



GETTING READY FOR THE
THIRD WAVE
OF PHYSICIAN-HOSPITAL INTEGRATION

Over the last 20 years, we have observed two major waves of physician-hospital integration. Now, partly in response to the recently passed healthcare reform legislation, we are faced with an impending *third wave* as the pace of physician-hospital integration is poised to accelerate over the next three to five years.

This article focuses on the implications of

this third wave of market forces for physician practices and hospitals/health systems, with some suggested action steps to assist in the organization and management of integrated physician relationships, including development of new Physician Services Organization (PSO) structures, processes and leadership.

It appears inevitable that, sooner rather than later, the Centers for Medicare and Medicaid Services (CMS) and other payors will require some forms of significant shared financial risks within new pay-for-performance and/or bundled payments. Consequently, the development of PSO structures to help organize and manage these expanding

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partnerships and promote care management is highly advisable.

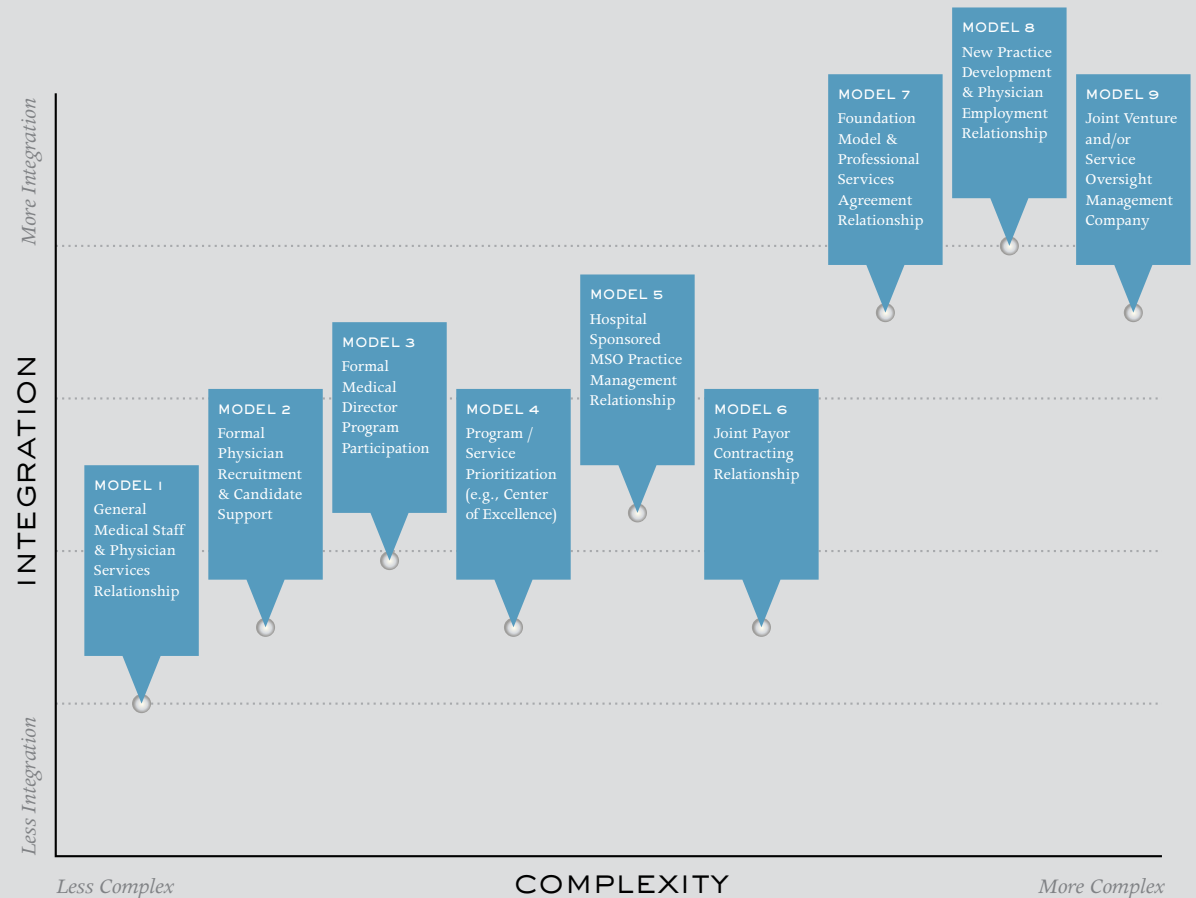
THE FIRST WAVE

In response to market pressures during the late 1980s through the mid 1990s, employers largely promoted the growth of Health Maintenance Organization (HMO) enrollment and utilization of capitated provider reimbursements (a contracted rate per-member-per-month regardless of the number or nature of services provided) to better control their sense of unbridled costs in pure fee-for-service indemnity health plans. Worried that they would not be able to compete for managed-care contracts, hospitals throughout the U.S. began acquiring primary care and other physician practices.

