignment

- Physicians must participate in the planning process and future governance
- The physician plan should be integrated with the organization’s overall strategic plan and its goals related to:
  - Program/service line offerings, facilities, technology, and other resources
  - Quality, efficiency, growth, access, and other objectives
- Integration strategies must be quantified and properly resourced
  - Detailed strategic and financial projections ensure the availability of capital to fund the strategies
### One Size Does Not Fit All: Independent Physician Stakeholders Typically Fall Into Six Distinct Cohorts

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Foundational</td>
<td>• Loyal, highly active physicians who drive quality and disproportionate amount of revenue and volume to the hospital; typically anchor a particular service line</td>
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<tr>
<td>Loyalists</td>
<td>• Physicians who admit 70% to 100% of their inpatients to the hospital; may or may not be foundational practices</td>
</tr>
<tr>
<td>Splitters</td>
<td>• Physicians who admit to multiple facilities, but admit 20% to 70% of their inpatients to your hospital</td>
</tr>
<tr>
<td>Occasional users</td>
<td>• Physicians who admit less than 20% of their inpatients to the hospital; barriers to securing their admissions are usually significant</td>
</tr>
<tr>
<td>Referring, non-admitting</td>
<td>• Upstream referral sources who may direct sizeable volume (usually to a specific specialty or subspecialty), usually from outside the market</td>
</tr>
<tr>
<td></td>
<td>• In the future, these physicians may represent a potential source of new business or a loss of existing business</td>
</tr>
<tr>
<td>Non-Users</td>
<td>• Physicians who do not utilize your system’s facilities and are still independent; as current situations evolve, these could represent growth opportunities</td>
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The Path to Physician Integration Will Require a Pluralistic Physician Model… at Least in the Interim

- Organizations that offer multiple alternatives to integration will be the winners
- Maintaining a hybrid strategy gives hospitals/health systems time to build capital and adequate practice management capabilities

<table>
<thead>
<tr>
<th>Independent physicians</th>
<th>Clinically integrated physicians</th>
<th>Employed physicians</th>
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<tr>
<td>• Independent physicians will likely continue to practice through a transition period</td>
<td>• Hospital systems will seek to partner with independent physicians in order to drive quality and effectiveness; <em>Clinically focused co-management programs and “clinical integration” strategies will be core to this effort</em></td>
<td>• Multispecialty groups will be organized around driving highest-quality healthcare</td>
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Physician Integration Models

- Four basic models for physician integration currently exist:
  - Practice acquisition/ employment
  - Technology support and integration
  - Contracting options
    - Physician-hospital organization (PHO)
    - Management service organization (MSO)
    - Accountable care organization (ACO)
    - Professional Services Agreement
    - Others
  - Increased customer service programs for independent physicians
Next Generation – Moving to a Clinically Integrated Model or an Accountable Care Organization

• The next generation of physician alignment is going to focus on a collaborative model that will have hospitals and physicians aligned to improve quality and efficiency (costs)
  – There are some good examples of functioning clinically integrated models
  – New skills and infrastructure are needed, such as ambulatory and acute clinical systems, utilization management and review, extensive care management intellectual property and infrastructure, new quality measurement systems, and more
  – Building these organizations and functions is evolutionary and not an event; incremental progress can be made in the short term (more on this later)
Technology Has Become a Successful Physician Integration Strategy

Key success factors to accelerate alignment and integration of technology between hospitals and their medical staff include:

- Integrated technology deployment to independent physicians
  - Define user requirements at the physician level
  - Establish technology oversight committee representing all constituencies
  - Integrate required process changes at all levels
  - Set target service level agreement (SLA) before development
- Limited physician investment in capital and time
- Emphasis on training: 3Cs – classroom, coaching, compliance
- Development of multiple portals across all sites of practice (office, hospital, home, etc.)
- Measurement of success through satisfaction surveys
Strategy 2. Ensure Sufficient Capital for Physician Initiatives

- Physician initiatives require significant capital, particularly:
  - New physician recruitment and employment, practice acquisitions, technology for ambulatory physician settings, physician joint ventures, and other asset-based arrangements

- Capital resource constraints mandate a focus on integration options that most effectively support strategic goals:
  - Spending needs for integration options must be identified, quantified, and prioritized
    - Market-based planning quantifies impact on volumes, revenues, expenses, investment in fixed assets and working capital, and downstream contribution margin
    - Solid analytics, using proven planning tools, enable organizations to assess the required level of investment relative to the assumed risk
Capital Considerations with Acquisitions and Employment

- The required investment is much more than the upfront purchase price
  - Significant first-year commitments related to facilities, equipment, and technology
  - Ongoing net working capital to fund the practice
  - Transaction related professional fees
  - Assumption of practice’s operating leases for facilities and equipment

- Practice operating losses can be significant
  - Current losses for PCP’s averaging approximately $130,000 per year per physician
  - Specialty losses can be as high as $300,000 per year per specialty/procedural physician
Typical Capital Commitment per Physician to Acquire a Primary Care Practice

