WHAT LIES AHEAD IN PHYSICIAN – HOSPITAL ALIGNMENT?

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Why Physician Alignment Is Important

➢ To achieve improved care coordination
  ➢ Enhanced quality / safety
  ➢ More efficiency
  ➢ Increased patient satisfaction

➢ Changing payment mechanisms
➢ Changing value systems in the workforce
➢ Secure / expand market position for key services
➢ Strengthen referral base
Payment Reform and Quality

• The new paradigm for reimbursement
• Transforming roles from passive *payer* to active *purchaser* of high value health care

• Examples:
  – Hospital quality reporting
  – Value based purchasing
  – Hospital acquired conditions
  – Readmissions
  – PQRS
  – Incentives and disincentives
Payment Reform Focused on Incentives for Quality & Efficiency

CMS=Centers for Medicare & Medicaid Services; DRA=Deficit Reduction Act; IOM=Institute of Medicine; MMS=Medicare Prescription Drug, Improvement and Modernization Act; QI=Quality Improvement;
The Message Is Clear...

- Healthcare today DEMANDS measurable performance
  - Quality, safety, efficiency, patient satisfaction

- Performance REQUIRES alignment, engagement and integration of the work force—and a CULTURE committed to performance

- The “work force” INCLUDES physicians, other clinicians, management, support staff, volunteers and trustees
Options for Physician Integration

- Employment
- Exclusive contracts with physicians or physician groups
- Service contracts for specific physician services to the hospital
- Provision of MSO services to independent physicians
- Hospital – physician integrated health plan contracting vehicles
- Formation and operation of ACOs, IPAs, PHOs and clinically integrated networks
- Joint ventures
Options Available to Hospitals

Less Effective

- PSA
- Gainsharing
- Tax Exempt Affiliate

More Effective

- Employment
- Service Line Co-Management
- “Pay For Quality”
- PAP Financial or Clinical Integration (PHO)
- ACO

Level of Integration
ACOs, IPAs, PHOs, OWAs

- Can preserve autonomy of private practices
- Shared risks and shared rewards
- Difficult (and expensive) to form
- Difficult to manage
- Questions re long term stability
- Nonetheless, lots of hospitals AND some medical groups are taking the plunge......
- Legal and compliance issues
No one really knows, but there are a lot more than there used to be

©Almost 45% of physicians are now employees
©About 55% of physicians under age 40
©ACC estimates 75% of cardiologists work for hospitals
©AHA estimates 25% of practicing physicians were hospital employees in 2010

There will be more tomorrow than there are today.
Why Are Hospitals Employing Physicians? (directly or indirectly…)

• Economic pressures on physician practices
• To prepare for reform and integrated clinical care
• Generational changes in the physician workforce
• Improved negotiating clout with payers
  • “Because the doctors wanted us to…”
  • “If I don’t, my competitor might…”
Economic Pressures

Cumulative Percent Change Since 2001 for the Medicare Conversion Factor, Not Hospital/IDS-Owned Multispecialty Group Operating Cost, and the Consumer Price Index

* 2010, 2011, and 2012 median operating cost values are three year moving average projections of previous years'data.
* 2010, 2011, and 2012 CPI figures are the July 2010 semiannual figure.
* 2011 MCF figure illustrates the estimated net impact of the 12/2010 legislation.
Changing Demographics

- **Physicians**
  - Currently 40% women; by 2020, a majority
  - Gen X and Gen Y values
  - Large number of (male, Baby Boomer) physicians approaching retirement
  - Almost 40% of physician work force is 55 or older
  - Younger physicians are employees, rather than owners
  - Primary care / specialist imbalance
No single “right” approach

Most organizations will use multiple approaches for different parts of their physician population

Among the factors driving choice of options are:

- Urban / suburban / rural location
- Physician specialty
- Group practice size
- Practice culture / hospital culture
- Hospital strategic objectives
- Physician preference / objectives
Legal and Regulatory Issues

Anti-trust laws -- “Market Power” (size and concentration) and “Joint Action” (“integration”) concerns

Stark – Physician financial and referral relationship with “designated health service” entity

Anti-kickback – No offer, payment etc. of any “remuneration” in exchange for, or to influence referrals. Statute and safe harbor compliance

Civil Monetary Penalties (CMP) – Gainshare and beneficiary inducement
Medical Practice Act/Form of Entity -- Corporate practice of medicine and legal form

Tax and Tax-Exempt Organization -- Tax treatment of transaction and under new relationship; charitable purposes and exempt organization control

Contract and Related terms -- Exclusivity, non-competes, term of agreement, unwind rights, benefit plans
Considerations in Physician Employment

- Fairness, reasonableness, and equity in compensation arrangements (including benefits) is essential
- Standard HR policies, with Board physician compensation committee to oversee and approve any variances
- Clarity on supervision and reporting relationships
- Clear expectations of time devoted to work, productivity and performance requirements, etc.
- Be willing to terminate if necessary
- Avoid “over-employing” and “under-using”
- Legal and compliance issues
Key Takeaways

• Physician/Hospital collaboration will continue
• Structural and cultural dimensions – frequently with different goals/perceptions depending on who’s asked
• Goals:
  • Stability/certainty with autonomy vs. align to achieve quality/ efficiency vs. hybrid
• Without collective understanding and buy-in (physicians, hospitals and boards), hospitals face significant losses:
  – Value Based Purchasing, HAC reductions, readmission
  – Getting into deals that should not be created
The Bottom Line

- Physician employment will continue to rise
- But there are other options
- There is no “one size fits all” solution
- Most organizations will use multiple integration strategies
- Align the strategy with strategic goals---of both the hospital and the physicians
- Be very careful to require performance standards and to assure legal / regulatory compliance
What Do CEOs Expect from CMOs?

• A national survey of CEOs and CMOs

• Asked to rank the importance of each of 25 possible characteristics of an effective CMO

• Results showed generally good alignment between CEO and CMO expectations---but some areas of significant difference

• The list can be a useful tool to achieve CEO / CMO alignment
Qualities of Effective CMOs

CEO Responses
1. Passionate about patient safety and quality
2. Encourages teamwork and collaboration among physicians
3. Committed to the organization’s mission and values
4. Committed to evidence-based medicine
5. Able to lead standardization of care processes

CMO Responses
1. Good problem-solving skills
2. Passionate about patient safety and quality
3. Inspires respect by peers and staff
4. Good listener
5. Advocate for patients

Top Five Responses from CEOs and CMOs
Qualities of Effective CMOs

And the bottom five...

**CEOs**

21. Disagreement with strategy or tactics is voiced only in private
22. Advocate for physicians
23. Capable in budget development and expense management
24. Prior management/administration experience
25. Effective manager for employed physicians

**CMOs**

21. Recognizes the CEO is in charge and he/she must follow the CEO's lead
22. Disagreement with strategy or tactics is voiced only in private
23. Strong disciplinarian—enforces standards for behavior and technical performance
24. Effective manager for employed physicians
25. Capable in budget development and expense management
The full list...

1. Highly respected clinician
2. Good problem-solving skills
3. Amiable personality
4. Good listener
5. Advocate for physicians
6. Passionate about patient safety and quality
7. Passionate about patient satisfaction
8. Committed to evidence-based medicine
9. Strong disciplinarian—enforces standards for behavior and technical performance
10. Inspires respect by peers and staff
11. Team player
12. Committed to the organization’s mission and values
13. Recognizes the CEO is in charge and he/she must follow the CEO's lead
14. Disagreement with strategy or tactics is voiced only in private
15. Advocate for patients
16. Leader in efforts to improve efficiency, reduce costs
17. Effective public spokesperson for the organization
18. Effective manager for employed physicians
19. Skilled in motivating physicians and staff to give their best effort
20. Capable in budget development and expense management
21. Able to lead standardization of care processes
22. Champion for EHR implementation and use
23. Encourages teamwork and collaboration among physicians
24. Prior management/administration experience
25. Prior medical staff leadership experience
Locations and Contact

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