Many of the physician employment and related Physician Hospital Organization (PHO) initiatives did not perform as expected. Increasing desires for enhanced health benefits choices, as well as other patient and employers' concerns, ultimately led to preferences for Preferred Provider Organizations (PPOs) and other alternatives to HMO enrollment. Seeking to avoid real and

FIGURE 1

SAMPLE CONTINUUM OF HOSPITAL-PHYSICIAN AFFILIATIONS



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perceived financial losses attributed to their initial foray into integrated practices, many hospitals moved to unwind their employed-physician relationships and/or avoid significant levels of physician integration.

THE CURRENT SECOND WAVE

During the last five to seven years, the accumulation of multiple market forces has created a “perfect storm,” leading to a resurgence of physician-hospital integration. The forces include:

- *Increasing shared economic pressures from an eroding mix of reimbursement payments*
- *Increasing operational/infrastructure expenses, further eroding bottom-line margins*
- *The changing profile of new physicians, who seek greater security and are more open to hospital employment*
- *The changing practice patterns of senior physicians (who are largely holding on to patients until they retire, are less able to “cash out” due to decreased buy-out opportunities, and have less interest in succession planning to ensure stability of their practices)*

- *Increased competition for the decreasing/mal-distributed physicians (including concentrations of surgical and procedural subspecialists in many metropolitan areas and corresponding under-supplies of similar physicians in more rural markets)*
- *Increased legal/regulatory scrutiny and constraints*
- *The limitations of compensation plans to drive desired behaviors*
- *Ongoing calls for further healthcare reform*

There has been no “one size fits all” solution for integration. Hospital systems and physicians of all subspecialties are assessing multiple affiliation options to advance their shared vision. *Figure 1* is a graphic overview of some of the affiliation models being used.

THE IMPENDING THIRD WAVE

Even further acceleration of current physician-hospital integration is coming. Providers are being required to jointly provide “care management” in response to the recently passed *Patient Protection and Affordable Care Act*. CMS

will continue to demand documented quality, service and efficiency in the anticipated future world of Accountable Care Organizations (ACOs), or similar integrated provider networks. Provider reimbursements ultimately will be based upon combinations of pay-for-performance and/or bundled payments. It is not clear what level of payments will be “bundled,” but certainly hospitals, physicians and related healthcare providers will be required to better perform together or risk further reduced reimbursements from CMS. Furthermore, commercial payors will take full advantage to re-base their reimbursements in a similar manner, including efforts to reduce their collective provider costs. Fair or unfair, the scorecards for reimbursement likely will include a range of clinical protocol and/or outcomes indicators, as well as service and accessibility measurements with more than token consequences for failures to meet the base line standards. In time, even the entry conditions for ACO participation likely will include a combination of efficiency (or at least willingness to accept shared financial risk), evidence-based performance standards, accessibility and service standards.

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Whether within the current wave or the coming third wave, there are several areas where the physicians' and hospital's interests and support must be aligned for an effective partnership: (1) vision and strategic direction; (2) shared control and decision making; (3) compensation alignment; (4) operational support and infrastructure; and (5) shared values and overall culture.

VISION AND STRATEGIC DIRECTION

All of the key drivers from the current wave of physician-hospital integration apply, but require even greater degrees of clinical and business leadership in anticipation of new shared risks and accountabilities under reimbursement reform from CMS and commercial payors.

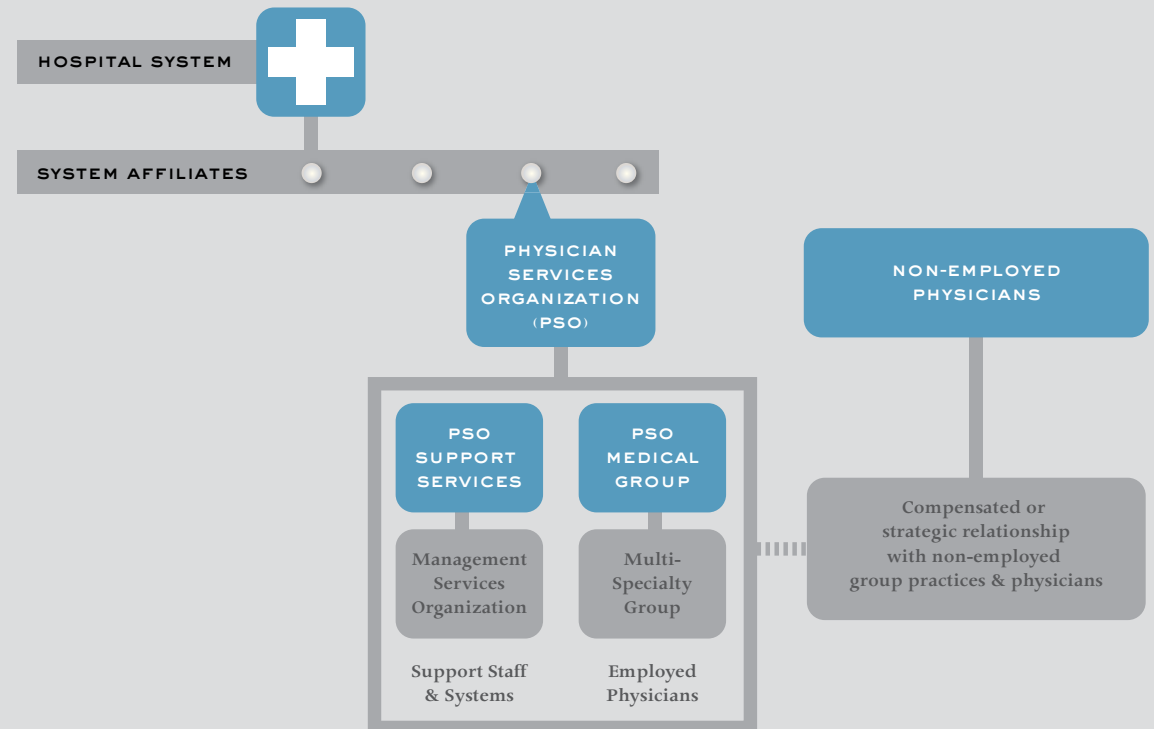
To address these needs for more sophisticated management and infrastructure support, hospitals and health systems should proactively develop well-defined Physician Services Organization (PSO) structures. More than just managing physician employment models, PSOs are increasingly being utilized to manage the full range of selected affiliation

models. Often the PSO includes one or more group practice models with shared governance and a Management Services Organization (MSO) infrastructure to

support employed and other affiliated physician relationships. *Figure 2* illustrates a PSO being utilized by one of EthosPartners' clients.

FIGURE 2

SAMPLE PHYSICIAN SERVICE ORGANIZATION STRUCTURE



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SHARED CONTROL AND DECISION MAKING

The more directly that senior governance members are “in the loop” regarding the hard choices that frequently must be made, the less likely that the hospital and/or physician participants in such relationships will be second guessed or successfully “end-run” by detractors. PSOs can help better coordinate and ensure sufficient governance, management and operational support for enterprise-wide physician-hospital affiliation strategies.

Careful consideration should be given to the potential additional advantages of requiring the parties to further develop care management standards and processes within a unified Multi-Specialty Group (MSG) structure for employed physicians, provided (1) there are sufficient delegated powers to the respective subspecialty divisions; and (2) physician compensation remains market competitive within each division.

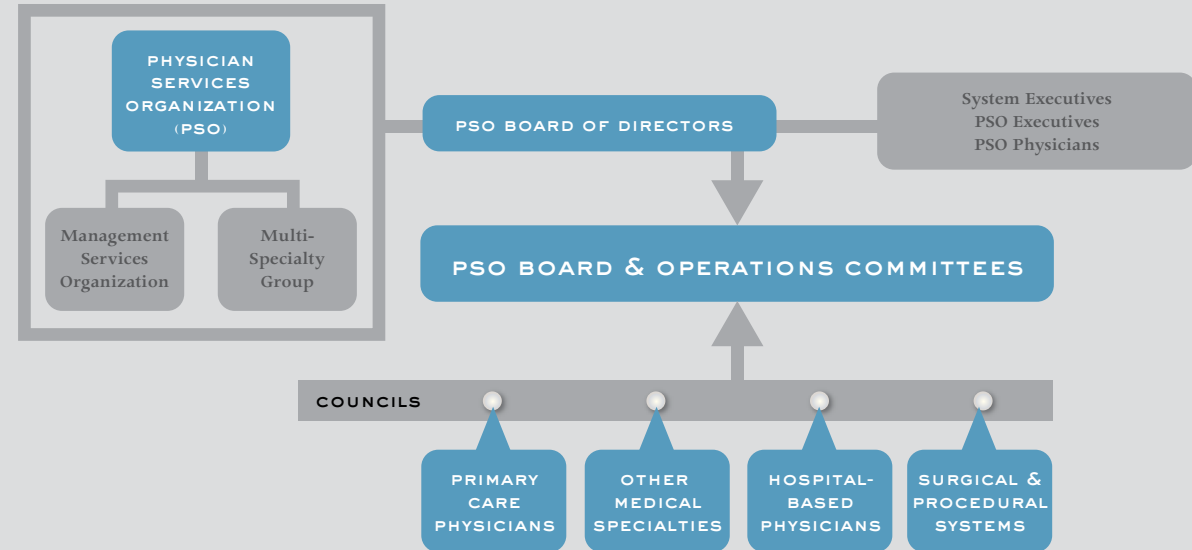
If the hospital or health system leadership is unwilling to provide significant voice and co-management opportunities for physician leadership of the PSO and other service line

