Preface

THE CHALLENGE

The US healthcare industry differs from any other industry in the world in some fundamental and alarming ways. It is huge and is fast approaching $3 trillion in expenditures annually (CMS 2013). It is fragmented, with hundreds of thousands of providers and facilities most often operating as independent businesses. It lacks performance standards, with little agreement regarding what constitutes high-quality care and how to improve outcomes. The consumers and providers who decide what services are provided are largely insulated from the cost of those services, which is borne by government and employers.

The results of these structural issues—lack of coordination, inability to define quality or efficacy of care, and misalignment of economic incentives—are by now recognized not only by those in the industry but by the general public as well. Costs have risen to unsustainable levels, with little evidence that people in the United States are any better off than residents of countries that spend a substantially smaller percentage of their GDP on healthcare. It is no surprise that we are witnessing an unprecedented movement, driven largely by these escalating costs, toward reforming both the organization and the financing of healthcare.

The challenge, of course, is that many provider organizations are ill equipped to adapt to the level of change that is required for this reform. As much as we like to talk about constant change being a way of life, the reality is that most healthcare provider organizations have enjoyed stability and a relatively benign competitive marketplace. By contrast, we need only consider the radical transformations that the banking, media, and consumer retail industries underwent following the advent of the Internet. Because of the stability that has existed in healthcare, nimbleness and innovation have not been necessities and therefore have not generally been developed as core capabilities.

As healthcare reimbursement shifts from volume- to value-based models, hospitals and physicians are under increasing pressure to work together. Clearly, providers will increasingly be rewarded for efficiency and outcomes of care (i.e., value), and hospitals need to place high priority on alignment with physicians to accommodate the coming changes in payment mechanisms. The success of healthcare organizations will depend on their ability to bring hospitals, physicians, and other providers together to improve the quality of care while reducing total costs. Unfortunately, many are discovering that hospital–physician alignment is difficult

to achieve, and increasingly so in the post-reform world. With notable exceptions, hospitals have historically tended to shy away from forming close alignment with physicians unless lucrative inpatient referrals were at stake. In the future, however, financial incentives will be radically transformed, and hospitals need to rethink how they approach their physician relationships.

For many organizations, hospital–physician alignment feels like uncharted territory. The purpose of this book is to provide in-depth information about creating and sustaining an economically integrated physician component within a larger health system.

PREREQUISITES FOR SUCCESS

Given the significant challenges ahead, certain characteristics are important for success as an integrated provider of healthcare services. From our work with organizations at varying degrees of readiness, the following themes are emerging:

- **Ability to define a vision for the future:** Many readers will recall how, while preparing for his 1992 campaign, President George H. W. Bush famously dismissed "the vision thing" and then went on to lose what should have been a relatively easy reelection against the less established but more eloquent challenger, Bill Clinton. The parallel between presidential politics and healthcare is not often drawn but is fitting in this case. Healthcare leaders have been primarily focused on operational issues, often to the detriment of strategic concerns. However, in a time when the environment truly is changing, healthcare leaders must increasingly be aware of regional and national developments, interpret them appropriately, identify the correct organizational response, and then communicate that response clearly and convincingly to their constituents.
- **Willingness to let go of the status quo:** Defining a vision for the future is one thing; seeing it through is another. One of the most common stumbling blocks is that the culture of independent hospitals and physicians stubbornly resists change. Too often, healthcare leaders say they want to set a new course and achieve alignment between hospitals and physicians, when the reality is that they want things to stay fundamentally the same. Organizations that are successful at physician alignment have leaders who recognize that they must share control with physicians, develop innovative contracting approaches, transform their clinical and business processes, and publish information on quality and outcomes.

- **Capital to invest in the physician enterprise:** With very few exceptions, hospitals and health systems that want to align with physicians in a meaningful way will end up acquiring at least some of those physicians' practices as well as recruiting new physicians into the enterprise. Most often, physicians will be employed, but the enterprise may also include "employment-like" models involving professional services agreements, such as are common in states with more stringent corporate-practice-of-medicine statutes. Capital requirements go far beyond the initial outlay for the acquisition itself and include money for starting up new practices, supporting ongoing operational deficits, and building the infrastructure needed to coordinate care and demonstrate value.
- **Physician practice management expertise:** As we discuss in this book, the integrated enterprise must be well versed in managing physician practices, because the consequences of poor management can be ruinous to an organization that is already operating on thin margins and facing large capital requirements. This type of expertise is not easily learned on the job; the integrated enterprise requires professional management by individuals who understand physician performance metrics, compensation, revenue cycle, and so forth.

Because not every hospital or health system has all of the above capabilities, success at achieving meaningful alignment with physicians will be beyond the reach of some organizations as they are currently structured. For those organizations, we see two paths, both of which are occurring with increasing frequency.[1] The first is to merge with another organization or organizations and pool the capabilities outlined above (or develop them together). Rather than being the primary integrator, the organizations that take this first path will be partners or subsidiaries of an existing hospital-based integrator.