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upfront net asset purchase price</td>
<td>$120,000</td>
</tr>
<tr>
<td>Upfront transaction costs</td>
<td>30,000</td>
</tr>
<tr>
<td>First year capital investment commitments</td>
<td>50,000</td>
</tr>
<tr>
<td>Structural investment in net working capital</td>
<td>120,000</td>
</tr>
<tr>
<td>Capitalized operating leases</td>
<td>150,000</td>
</tr>
<tr>
<td>Capitalized operating losses</td>
<td>300,000</td>
</tr>
<tr>
<td><strong>Total estimated commitment per primary care physician</strong></td>
<td><strong>$770,000</strong></td>
</tr>
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Strategy 3.
Use a Disciplined Approach to Practice Acquisitions

History of physician and hospital integration efforts

- During the past 15 years, there have been three distinct periods with three distinct perspectives on physician integration
- Are we headed back to an “acquisition frenzy” or towards the development of sustainable collaborative models?
A Disciplined Approach to Practice Acquisitions and Employment Is Required

Steps in building a formal “acquisition program”

Timeline is dependant on the transaction complexity, availability of data, and cooperation from the practice
Identifying/ Assessing Practice Acquisitions Opportunities

• Use consistent decision criteria
  – Is the organization going to pursue a growth strategy, a defensive strategy, or both, and what are the specific strategic goals?
  – Which practices/ physicians should be targeted in order to meet the these strategic goals?
  – Which practices/ physicians should be avoided or put on hold in the near term (or long term) because they do not meet the goals?

• Set specific acquisition parameters
  – Specific specialties and geographic coverage goals in the context of organizational and service line priorities
  – Existing volumes and potential incremental volumes associated with proposed acquisitions
  – Baseline quality metrics for selection
  – Baseline financial performance requirements
  – Strategic fit and sustainability analysis
  – Cultural fit with the hospital or health system
Practice Acquisition Deal Structures Have Become Simpler Over Recent Years

- 99% of the deals are executed as an asset purchase due to tax implications and liability for malpractice and governmental billing.
- Accounts receivable are typically not acquired but are dealt with under a custodial arrangement.
- Two to Three year employment agreements are being used that re-index based on productivity and market changes after a set period of time.
- Payment for goodwill is rare; some payment for defined intangibles occurs occasionally (medical records, workforce in place, etc).
- Signing or retention bonuses are occasionally paid as part of initial consideration.
- Of the three valuation approaches (income, market, and cost), the cost approach is the predominate approach being pursued, leaving less subjectivity to the appraiser.
- Non-compete requirements are still prevalent.
Strategy 4. Structure Effective Physician Compensation Programs

• Employment, or significant contractual arrangements, are here to stay and are required to be successful
• Physician employment models don’t have to lose money
• Physician recruiting must be customized to meet specific organizational goals and physician needs; packages should offer more than just monetary rewards
• The key principle: Apply the same compensation standards and metrics consistently across physicians, locations, and specialties, where applicable
  – Quality
  – Work effort and productivity
  – Patient access
  – Support of the organization’s non-clinical objectives
Physician Compensation Models – Compensation per wRVU Has Emerged as the Preferred Method

• After a decade of experimenting with a wide range of complex compensation methods, compensation per wRVU is gaining widespread acceptance for the following reasons:
  – The physician is only held accountable for his/her productivity and clean charge entry
  – The benchmark data for “reasonable compensation reviews” is readily available
    ✓ This method breaks the linkage to ancillary revenue which makes it viable for specialist acquisitions
  – The compensation per paid wRVU can be indexed up or down to move with net collections per wRVU on a timely basis (quarterly, monthly, etc.)
    ✓ This method ties in nicely to optimal benchmarking data
Compensation per wRVU Can Be Used to Incent Non-Productivity Goals as Well

- Quality and citizenship incentives can be added to reward system goals that would be paid out proportionally to productivity as an enhancement to the clinical compensation paid per wRVU. Examples of these include:
  - Exceeding defined quality thresholds
  - Exceeding patient or referring physician satisfaction goals
  - Exceeding system patient access goals
  - Exceeding expense management goals
Beware of Being Locked into Benchmarks; “Figures Don’t Lie, but Liars Figure”

- Due to recent trends in physician compensation, the lag in benchmark data (up to two years) can lead an organization to substantially over compensate physicians based on current levels in the local market

- This lag can drive significant variances
  - Published 2009 mean blended cardiology income $555,800 in total and $56.34 per wRVU (most recent published survey)
  - Midwest market 2010 customized survey $418,700 in total or $42.44 per wRVU, a 25% decrease
  - Eastern market 2010 customized survey $435,100 in total or $44.11 per wRVU, a 22% decrease
  - Growing variance between independent and employed compensation levels (16% current gap)
Structure of Employment Compensation Agreements

- Agreements must be structured competitively, but must be sustainable over the long term. We recommend:
  - Two- to three-year initial agreements with “evergreen” or automatic renewals, requiring sufficient notice after the end of the first term; this allows both parties to evaluate the other and to address any concerns that may emerge over the term of the agreement
  - Short-term (quarterly or annual) rebasing or repricing of key compensation metrics, which allows the hospital to make adjustments that may be needed, based on productivity and market changes, to protect both the hospital and the physicians for increases and decreases in reimbursement and changes in payment structures
  - Non-compete clauses to protect the practice and hospital in the future
  - Additional compensation metrics for non-clinical activities, such as administrative, research, teaching, strategic, and service-related activities, as appropriate
Strategy 5. Create Effective Clinical Integration Programs or Other Value Based Programs

- The goal of clinical integration programs is to improve the quality and efficiency of healthcare and patient and provider satisfaction
  - Requires the participation and support of a significant portion of an organization’s medical staff
  - At this time, requires the creation of a contracting entity to negotiate fees and set quality thresholds for improvement
- Many organizations currently are pursuing a clinical integration strategy based on contractual arrangements
Management Expertise and Infrastructure Requirements for a Full Clinical Integration Program

- Integrated electronic medical records
- Coordinated utilization management and review systems
- Proven care management programs
- High-quality management reporting systems
- Efficient incentive payment systems
- Payor contracting expertise
- Financial and capital planning/management expertise
An Evolutionary Approach to Clinical Integration Programs Is Recommended

• Start with a clear market- and financially based understanding of clinical areas that warrant focus
  – Identify programs that could achieve the largest improvement in clinical quality without having in place all of the required infrastructure and expertise

• Identify critical expertise and infrastructure gaps in current capabilities and work to fill gaps

• Involve physicians throughout the process, particularly with goal development/design

• Demonstrate early successes with incremental improvements
Many Providers Will Stop at Clinical Integration

• The ACO model appears to offer higher risk than reward

• In fact, in the early years, the ACO model is likely to result in financial losses and large investment in capital assets and management talent

• Providers likely to pursue the development of an ACO are those which already have several features in place:
  – Care coordination capability
  – Information systems sophistication
  – Well-planned service distribution
  – Cost management controls
  – Scale
  – Financial/capital capacity
  – Effective payor relationships
Strategy 6. Proactively Manage Physician Integration Initiatives to Achieve Goals

- Performance must be measured against defined indicators of success related to:
  - Financial performance, quality, outcomes, efficiency, market share, satisfaction, and other core goals

- With employed physicians, detailed budgets should be developed prior to practice acquisition or employment
  - Monitor and manage the following on a regular basis: productivity, total revenue, physician compensation, non-physician staffing and compensation levels, physician revenue cycle performance, occupancy, supply chain costs, contracting, revenue cycle, overhead management, and technology costs
  - Financial systems must be able to link compensation to specific productivity and quality/outcomes metrics

- Plans must be developed and implemented to respond to less-than-anticipated performance
Physician Involvement Is Key to Achieving Goals

- Transparency, governance, leadership, and customer service will all drive performance
  - Investment in physician leaders and the professionals running the physician enterprise is required
  - Transparency in engaging with physicians will make or break the success of physician integration efforts
  - Leveraging physicians on operating committees increase commitment to achieving goals
Common Attributes of High-Performing Hospitals and Health Systems Relative to Physician Integration

- Good geographic coverage in their primary markets
- Substantial investment made in technology, placing them in the leading quartile amongst their peers
- All have multiple models of physician alignment:
  - Employed
  - Contracted
  - Independent
- Strong medical leadership and medical management functions
- All have multiple physician organizations with strong physician governance
- Infrastructure to manage risk
Early Results

- CI programs have shown their ability to improve quality, but many of the organizations that have pursued them have actually seen their total costs *increase* or have failed to transform contracts due to lack of a compelling value proposition.
- CI appears to be fostering oligopolies in certain local and regional markets.
- Technology infrastructure and management skills are lacking.
- Increasing pressure on PCP coverage as physicians align.
- Volume growth will be needed to offset discounts on bundled care; often volume is not materializing.
- Capital requirements are more significant than originally anticipated and leading to further duplication of assets.
Forecast

• Hospitals and physicians must and will focus heavily on clinical integration

• Only a few systems will be in a position to evolve into ACOs in the next few years

• The interest in integration and potential ACO formation will continue to spur consolidation among providers

• Independent physician practices will continue to have a place, but some specialties will move heavily toward hospital alignment

• Physician income is going to continue to decrease unless existing trends are reversed

• Physician regulatory enforcement is going to increase as many reactive deals are not going to meet regulatory thresholds
Closing Comments: The Challenge

• To successfully serve patients and communities, hospitals must develop multiple models to align with their physicians to improve quality, efficiency, and access within the constraints of current capital resources and to assure access to physicians in your local community.

• The common attributes of organizations who will achieve alignment and integration with their physicians are management expertise, shared hospital-physician leadership, extensive investment in intellectual property supporting the clinical enterprise and a well-developed integration infrastructure.

• Hospitals and health systems that act early to build these attributes based on solid planning and monitoring are poised for future success in their markets as first to market will attain a significant market advantage.
Questions and discussion?
For More Information

Six Essential Strategies for Successful Hospital-Physician Integration

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Getting to There from Here: Evolving to ACOs Through Clinical Integration Programs
Including the Advocate Health Care Example as Presented by Lee B. Sacks, M.D.

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