activities, the ability of the PSO physician partners to positively influence efficient and effective healthcare services throughout the

system will be compromised. *Figure 3* illustrates a sample governance structure for a PSO with a unified MSG model.

FIGURE 3

SAMPLE PHYSICIAN SERVICE ORGANIZATION STRUCTURE



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COMPENSATION ALIGNMENT

Even in a predominantly fee-for-service reimbursement market, where higher productivity generally produces more revenue, integrated and private practices should avoid extreme designs such as pure base salary (which lack sufficient productivity incentives) and individual net collections (which could lead to cherry picking for the best-paying patients or rates). Employed physician compensation plans should include minimum work standards and qualitative incentives, as well as potential productivity incentives. The anticipated shared risks associated with reimbursements based upon pay-for-performance, global and/or bundled payments in a new care management era further suggest that the compensation plan design include metrics for efficiency, accessibility, patient satisfaction and/or clinical outcomes.

Failure to include incentives for qualitative performance (even if over time) is a lost opportunity to reinforce the importance and accountability for how professional services are rendered.

Furthermore, CMS is expected to continue to use a range of bundling, pay-for-performance and conditions of performance requirements to demand higher levels of cost-efficiency, service and acceptable clinical outcomes. As higher levels of reimbursements (with limited upside funds and significant potential reduced payments) are tied to “scorecard” performance, it will become imperative that the physician compensation plan measure, report and incentivize higher levels of qualitative performance.

OPERATIONAL SUPPORT AND INFRASTRUCTURE

In addition to ensuring that the MSO leadership, staff and infrastructure systems are selected and supported based upon the unique aspects of physician practice needs, the MSO should assist with other related but potentially broader physician services strategy functions (e.g., physician recruitment, outpatient ancillary services planning, related medical staff development planning, etc.).

One of the more controversial issues to be addressed in the potential future of ACOs and care management mandates is where the leadership and infrastructure will be developed to measure and manage the providers’ collective performance. Some organizations will dust off prior Physician Hospital Organization structures and include the PSO as simply part of the network. However, careful consideration should be given to development of the care management infrastructure support needs for integrated and affiliated physician network relationships within the PSO.

SHARED VALUES AND OVERALL CULTURE

One of the more challenging aspects of physician-hospital integration in the current wave of integration is the need to challenge the concepts of “hospital-centric” and “physician-centric” cultures. The best observed integrated practices are developed and managed as hybrid organizations that share the mission, vision and values of their

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health system parent organizations. Formalized physician compacts and defined minimum work standards promote needed and desired behaviors; however, the recruitment and retention of like-minded physicians who are willing to be held accountable for shared goals will go even further.

Physician culture is one of the most difficult dynamics to develop and/or change. We already have been challenged with the current market realities that many physicians were brought into integrated practices with the expectation that they would have significant operational and practice autonomy. The third wave of shared care management will require acceptance of a more common group culture and standards for basic operations, including clinical judgment / autonomy in the delivery of patient care. Assuming higher degrees of reimbursement will be based upon demonstrated quality via adherence of evidence-based protocols and/or documented clinical outcomes, then current levels of practice autonomy will have to give way to newly developed, more inter-disciplinary care management approaches. The impact upon integrated

practice physician culture will be profound – and potentially highly positive in the end.

Both political and operational skills by health system and PSO leaders will be required to carefully ride the wave toward enhanced care management, rather than trying to play catch-up together later.

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