The second path is for the hospital to provide inpatient services under contract to another entity or entities. This entity could be a hospital-based system, a medical group, or a health insurance company. We see this arrangement—the hospital as a vendor of services—in several markets already. For example, Group Health Cooperative in Washington State has made the strategic decision to exit the hospital business altogether and instead contract with several hospitals in its service area for inpatient services. Similarly, several independent practice associations in Southern California are accepting inpatient insurance risk and contracting for these services through local hospitals. In both cases, these organizations provide inpatient services through contracts with area hospitals without taking on the financial commitment of owning and operating hospitals.

Most organizations would rather be the dominant party in integration efforts, but many (in fact, most) hospitals will either be a part of someone else's system or

serve as a vendor of hospital services to one or more unaffiliated systems. Although it may be difficult for a hospital to accept that these are its best available options, the hospital must pursue strategies that reflect this reality.

HOW IT WILL PLAY OUT

To be sure, many unknowns await healthcare providers in the foreseeable future. To develop an effective response—to the extent this is possible—healthcare leaders must have reasonable expectations regarding how events will unfold. We anticipate the following trends:

- **Industry consolidation will continue.** The trend toward consolidation within the healthcare industry will continue well into the foreseeable future and will include both horizontal (e.g., hospital–hospital) and vertical (e.g., hospital–physician, payer–hospital, payer–physician) consolidation. A wide range of factors will drive this consolidation, including the need to succeed under value-based reimbursement; physicians' desire to practice within large, established organizations rather than in small, private practices; and the inevitable failure of some organizations to succeed as integrated entities. Although consolidation is widely recognized as a necessary precondition for healthcare reform to succeed, how fully it will be accepted by the agencies charged with antitrust regulatory enforcement remains to be seen. Our expectation is that developing appropriate regulations will be a slow and frustrating process, regardless of the political climate.
- **New healthcare organizations will emerge.** Hospitals have been the dominant focus of integration in the past, primarily because they have had both the capital and the management needed to acquire medical practices and negotiate with payers. Hospitals have not, however, been nimble innovators. Driven by payment reform, the need for scale, and competitive pressures, more entrepreneurial models will appear with frequency. These models will range from narrow networks created by health insurers to accountable care organizations (ACOs) developed by large physician groups to partnerships between providers, insurers, and financiers. Hospitals and health systems will have to find ways to be at the table when these arrangements are being developed.
- **Private practice will shrink.** More than half of all physicians in the United States now belong to hospital-owned practices. We are seeing no slowdown in the pace of this transition, and we believe that the era of the independent private practice as we know it is drawing to a close. The few physicians who

remain in private practice will be either in small subspecialties or unsuited, for a variety of reasons, for work in a large, bureaucratic organization. Most physicians will seek employment in integrated systems and large medical groups for reasons other than the fact that it is a better model; an increasing number of physicians simply do not want to be in private practice, where they have to be small business owners as well as clinicians, and many hospitals will need to employ physicians to meet the community's needs or to prevent them from working for the competition.

- **Specialty physician compensation will change.** Changes in reimbursement will have a major impact on the economics of various specialty practices, with a resulting redistribution of physician compensation. We expect that ancillary margins will continue to decline, advantageous 340B pricing for chemotherapy drugs may be revisited, and incentives for managing the continuum of care will be increased. As a result, primary care physicians and hospitalists will be in even greater demand, and their compensation will increase accordingly. Specialists, particularly those whose incomes have historically been driven by ancillaries such as cardiology, oncology, and some surgical specialties, will see relatively smaller compensation increases. Further, broader use of evidence-based medicine protocols may lessen the volume of tests and procedures, limiting the revenue generated by specialists. Compensation will change only incrementally over time, because many employed physicians' compensation arrangements are based on published benchmarks and tend to reinforce those benchmarks. Moving forward, physician compensation methodologies should reflect the new paradigm of value-based reimbursement rather than the production-based systems that are being replaced.

ABOUT THIS BOOK

This book is organized into three parts. Part I addresses issues that are common to integrated models. *Integrated* refers to employment or employment-like[2] models in which the hospital or health system owns the clinic assets, employs the staff, and manages the physician practice. Part I begins with a discussion of the correct mind-set and expectations prior to acquiring physician practices and then moves on to explain managing an acquisition, building effective physician leadership, compensating physicians, and managing operations and revenue cycle. In Part II, we address several alignment models in which physicians continue to maintain practices independent of the hospital or health system. In particular, these models include clinical joint ventures, clinical comanagement arrangements, ACOs, and

the use of information technology. Finally, in Part III, we address two topics that are applicable to both integrated and more loosely affiliated models: fair market value and payer contracting strategies.

Creating this book has been a major undertaking, but for us it has been a labor of love because it reflects many years spent addressing interesting and important issues in collaboration with organizations that we respect and admire. We hope the reader will find it relevant and informative.

David A. Wofford
Stephen F. Messinger

NOTES

1. A potential third path is to serve as a major referral center for highly specialized services, such as organ transplant, with more traditional hospital–physician relationships and payer contracts. However, this option is not realistic for the vast majority of hospitals and health systems.
2. For example, in states where corporate-practice-of-medicine laws exist, professional services agreements are commonly structured with nonemployed physicians, who provide physician services in outpatient facilities that are owned and operated by the hospital or health system.

REFERENCE

Centers for Medicare & Medicaid Services (CMS). 2013. "National Health Expenditures Projections 2011–2012." Accessed February 12. www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf.