



A Guide to Physician Integration Models for Sustainable Success

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A GUIDE TO PHYSICIAN INTEGRATION MODELS FOR SUSTAINABLE SUCCESS

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Executive Summary

As health care delivery and financing shifts from a volume-based to a value-based business model, provider success will be achieved through offering services with the best possible quality, outcomes and access for the lowest possible cost across the continuum of patient care services and sites.

Improved alignment between hospitals and physicians will be essential to changing the way care is delivered, enhancing patient and physician satisfaction and improving each element of the value equation—quality, outcomes, cost and access.

Because physicians are responsible for driving the clinical care of patients, their incentives must be based on value and aligned with those of hospitals and health systems. Properly structured hospital-physician ventures reduce duplication of assets in communities and overall costs to payers, employers and patients. Such ventures also improve quality, access and satisfaction, reduce inappropriate clinical variation (which reduces quality and increases costs), and increase operating and capital efficiency.

A Guide to Physician Integration Models for Sustainable Success describes the groundwork and prerequisites required for successful hospital-physician integration and offers an overview of integration models currently deployed at hospitals and health systems nationwide. These models include customer service offerings, contractual ventures, joint venture/shared equity arrangements and employment/practice acquisition models. This guide also presents key considerations involved in implementing the models and sustaining their success, and offers 12 strategies to guide the integration efforts. These are:

1. Understand the forces affecting physicians; design strategic offerings to meet the needs of local physicians.
2. Understand the hospital or health system's specific capabilities and infrastructure in the context of the communities served.
3. Ground physician-integration efforts on a well-defined strategic financial plan with sufficient resources and performance targets.
4. Ensure strong physician participation, leadership and governance.
5. Use technology to connect with physicians.
6. Ensure objective assessment of organizational readiness for value-based care transformation efforts, including a formal clinical integration program.
7. Use a disciplined, integrated approach to practice acquisition and employment.
8. Document and communicate the level of financial commitment required to employ physicians.
9. Before employing physicians, model alternative compensation arrangements.
10. Structure effective and sustainable compensation programs for employed physicians.
11. Manage employed physicians to achieve goals.
12. Use a structured process to ensure creation of a sustainable venture and consistency over time.

This guide provides examples of physician-integration initiatives at organizations of different types and sizes, including a hospital, health system, regional medical center, integrated delivery system and university health system.

For the purpose of this report, "clinical integration" will refer to a formal clinical integration program or network that is compliant with Federal Trade Commission and Department of Justice laws, rules and regulations.

Introduction

Hospitals and health systems are facing an increasingly challenging environment as health care delivery and financing begins to shift from a volume-based to a value-based business model. Under the new model, provider success will be accomplished by offering services with the best possible quality, outcomes and access for the lowest possible cost across the continuum of patient care services and sites.

Both care delivery models and payment systems will change. The episodic approach to care, characterized by one physician directly caring for each patient, in one facility for each individual care “event,” will be replaced by a team-based longitudinal approach across multiple facilities and sites, including the patient’s home.

Under the value-based model, provider payment will be tied to results for quality, access and efficiency. When threshold performance levels are met, providers will benefit from shared saving. When threshold performance levels are not met, hospitals and physicians will be at risk for reduced payment, no payment or exclusion from a network.

Improved alignment between hospitals and physicians is essential to changing the way care is delivered, enhancing patient and physician satisfaction and improving each element of the value equation—quality, outcomes, cost and access. Because physicians are responsible for driving the clinical care of patients, their incentives must be based on value and aligned with those of hospitals and health systems. Properly structured hospital-physician ventures can reduce costs and duplication of assets in communities, improve quality, access, and satisfaction, and increase operating and capital efficiency.

Organizations must prepare for the future value-based health care system while ensuring sustainable performance under the current payment and delivery model. This requires the participation and coordination of all stakeholders across the care continuum and the close management of key indicators. Transition success will be determined by organizational readiness, culture, operating capabilities, infrastructure and leadership.

Organizations need to manage the transition appropriately. Value-based contracting arrangements should be secured only when organizations can demonstrate their value-driving capacity and when their infrastructure can support the needed changes. Arrangements secured too late into the performance-building process may result in payers not partnering financially in these efforts because results have been fully demonstrated without their involvement.

This guide offers an overview of physician integration models currently deployed at hospitals and health systems. These models include a wide array of programs, covering customer service offerings, contractual ventures, joint venture/shared equity arrangements and employment/practice acquisition models. The legal, taxation and regulatory issues surrounding hospital-physician integration are complex and changing. This guide does not intend to provide recommendations in these areas; providers should seek expert advice.

In summary, the guide:

- Describes the groundwork required for successful hospital-physician integration;
- Presents key considerations involved in implementing these models and sustaining their success;
- Offers 12 strategies to guide integration efforts; and
- Provides examples of hospital-physician integration initiatives at organizations of different types and sizes, including a hospital, health system, regional medical center, integrated delivery system and university health system.

Your comments and questions are always welcomed at hpoe@aha.org.

Laying the Groundwork for Successful Integration

To achieve a hospital-physician integration strategy that is sustainable for both parties, hospitals and health systems must lay the needed groundwork of knowledge, capabilities, infrastructure, resources, performance targets and physician participation. Implementation of the first four strategies lays that groundwork.

Strategy 1. Understand the forces affecting physicians; design strategic offerings to meet the needs of local physicians.

Many physicians in private practice have been struggling during recent years due to flat or declining revenue and increasing expenses in benefit costs, malpractice insurance rates and rapidly escalating technology requirements to support an electronic health record. These factors have put substantial pressure on physician and practice income. Additionally, uncertainty about the viability of private practices, the shift from a volume- to value-based business model and the advent of a new generation of physicians who have different work and lifestyle expectations are creating additional pressures.

As a result, physicians are exploring alternate ways of working with hospitals and health systems. Since 2000, hospital employment of physicians has increased 32 percent, with 17.3 percent of all physicians now directly employed by hospitals or health systems.¹ Physicians are exploring arrangements with other partners, such as payers, independent practice associations and large multispecialty practices.

To meet the needs of physicians, hospitals and health systems should be designing strategic offerings based on their organizational capabilities and local service area characteristics (as described in the next section). Based on observations in working with hospitals and health systems nationwide, organizations making more rapid progress with physician integration offer multiple points of entry. The path to physician integration typically is through a pluralistic model, with three key alternative offerings:

1. *Independent physician programs*: Hospitals develop and refine programs to support and align with physicians who wish to remain independent.
2. *Employed physician programs*: Hospitals and health systems acquire and organize primary care and multispecialty practices around driving high quality health care.
3. *Clinically integrated networks or accountable care organizations*: These include both employed and independent physicians, who are aligned through formal clinical integration programs and other value-based integration options, such as the Medicare Shared Savings Program.

Strategies related to these offerings may be proactively pursued or may occur reactively in response to physician approaches. Flexibility must be demonstrated to accomplish organizational goals while accommodating physician needs. Figure 1 is a matrix of alignment options.

¹ AHA Hospital Statistics: 2012 Edition, based on 2010 data.

Figure 1. Alignment Options

Integration Alignment Matrix

Proactive	<ul style="list-style-type: none"> • Employment • Physician JVs • Risk Sharing • Clinical Integration 	<ul style="list-style-type: none"> • Technology • Customer Relationship Management • Referring MD • Contracting
Reactive	<ul style="list-style-type: none"> • Employment • Physician JVs • Pay for Performance/Comanagement 	<ul style="list-style-type: none"> • Management Services Organization • Recruitment
	Partner/Employ	Customer Service

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Strategy 2. Understand the hospital or health system’s specific capabilities and infrastructure in the context of the communities served.

Two major variables are critical in understanding an organization’s ability to develop specific physician-integration strategies.

The first variable is the service area, including the patient-population characteristics, local and national payers and the nature of the competitive environment. Hospitals and health systems should understand the mix of payers and how this mix is expected to evolve over the next decade. Additionally, they need to consider how innovative the existing payers are. Just as different providers have differing capabilities to execute new strategies, different payers have different appetites and capabilities for collaboration and innovation in supporting changes in care delivery under the new business model.

The second variable relates to the provider organizations themselves. Integration and alignment programs need to be based on a well-informed and objective assessment of the hospital’s or health system’s core capabilities and operating competencies in both acute and ambulatory settings. Care coordination across a variety of acute, ambulatory and post-acute settings is important as organizations begin to manage a population’s health.

To effectively offer services in a value-based environment, some form of integration with employed and private practice physicians is a core competency. Whether or not an organization chooses to pursue a formal clinical integration program, the organization should be developing the required infrastructure and competencies to support a broader approach to managing care across the continuum. Five core areas can be the focus: provider alignment, care delivery, information technology, data management/analytics and payment management (Table 1).

Table 1. The Core Capabilities of Value-Based Care Delivery

Provider Alignment	Care Delivery	Information Technology	Data Mgmt./Analytics	Payment Management
<ul style="list-style-type: none"> • Governance • Organizational structure • Foundational primary care • Primary care/ specialist communication • Network development and management • Contracting • Clinical collaboration forums 	<ul style="list-style-type: none"> • Prevention and wellness initiatives • Evidence-based protocols • Care transition initiatives • Patient health tools • Health management support 	<ul style="list-style-type: none"> • Patient registry • Electronic medical record • Computerized physician order entry (CPOE) • Case management workflow tools • Decision support • Provider portal • Billing/claims • Contracting • Health information exchanges 	<ul style="list-style-type: none"> • Patient/condition identification • Clinical outcomes • Quality reporting • Utilization reporting • Movement toward data standardization 	<ul style="list-style-type: none"> • Patient attribution • Incentive distribution/ funds flow

Source: Kaufman, Hall & Associates, Inc. Used with permission.

Example: A Hospital Assesses the Feasibility of Clinical Integration

Hospital X is a 500+bed independent hospital located on a coast with a fragmented service area, serving a population insured through many different payers. The hospital identified the need to prepare itself for value-based reimbursement models through development of a clinically integrated network of physicians. The leadership team believed the organization was at risk both of being marginalized and of a diminished ability to remain independent in a region experiencing increasing consolidation.

Hospital X assessed the feasibility of developing a formal clinical integration program. The first step was to obtain a data-based understanding of its specific capabilities and infrastructure in the context of local service area conditions.

The assessment identified key characteristics of Hospital X’s provider/physician service area. These included the following:

- Highly competitive, yet fragmented, service area with strong specialist representation;
- Strong physician preference for private practice;
- Limited coordination of care transitions among providers;
- Active discussions in the service area related to narrowing of provider networks; and
- Room for improvement across the service area from both a cost and quality perspective.

To further assess the feasibility of formal clinical integration, a clear value proposition was identified for each stakeholder, including member physicians, Hospital X and the community. To engage physicians in the program, a value proposition was developed

for each physician segment, including private practice physicians, hospital-employed physicians, academic physicians and employed foundation physicians. Elements of value for physicians included:

- Access to reasonable payment rates;
- Ability to maintain current levels of productivity;
- Coordination and alignment of care;
- Involvement in administrative efforts to impact care delivery;
- Access to information technology solutions;
- Practice promotion and branding;
- Reduction in practice overhead costs; and
- Access to performance data and benchmarks.

However, these elements were highly specific to the service area. For example, physicians in growing, well-reimbursed areas had very different drivers than physicians in flat or shrinking areas where new entrants increased the competition.

Hospital X took a close look at each of the attributes driving feasibility for value-based care delivery (Table 2) and rated its level of preparedness for an ACO, a formal clinical integration program, or risk-based contracting as compared with key characteristics of well-prepared organizations. From this study, the organization identified performance dimensions that needed to be strengthened or partners already accomplished in selected dimensions with which collaborative arrangements could be secured.

Table 2. Feasibility Dimensions for Value-Based Care Delivery Transformation

Performance Dimensions	Key Characteristics of Most Prepared
Service Area—Intrinsic	Service area characteristics and overall composition (e.g., size, scale, demographics, economics) support and enhance fee-for-service-based clinical integration initiatives.
Differentiation	Clinical integration provides differentiating value to community, enabling value-based innovation and initiatives.
Organizational Capacity	Institutional quality infrastructure is robust and scalable. Financial and capital capacity supports ongoing and strategic investment in the organization.
Value Proposition	Clear, discernible, and communicable value propositions exist for all major stakeholders, including primary care and specialty physicians, hospitals, the community and payers.
Physician Alignment	A highly aligned medical staff is characterized by shared goals, outcomes-based contractual arrangements and significant planning input. Physicians are adequately represented in organizational governance.
Physician-Change Awareness	Providers are highly aware of the transformational change occurring across the healthcare landscape, including timing and operating pressures associated with this change.
Culture of Collaboration	A high degree of collaboration exists; care transitions are highly coordinated among primary care physicians, specialists, post-acute care, and other components of the system of care.
Technology	High level of EHR adoption by community physicians exists. There is also sophisticated utilization of these systems to advance quality initiatives and capabilities.

Source: Kaufman, Hall & Associates, Inc. Used with permission.

This approach helped Hospital X's leadership team understand that service-area elements were unfavorable for a formal clinical integration program and that becoming an ACO through participation in the Medicare Shared Savings Program could build physician alignment and advance the value-based transformation with less risk.

Strategy 3. Ground physician-integration efforts on a well-defined strategic financial plan with sufficient resources and performance targets.

To pursue a pluralistic physician strategy with private practice, clinically integrated and employed physicians, hospitals and health systems must develop a well-defined strategic financial plan that identifies the specific strategies and quantifies the direct and indirect revenue, cost and performance targets of each alternative.

Most hospitals and health systems have limited resources; therefore, it is important to ensure that capital spending needs and operating performance levels of physician strategies are identified and quantified before a commitment is made. Organizations should focus financial and human resources on options that support the quality targets, service lines, geographic access cost efficiencies and other goals in their communities. Goals must align appropriately with local service area drivers. Integrated strategic financial planning will enable the organization to determine the level of financial commitment versus the level of operating improvement offered by specific strategies, both separately and in combination. Capital allocation plans must balance the need for growth, quality and access across physician strategies.

Initiatives that require significant amounts of capital include: recruitment, employment, practice acquisitions, technology, physician joint ventures and other asset-based ventures. Market-based planning is required to quantify the impact of these initiatives on volumes, revenues, expenses, investment in fixed assets and working capital and downstream contribution margin. Solid analytics, using proven planning tools, help leadership assess the required level of investment relative to the risk.

Few hospitals and health systems can afford employing a majority of their independent physicians without a negative financial impact on the overall operating and capital position. Transaction costs, operating costs and transitional capital expenditures tend to be higher than anticipated (Table 3).

Table 3. Example of Estimated Capital Impact per Employed Physician

	Primary Care MD		High-Cost Specialist	
	Year 0	Year 1	Year 0	Year 1
Purchase Price	\$75,000		\$150,000	
Transaction, Tail and Bonuses	\$65,000		\$100,000	
Net Working Capital		\$100,000		\$150,000
Capital Expenditures		\$50,000		\$100,000
Capitalization of Op. Leases*	\$250,000		\$300,000	
Capitalization of Losses†	\$400,000		\$600,000	
Typical Impact	\$790,000	\$150,000	\$1,150,000	\$250,000

* Capitalization of operating leases assumed for 10 years upon acquisition and based only on equipment leases.

† Annual operating losses multiplied by 4.

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To adequately develop and deploy a strategy and to ensure that limited capital resources are optimized with independent physicians, organizations should segment their medical staff into a number of distinct cohorts. These include foundational, loyalist, splitter, occasional user, referring non-admitting and non-users. Table 4 defines each cohort. Integration plans should address the needs of these unique groups of physicians in the context of organizational capabilities and service area characteristics.

Table 4. Distinct Cohorts of Independent Physicians

Cohort	Definition
Foundational	<ul style="list-style-type: none"> • Loyal, highly active physicians who drive quality and a disproportionate amount of revenue and volume to the hospital; typically anchor a particular service line.
Loyalists	<ul style="list-style-type: none"> • Physicians who admit 70 to 100% of their inpatients to the hospital; may or may not be foundational practices.
Splitters	<ul style="list-style-type: none"> • Physicians who admit to multiple facilities but admit 20 to 70% of their inpatients to the hospital.
Occasional Users	<ul style="list-style-type: none"> • Physicians who admit less than 20% of their inpatients to the hospital. • Barriers to securing their admissions are usually significant.
Referring Non-admitting	<ul style="list-style-type: none"> • Upstream referral sources who may direct sizable volume (usually to a specific specialty or subspecialty), usually from outside the service area. • In the future, these physicians may represent a potential source of new business or a loss of existing business.
Non-users	<ul style="list-style-type: none"> • Physicians who do not use the organization’s facilities and are still independent. • As current situations evolve, these physicians could represent growth opportunities.

Source: Kaufman, Hall & Associates, Inc. Used with permission.

Developing a three-to-five year plan will ensure that the proper level of resources (financial and human) exist to support the successful implementation of the strategy. In general, when working with physicians, organizations have only one chance to “get it right,” after which their credibility with physicians will be diminished.

Example: A Health System Builds a Viable Physician Strategy within Capital Constraints

Health System X developed a comprehensive and proactive strategy for physician integration across its network of employed and independent physicians. Located in a competitive service area, Health System X has three acute care hospitals and other health facilities. More than 1,000 independent physicians are part of its medical staff and many other physicians refer patients to the system’s hospitals. When it started planning, Health System X employed less than 50 primary care physicians and a similar number of specialists.

Although a limited amount of practice-acquisition activity had been observed in the system’s communities up to that point, competitive threats were on the horizon. Specialty and primary care physicians were starting to align with large academic medical centers and several area health systems.

While Health System X’s financial performance was strong, capital constraints were a strategic reality. The capital capacity to acquire large numbers of primary and specialty practices simultaneously was not available. Estimated capital impact of practice acquisition, before the impact of operating losses, averaged \$500,000+ per physician. The organization, therefore, wanted to create models that would align physician and health system needs in a rapidly changing environment and accomplish this goal within financial capabilities.

Health System X wanted to offer physicians multiple options for aligning with the system—from improved physician support functions to employment. The health system also wished to create a replicable practice-acquisition program that clearly defined the process to acquire physicians, and a process to quickly evaluate and define the future operational and financial commitments to support physician initiatives.

Beyond the employment model, Health System X evaluated the following options.

- Service-based contracting model—This option would create a management service organization that would support employed and independent physicians, offering services such as billing, medical malpractice, group purchasing and others “a la carte.”
- Quality-/performance-driven contracting model—Under this option, the health system would partner with physicians through a traditional physician hospital organization, a clinical integration program or an ACO, to jointly contract with payers and employers to provide health care services with performance-based incentives related to quality, access and cost management.
- Loosely or highly integrated technology alignment—This option would offer physicians easier use of technology-enabled services or development of systems, interfaces and processes that tightly integrate clinical quality information and outcomes data—through EHRs, CPOE systems and picture archiving and communication systems.
- Customer service model—This option would offer a physician concierge program, office coordinators and other high-touch services.

Health System X evaluated each strategy for how well it: 1) supported organizational and physician needs; and 2) stayed within the investment guidelines (Figure 2). The system pursued a multi-pronged approach.

Figure 2. Evaluation of Physician Strategies across Strategic and Financial Dimensions

	Employment	Contractual		Technology Alignment		High-Touch Customer Service
		Service-Based Model	Quality-Driven Contracting	Loosely Integrated	Highly Integrated	
Foundational Loyalists	High	Moderate	High	Low	High	Low
Foundational Splitters	High	Moderate	High	Low	High	Low
Loyalists	Moderate	Moderate	High	Low	High	Low
Splitters	Moderate	Moderate	High	Low	High	Low
Occasional Users	Low	Moderate	High	Low	High	Low
Referring Non-admitting	Low	Moderate	High	Low	High	Low
Estimated Capital Requirements	High	Low	High	Mod	High	Low
Degree of Alignment	High	Low	Mod – High	Low	Mod – High	Low
Degree of Differentiation	High	Low	Mod – High	Low	High	Mod
Estimated Coverage (Preliminary)						
Headcount	25%	10%	75%	90%	90%	100%
Volume	50%	10%	95%	95%	95%	100%

Level of Alignment with Strategic Goals: High Moderate Low

Source: Kaufman, Hall & Associates, Inc. Used with permission.

Strategy 4. Ensure strong physician participation, leadership and governance.

Physician involvement at all levels of the organization must be supported by executive leadership and the board of trustees. Clinical and administrative physician leaders should be included in planning and development of new networks, operating models and other integration initiatives. Value-based health care is not possible without physician leadership. Physicians drive the design/redesign of clinical care delivery within this model. Both boards and executive teams should empower physician leaders with the authority to drive change, recognizing their vital role in the value equation. Leading health systems that are moving to a value-based system consistently mention physician leadership and participation as key differentiating factors.

At this time, most organizations do not have adequate physician representation at the executive leadership and board levels. Currently, physicians comprise less than 30 percent of senior leadership teams (senior vice president and higher) in 88 percent of organizations; 36 percent of organizations report no physicians on the senior leadership team.²

Example: A Regional Medical Center Develops a Clinically Integrated Care Delivery Model through Physician Collaboration

An independent 220-bed regional medical center in the Midwest, serving residents in 10+ counties, updated its strategic financial plan to identify and quantify a set of initiatives to achieve success under the value-based business model. New projections of reform and new era-related volumes, expenses and capital expenditures were added to baseline financial projections to study the impact of changes on hospital profitability, liquidity and debt capacity.

An assessment of the plan indicated six critical factors for future success:

- Maintaining a consistent revenue base—Maximizing the number of lives and managing the care of those lives were critical.
- High quality at the absolute lowest cost—The ability to drive strong operational performance while delivering high quality care would be a key element driving financial performance in a model predicated on achieving maximum efficiencies.
- Physician integration—Effective physician engagement and alignment would enable the center to move to a population health management model; physician leadership would be required around key initiatives, from clinical integration to regional growth planning.
- Access to capital and talent—These attributes would support investment needs and clinical and non-clinical resources.
- Effective infrastructure—IT facilities and equipment would allow users to achieve the required performance.
- A sustainable competitive position—Partnerships with regional employers, programs, physicians, facilities and infrastructure would provide the center with a sustainable competitive advantage/differentiation in its community.

At the commencement of planning, the center's specialty medical staff was largely in private practice; primary care physicians were mostly employed. Leaders recognized the ability to effectively and efficiently integrate care with physician collaboration would be critical to driving improvement in quality and outcomes. The organization committed to establishing a clinical-integration platform for the region.

² HealthLeaders Media Industry Survey, Feb. 2012.

To plan and develop a comprehensive and functional clinically integrated care delivery model, the center's key leaders and representatives from the critical stakeholder groups were engaged. These groups included physicians, staff, administrators and board members. The participation of physicians on the board provided needed input. Physicians could also educate the board on the magnitude of change being recommended and the critical nature of holding "the professionals" accountable for leading the organization during planning and implementation. Clinical leaders were involved early and throughout the process. Active participation of senior leadership demonstrated the center's commitment to clinical integration as an immediate organizational priority.

A specific group of physicians was identified to lead the efforts. The group included service-line representatives and quality and thought leaders who participated on a steering committee. This committee's worked to:

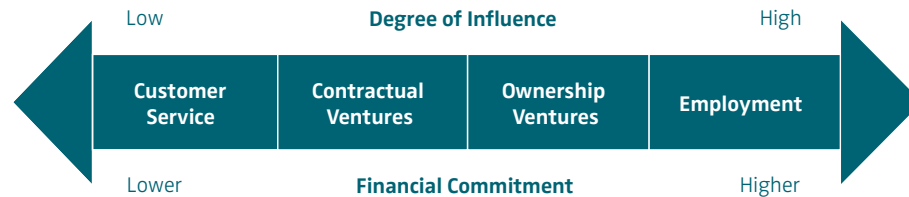
- Identify and define contracting goals, structures and mechanisms; quality goals; timetable to initial implementation date; role of existing physician contracting structures; proposed organizational structure; and a proposed governance model.
- Review business models used at other organizations and select an optimal business model, defining key operating statistics and requirements.
- Develop a business plan and business case for a clinical integration program, including start-up costs and ongoing capital requirements; utilization and quality impacts; clinical infrastructure requirements; technology requirements; care management requirements; reimbursement impacts; identification of required services to purchase or operationalize; reporting requirements; patient and physician satisfaction measurement requirements; physician payment mechanism; and high-level financial projections.

Based on the committee's work, the management team and board reached a decision to proceed with the clinical integration program as defined in the business plan.

Integration Options

In today's environment, hospitals and health systems have four primary physician-alignment options: customer service programs, contractual ventures, joint-ownership ventures and employment. As indicated in Figure 3, these options range from a lower financial commitment and degree of integration influence (customer service option) to a higher degree of integration influence and financial commitment (employment option). A description of each option follows.

Figure 3. Spectrum of Integration Options along Influence and Financial-Commitment Dimensions



Source: Kaufman, Hall & Associates, Inc. Used with permission.

Customer Service Programs

These programs provide support and services to physicians in technology, revenue cycle, medical malpractice insurance, training, co-marketing programs and other administrative support services. The focus is on improving independent physician practice performance and satisfaction, while aligning physician goals with hospital and health system goals.

Hospitals and health systems are focusing on overall improvements in physician customer service, creating new and innovative programs to enhance physician experience across all aspects of operating performance. These initiatives are technology dependent, specifically electronic medical records (EMRs). An EMR is a computer system composed of multiple, integrated applications that enable clinicians to order, document and store patient information. The term electronic health record is sometimes, and incorrectly, used interchangeably. In contrast, an EHR is patient health information from multiple care delivery organizations' EMRs, comprising a patient-centric, longitudinal view of a patient's encounters with health care providers. An EHR may also include electronic data from payers, pharmacy benefits managers and patients.

Technology Programs

Technology has been and will continue to be one of the most successful tools to engage physicians with hospitals and health systems. The provision of incentives by the Centers for Medicare & Medicaid Services for "meaningful use" of EMR technology has provided further stimulus to physician-hospital alignment efforts, since most physicians in private practice are challenged to qualify for these incentives without involvement of a hospital or health system at some level.

The relaxation of Stark Laws has allowed hospitals to subsidize up to 85 percent of the cost of an EHR or EMR system for community physician practices. Many hospitals are finding that equipping community physicians with the hospital's EHR system is an attractive option for both parties—a means to improve patient care and align goals at a significantly lower cost than employing physicians.

The success of an organization’s physician-integration efforts is substantially contingent on the effectiveness and reach of its clinical systems. Value-based care requires functional clinical systems that provide interoperability between ambulatory and acute settings. Physicians will not want to use more than one EMR platform; therefore, the race among hospitals to “own physicians’ desktops” and link ambulatory and acute care is intensifying.

To accelerate the integration of technology platforms between hospitals and physicians, organizations must ensure thorough technology planning that defines user requirements at the physician level and engages physicians early in the process. A technology oversight committee with representatives from all constituencies is recommended. This committee can set target service-level agreements with vendors and partners before implementation occurs.

To ensure the success of technology programs, hospitals must also:

- Limit the required level of physician investment of both capital and time;
- Emphasize physician training by providing appropriate and versatile training in EMR use, such as on-site coaching, as well as classroom time;
- Enable multiple access points across all sites of practice (office, hospital, home, etc.); and
- Measure success through satisfaction surveys and physician adoption rates.

Strategy 5. Use technology to connect with physicians.

The options for leveraging technology across the physician enterprise—employed and independent physicians—require interoperability across the spectrum of physician activities—clinical, business and customer service domains. Table 5 presents some of the many options to leverage technology within a physician enterprise.

Table 5. Examples of Technology Used to Connect with Physicians

Clinical	Business	Customer Service
<ul style="list-style-type: none"> • Clinical systems <ul style="list-style-type: none"> – Comprehensive – A la carte + EHR + Results reporting + Pharmacy + Patient alerts • Clinical education 	<ul style="list-style-type: none"> • Scheduling • Registration • Data integration • Contracting/contract management • Management Service Organization (MSO) • Electronic consent programs 	<ul style="list-style-type: none"> • E-mail • Telephony • Customer relationship management (CRM) program • Referring physicians support systems • Call centers

Source: Kaufman, Hall & Associates, Inc. Used with permission.

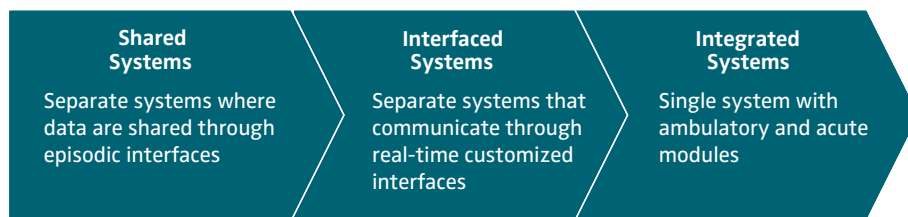
For physicians to use and interface with hospital/health system technology, the following criteria must typically be met:

- It takes the same or less time than their current technology or offers a significant advantage in another area when it requires more time.
- It does not require more than one user interface.
- It requires a low-to-moderate level of investment.
- It allows two-way information flow between the physician and hospital/health system.

- It eliminates duplication of work effort.
- It supports or improves existing workflow.
- It is proven technology—not an “alpha” or “beta” version of developmental technology.

Ultimately, from the physician perspective, technology that facilitates the practice of medicine provides access to relevant information to allow effective decision making. The choice of systems, whether shared, interfaced or integrated, will affect the depth and quality of information available, and the degree of workflow integration that can be supported. The point of clinical technology is to enable and improve clinical workflow. The more it does so, the more successful adoption efforts will be, and the more connectivity that can be achieved (Figure 4).

Figure 4. Progression of Technology Connectivity



Source: Kaufman, Hall & Associates, Inc. Used with permission.

Physician input, preferably physician leadership input, must be obtained before selecting and implementing technology that affects physicians. Understanding what it will take to gain physician support and participation is critical. Long-term technology alignment is predicated on end-user functionality of the technology, not its technical architecture or price. With technology ventures that involve physicians, it is imperative to under commit and over deliver. Some recent technology applications have been disruptive to daily physician practice operations and have materially underachieved relative to promised performance levels. Early and educated engagement of practicing physicians will mitigate this risk. Service-level agreements and technology support are crucial for physicians’ long-term commitment to a hospital or health system’s technology initiatives.

Contractual Ventures

These alignment options involve developing a contract or series of contracts with a physician or physician group(s) to either purchase services from them or provide services to them.

Most contractual ventures are entered into to improve efficiency. Ventures can range from programs such as *pay-for-performance initiatives* to *comprehensive management services organizations*. They have a limited scope and traditionally have been short-term, focused initiatives, with a half-life of about two or three years. Typically, such contractual ventures are a useful starting point for aligning incentives, building trust and establishing the basic performance requirements for a transformation to value-based care. Expectations must be managed to ensure that physicians understand that the programs are transitional and not sustainable in the long term due to the rapidly changing health care environment.

Contracting arrangements can be developed in a number of different ways:

Professional Services Arrangement. A PSA is the most common direct contractual arrangement between hospitals and hospital-based physicians or physician groups for professional services provided by the physicians, including radiology, pathology and anesthesiology.

Physician-Hospital Organization. A PHO is a legal entity formed by a hospital and one or more physicians or physician groups for the purpose of negotiating and obtaining contracts with insurance plans and employers. Historically, most PHOs have been “messenger models,” meaning that a payer submits fee schedules to an agent or third party, who transmits this schedule to the network physicians. Each physician can decide individually whether to accept or reject that fee schedule. The messenger or agency communicates the decisions to the payer, who then contracts with the physicians who have accepted the terms.³ There are numerous variations of this model and many PHOs are evolving into clinical integration programs.

Comanagement Agreement. A comanagement agreement involves a contractual agreement between a hospital and management services company (typically a new company) or a group of individual physicians. The latter agree to perform clinical and management services with specific improvement targets in exchange for a predetermined fee. Under a comanagement arrangement, the hospital enters into a contractual arrangement with a new company or a group of physicians individually. The new company or physician group agrees to provide defined services to the hospital for a set price for a limited period of time.

Other considerations include the following:

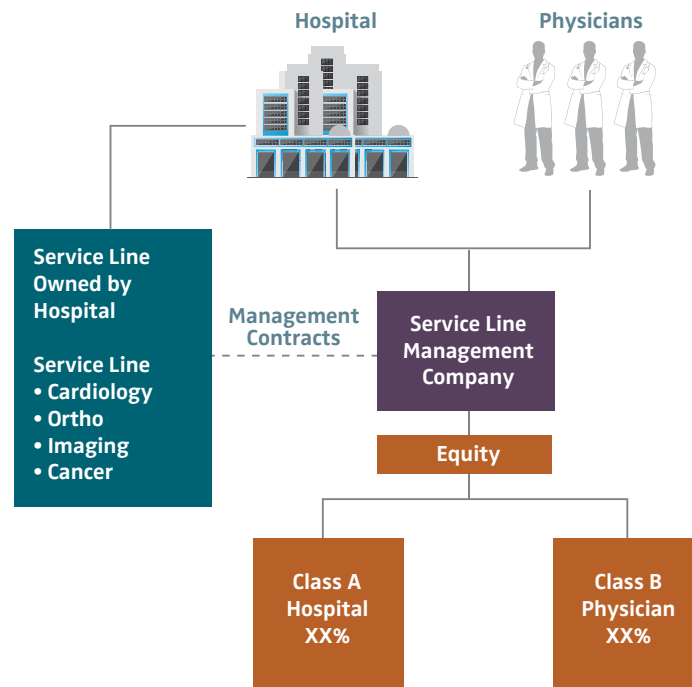
- The new company includes both physicians and professional management. It may include physicians from a single practice or from multiple practices.
- There are defined deliverables and performance levels. These contracts include service-level agreements tied to specific quality, operating and financial goals that form the basis for renewal or extension of the agreements.
- Comanagement agreements can be as simple as assisting the hospital in developing a new program or care center or can be as extensive as managing an entire service line or ambulatory service venture.
- Limited, if any, capital investment is typically required of physicians.
- These arrangements can be set up as management services agreements or as consulting engagements.
- Equity return rates can only be earned if material levels of equity are at risk for nonperformance; otherwise, payments must be tied to work effort.
- Such agreements have a limited applicability across clinical services.
- The arrangement must be well-defined with a high degree of specificity.
- Duties must require the involvement of physicians.
- The overall required level of work effort and the individual hours incurred by each physician must be reasonable.
- The imputed or actual rate per hour must meet standards for fair market value.
- Contemporaneous time reporting must be maintained.

³ Ross, D.: *Physician IPAS: Messenger Model*. FTC/DOJ Health Care Hearings. www.ftc.gov/ogc/healthcarehearings/docs/030925douglasross.pdf (accessed Aug. 21, 2012).

Comanagement is a relatively quick and proven method for hospital-physician collaboration. It usually takes about 90 to 120 days to establish the program, draft the documents and commence operations—a time frame which is much shorter than with other approaches. Figure 5 illustrates the typical comanagement structure.

Comanagement arrangements continue to draw increased regulatory scrutiny, so expert counsel should be sought to ensure legal and regulatory compliance.

Figure 5. Example Comanagement Structure



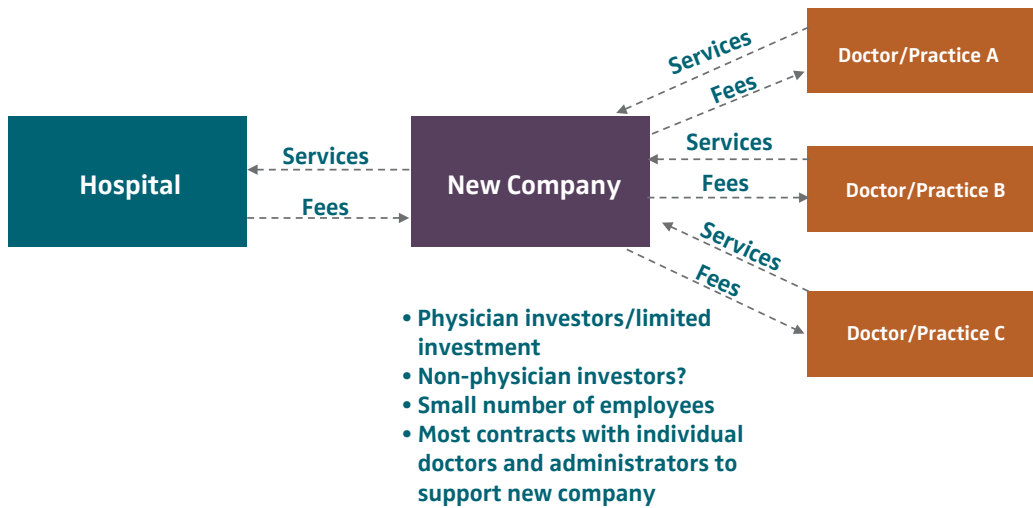
Source: Kaufman, Hall & Associates, Inc. Used with permission.

Management Services Organization. Under an MSO, the hospital or health system forms a new division or company, (“Newco”), for the purpose of managing a defined set of activities for the members of their medical staff. MSOs have gained popularity, especially in the areas of clinical technologies and physician revenue cycle, where significant investment in infrastructure can be spread by health care organizations across a larger physician base.

The Newco would typically include both physicians and management professionals and would provide the agreed-upon services at an amount equal to or less than the current cost level for the independent physicians. These agreements usually include service-level standards for key financial, service and quality indicators.

MSOs can be used in the management of any physician specialty or ambulatory venture where physicians seek assistance in lowering their cost structure. Figure 6 illustrates the typical MSO structure.

Figure 6. Example of the Structure of a Management Services Organization



Source: Kaufman, Hall & Associates, Inc. Used with permission.

Clinical Integration Program. CI programs involve collaboration between private practice and employed physicians and hospitals to increase quality and efficiency of patient care and allow for joint contracting with fee-for-service health plans on this basis, subject to review by the regulatory agencies.

While this concept has generally been understood for many decades, clarity about the official definition is critical. Antitrust laws generally prohibit doctors and hospitals from negotiating jointly with health insurers. And, because financial collaboration between non-employed providers (physicians in private practice), hospitals and insurers often involves contractual agreements, clinical integration programs have been—and are now—the subject of Federal Trade Commission and U.S. Department of Justice scrutiny related to possible anticompetitive practices.

The following is a list of key components of regulatory-compliant clinical integration programs:

1. Collaboration between hospitals and both employed and private practice physicians. Typically, CI programs require the participation and support of a significant proportion of an organization's medical staff.
2. Purposeful agreement to measurably improve the quality and efficiency of care, access, clinical outcomes, utilization and other defined factors.
3. Use of evidence-based practices and data-driven performance improvement, supported by IT tools to accomplish the goals itemized in #2.
4. Some form of intervention to address program/network members who do not meet performance expectations.

Antitrust laws forbid collective negotiations unless the involved parties are either truly clinically integrated (as defined above) or financially integrated. Financial integration occurs when the hospital owns all of the participating physician practices and employs the doctors, or through financial risk sharing. Therefore, clinical integration requirements apply only to fee-for-service contracting arrangements with commercial payers and not to risk-based contracting models or government payers, such as Medicare or Medicaid.

Sidebar 1. Is Your Clinical Integration Program Allowed by the FTC and DOJ?

An affirmative response to each of these questions could indicate that your clinical integration program is likely to be allowed by the FTC and DOJ, but legal counsel is required.

- Is joint contracting with fee-for-service health plans “reasonably necessary” to achieve the efficiencies of a CI program? Proving clinical integration (i.e., demonstrating higher performance through coordination and measurement) without joint-contracting negotiations will show that the hospital does not need the joint-contracting arrangement to drive the increased alignment.
- Does the CI program consist of authentic initiatives that include specific metrics and processes actually undertaken by the network, involving all physicians in the contracting network and applying to the physicians’ practice patterns for fee-for-service patients?
- Will each physician in the network have five to 10 measures that apply specifically to his or her practice?
- Is the program likely to achieve improvements in health care quality and efficiency?
- Are there significant penalties (such as network removal) for physicians who do not perform?
- Can physicians participating at any level explain the program’s aims and objectives?

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An affirmative response to each of the questions in sidebar 1 could indicate that the hospital-physician CI program is likely to pass the acid test for clinical integration, as allowed by the agencies. However, being clinically integrated is not an automatic or complete exemption from antitrust challenges; it merely removes one from automatic, or “per se” violation of the rules. The program or network could still be subject to antitrust action on the basis of the “rule of reason” if it has consolidated significant pricing power in its service area without demonstrating value in quality and efficiency. Due to the complexity of legal and regulatory requirements, retaining expert legal counsel is a key part of building a clinical integration program.

Clinical integration is only one route toward developing the capabilities that will enable success in a value-based payment system. The elements outlined in Tables 1 and 2 determine whether it is feasible for an organization to start with clinical integration, as opposed to the Medicare Shared Savings program or risk-based contracting arrangements. Early CI programs have enabled hospitals, physician networks and other providers to collectively negotiate with managed care companies and health plans to improve the quality and efficiency of care.

Continued growth of clinical integration is expected in many areas of the country, because it provides physicians and hospitals, in appropriate circumstances, with a powerful business and clinical strategy to succeed in the new era of value-based care. However, due to the significant infrastructure and care delivery requirements of a formal clinical integration program, many organizations are not well positioned to pursue such FTC-compliant programs at this time. An objective evaluation of the key factors in Table 2 will position systems to choose the appropriate path forward in a value-based system and maximize the return on a significant investment.

Example: An Integrated Delivery System Develops a Clinical Integration Network

The example integrated delivery system is a seven-hospital organization with a 1,000+ physician medical group, 2,000+ affiliated independent physicians and a health plan with more than 500,000 enrollees. With intense competitive pressures in its region, the IDS developed a CI program that enabled it to proactively respond to changing service area dynamics and drive value-based care delivery.

The IDS aimed to improve quality, enhance access, lower costs, achieve clear first-mover advantage, improve stakeholder (physician and patient) satisfaction and improve its performance in a value-based reimbursement environment.

The network’s goal was to assess and transform the practice patterns of participating physicians to create a high degree of cooperation among its physicians, thereby controlling costs and improving quality. The IDS transformed care delivery by:

- Enabling primary care physicians to serve as the coordinator of the delivery network;
- Using approaches similar to a medical home model;
- Ensuring a patient-centric EHR accessible by all stakeholders; and
- Providing health management functions throughout the network.

The IDS identified specific drivers of cost reduction in each of three categories: decreased demand for medical services; decreased episodic cost for medical services; and a decreased administrative cost structure. Table 6 presents key physician participation terms deemed critical to achieving the network’s goals.

Table 6. Criteria for Participation in a System’s Clinical Integration Network

Participation Criteria	2012 Requirements
Adopt and adhere to physician-developed standards to improve quality and efficiency	<ul style="list-style-type: none"> • Work towards the goals and metrics targets identified by the Clinical Integration Committee of the IDS network • Evaluate and share clinical processes to reach targets as appropriate
Agree to be measured and share information to facilitate measurement	<ul style="list-style-type: none"> • Share clinical and business data as appropriate • Permit a network-selected data aggregator tool to collect the data for performance measurement
Collaborate with network participants to improve performance	<ul style="list-style-type: none"> • Participate in and contribute to regional clinical management forums and/or network workgroups to review performance, share clinical processes, and make recommendations to improve care delivery
Promote, refer to, and communicate with network participants appropriately and effectively	<ul style="list-style-type: none"> • Work effectively with other network participants • Refer patients within the network when appropriate and in accordance with patient preference
Adopt technology offered and/or recommended by the network, including high-speed internet access, E-prescribing, disease registry, and data exchange tools	<ul style="list-style-type: none"> • Maintain high-speed internet access • E-prescribing • Use a disease registry • Begin migration to connectivity solutions that will allow sharing of clinical information
Maintain medical staff membership in good standing at an IDS hospital or credentials according to an IDS-affiliated hospital standards	<ul style="list-style-type: none"> • Maintain medical staff membership in good standing at an IDS hospital or credentials according to IDS-affiliated hospital standards

The clinical integration network/program went “live” after an 18-month development and design process. Table 7 summarizes the initial 100+ clinical physician performance metrics for year one. With nearly 1,500 physicians in the network, including nearly 300 private physicians, the IDS has contracted with its first group, the IDS employee pool, which has approximately 25,000+ covered lives.

Table 7. Physician Performance Program Metrics, Year 1

Metric Source/ Type	Number of Metrics by Source/Type	Target	Threshold
PQRI	45	Improvement goal of 10%	One standard deviation
HEDIS	9	75 th percentile	25 th percentile
SCIP/CORE	28	90 th percentile	One standard deviation
Incidence	1	None	One
Administrative	3	Met requirement	Did not meet requirement
Other	18	–	–

The key success factors expected to contribute to the IDS network’s success going forward include:

- Service area relevance;
- Building and maintaining the right physician network with the right criteria;
- Strong physician governance and leadership across multiple physician constituencies;
- Strong practice management base capabilities (e.g., revenue cycle, contracting, physician compensation models)
- Transparency and engagement with physicians at all levels;
- Financial incentives tied to volume and quality of care;
- Significant investment in technology to enable all partnered physicians to operate on a common platform, either directly or through a health information exchange; and
- Strict adherence to quality guidelines.

Strategy 6. Ensure objective assessment of organizational readiness for value-based care transformation efforts, including a formal clinical integration program.

Before committing to investment in the design, development and implementation of a formal CI program, hospitals and health systems need to understand the feasibility of the CI approach for their unique service area and their internal capabilities and culture. They should also understand and quantify the requirements for investment in people, processes and technology needed to yield value in serving a defined population and to identify the barriers to implementation.

Organizations can benefit from a feasibility assessment, since it will identify the functions and capabilities that will be needed to compete in evolving reimbursement environments. This assessment, which typically takes two to three months to complete, provides the hospital or health system with a comprehensive fact base and an understanding of the potential opportunities to advance the organization’s value-based agenda. The assessment also helps define opportunities for the organization to participate in value-based initiatives with government and/or commercial payers.

The assessment should include both qualitative and quantitative analyses, covering the elements identified in Sidebar 2. This process requires engagement of key stakeholders—including physicians, payers, employers, patients and the hospital or health system—in defining the value proposition for each element. The process should also include development of a high-level business case for each integration initiative, including a CI program, with identification of the gaps in the organization’s current capabilities and financial modeling related to the opportunity.

Joint Venture/Shared Equity Arrangements

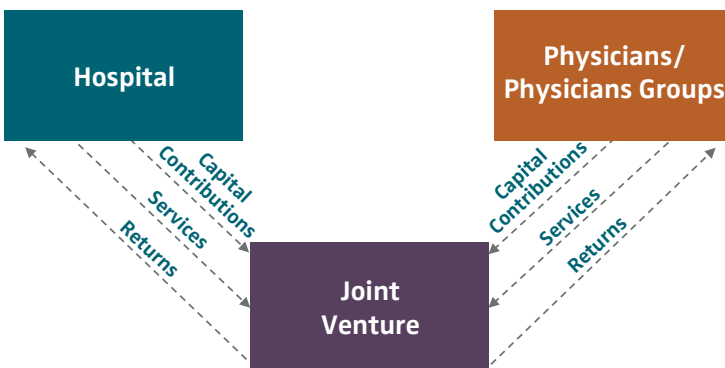
These arrangements involve a short or long-term agreement with risk and benefit sharing between a hospital or health system and one or more physician groups or individual physicians to form and operate a common enterprise (Figure 7). Returns are distributed based upon the proportionate investment of both parties.

Typically, ambulatory surgery centers, imaging facilities, endoscopy centers, urgent care centers and other outpatient diagnostic and treatment facilities are involved. Such facilities may be started by physicians or by the hospital/health system. Due to declining payment rates for care received in ambulatory settings, many of the physician-owned entities are now seeking hospital participation in joint ventures as a partial exit strategy for the physician investors.

Ownership distribution between the hospital or health system and the physicians has a big impact on payment levels and is one of the most significant issues with joint-venture equity structuring. Financial integration or sharing does not assure clinical integration, as most ambulatory joint ventures are still predicated on maximizing volumes and revenues.

For-profit operators are increasingly being introduced as a third class of investors to improve margins and operating efficiencies and to function as an independent buffer between physician and hospital interests.

Figure 7. Sample Model of a Joint Venture



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Before initiating joint venture discussions and setting physician expectations, organizations must assess the goals of the joint venture and determine whether these are strategically aligned with organizational goals. Key questions to be answered include:

- Does this venture support the organization's strategy?
- If the joint venture is a reactive response to service area pressures or requests for partnership from physicians, has leadership assessed other options?
- Is the organization setting a precedent with requests for joint ventures with physician-owned facilities?

Sidebar 2. Elements of a Value-Driven Feasibility Assessment

- Physician and administrative leadership interviews
- Focus group with local payers, employers and patients
- Service area assessment and demand analysis
- Geographic reach, service mix and physician capacity gap analysis
- Utilization, revenue and cost opportunity analysis
- Definition of key program requirements and organizational gaps
- Infrastructure and capabilities gap analysis
- Recommendations of priority focus areas
- Development of a high-level action plan for program development and implementation

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- Will the first joint venture lead to many more, and, if so, is that desirable?
- How will payers and patients view this venture?
- How flexible are the governance requirements?
- If the organization doesn't pursue this venture, will it cause a "gap" in its physician coverage (e.g. loss of orthopedics or radiology)?
- What will the financial impact of the joint venture be on existing operations?
- Will the joint venture be sustainable over the long term or is this just a short-term solution to an immediate situation?

Before pursuing any joint venture, an impact analysis must be performed to determine the effect of the new venture on existing organizational performance. This ensures that the new venture does not dilute existing performance levels. Legal and regulatory issues are complex; again, expert counsel is required.

Physician Employment/Practice Acquisition

Many hospitals and health systems are employing physicians to secure physician loyalty, increase service volumes (under the current fee-for-service system) and achieve the ability to provide integrated, high-quality and cost-efficient care across a larger care continuum under a value-based delivery system. Practice acquisition activity is much greater now than in prior years. In particular, specialty practice acquisitions are growing rapidly, occurring at or exceeding levels experienced in the mid-1990s.

Physician employment may take many different forms, including:

- Direct employment by the hospital;
- Employment by a wholly owned tax-exempt subsidiary;
- Employment by a wholly owned taxable entity;
- Employment by an independent or joint-ventured entity; and
- Employment by an independent, financially aligned foundation.

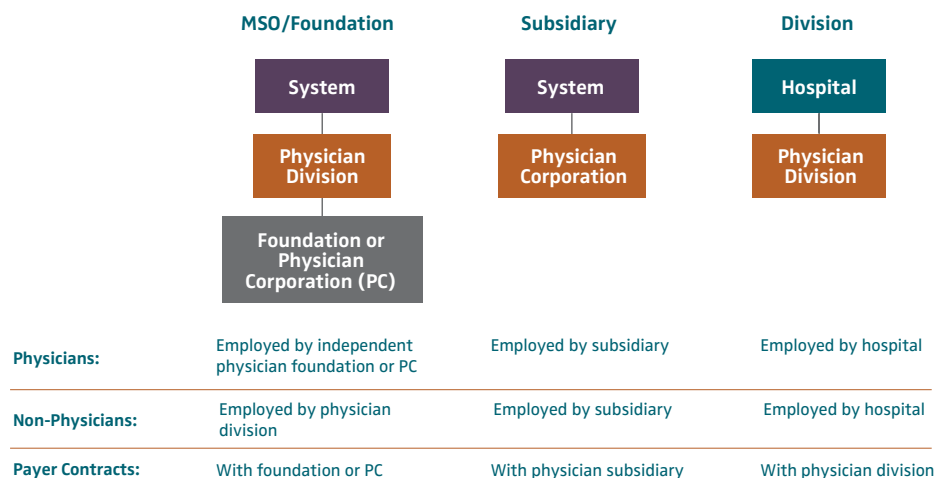
Hospitals are structuring practice acquisitions in a very straightforward way, as compared with the arrangements that were consummated during the 1990s. Asset-purchase agreements are the dominant purchase structure due to tax implications and liability issues; virtually no equity deals are being pursued. Goodwill payments are rare; some payment for defined intangibles occurs occasionally (for example, medical records, work in process), typically to assist physicians in paying taxes and medical malpractice insurance tail costs. Due to Medicare rules, accounts receivable typically are not acquired but are addressed under a custodial arrangement in the asset-purchase agreement. Three- to five-year employment agreements are being offered to physicians, with the specific compensation metrics re-indexed quarterly or annually based on productivity and market changes. Signing or retention bonuses are occasionally paid as part of initial consideration. Non-compete provisions are still prevalent.

Alternative Structures

Figure 8 illustrates three basic models for physician employment. An organization's selection of a specific model should be based on its integration strategy. Key considerations that will impact the organization's financial and operating performance

based on the model selected include: wage and benefit structure; flexibility in retirement packages; non-physician/ambulatory wage scale; parity pay (W-2 vs. K-1); medical malpractice; degree of control/influence in admissions and utilization; technology implications; funding implications; and contracting.

Figure 8. Alternative Models for Physician Employment



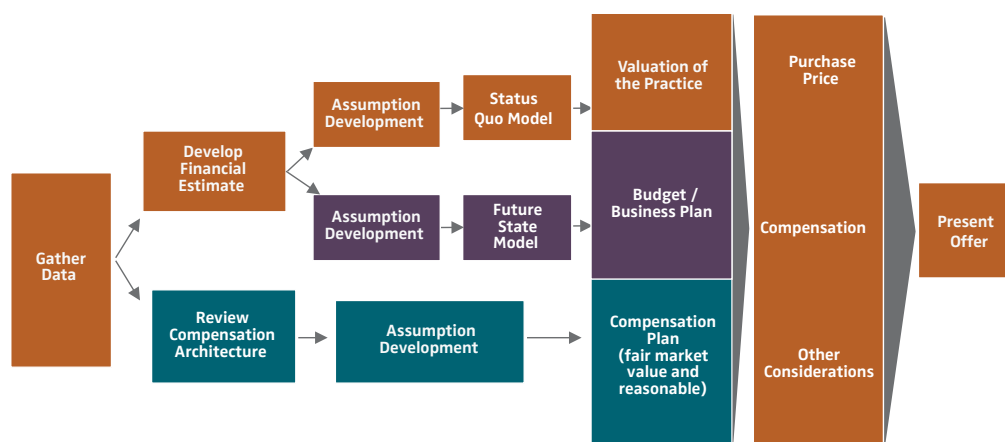
Source: Kaufman, Hall & Associates, Inc. Used with permission.

Whichever model is pursued, solid information technology capabilities are required to effectively manage practices and to monitor ongoing performance across many domains. Physician acquisitions and employment do not guarantee meaningful integration and alignment. Clinical and financial incentives must be aligned, and shared goals must be established and achieved. Implementation of strategies seven through 11 is recommended.

Strategy 7. Use a disciplined, integrated approach to practice acquisition and employment.

A formal acquisition program is required for large organizations, and a disciplined process is required for all organizations. A disciplined approach to practice acquisition includes standardized activities that are completed at all stages of an acquisition, from the preliminary screen to the final due diligence (Figure 9).

Figure 9. Steps in a Disciplined Approach to Practice Acquisitions



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Given the current competitive environment around physician alignment and the tsunami of physician employment programs, hospitals and health systems need to take a long-term perspective regarding strategic goals and avoid reacting to immediate market pressures. Many organizations indicate that the most difficult issue with physician acquisition and recruitment is having the discipline to say “no” to physicians who approach the system seeking employment, when their employment is not in the organization’s best interest.

Use of a high-level screening tool to assist in making an early determination of “go” or “no go” is recommended. Specific parameters for practice acquisitions should include:

- Specific specialties and geographic coverage goals in the context of organizational and service line priorities;
- Existing volumes and potential incremental volumes associated with proposed acquisition;
- Baseline quality metrics used for selection;
- Baseline financial performance requirements;
- Strategic fit and sustainability analysis; and
- Cultural fit with the hospital or health system.

Recruitment efforts and acquisition plans must be incorporated in the organization’s strategic and financial planning assumptions. When communicating about practice acquisitions and employment with the hospital’s board, the bond rating agencies and other capital market participants, the management team should focus on the impact to the organization’s income statement and balance sheet.

Long-term strategy with physician acquisition/employment must be front and center, as the shorter-term results may require sustained investments and funding of losses. Again, the legal and regulatory issues are complex; expert legal counsel is required.

Strategy 8. Document and communicate the level of financial commitment required to employ physicians.

Planning, budgeting and forecasting enables hospitals and health systems to thoroughly understand the level of ongoing financial commitment required of physician employment. These activities are not discretionary, but mandatory. Currently, too many organizations are underestimating the ongoing level of operating losses that their employed physicians will generate. Rating agencies, boards and leadership teams do not like surprises or variances. As acquisition plans are developed, annual budgets prepared, and long-term plans developed, detailed plans must produce realistic estimates that are attainable and for which management and physicians can be held accountable.

When a hospital acquires an independent physician practice, such change in ownership will almost always create an operating loss with the practice, even when productivity and compensation are held constant. Direct operating cost differentials that cause this loss typically include items such as more comprehensive non-physician employee wage and benefit programs, significantly large investment in technology, strategic investments in facility upgrades and higher medical malpractice coverage requirements. These additional costs are part of “doing business” for organizations that employ physicians. Costs need to be managed, but it is almost impossible to reduce these losses to a breakeven performance level.

Indirect or allocated costs can have a significant negative impact on practice performance. Such costs are typically outside the direct control of practice management and the physicians. Therefore, when developing budgets and assigning accountabilities, these costs can be presented below the operating-line level for managerial or non-generally accepted accounting principles purposes. Such items need to be reviewed and negotiated but typically are not part of physician and management incentive programs.

Strategy 9. Before employing physicians, model alternative compensation arrangements.

Compensation modeling enables management to understand the financial impact of alternative compensation frameworks before practices are acquired or compensation agreements are signed or renewed. Modeling also allows physicians to see the impact of proposed changes to their compensation before the changes occur.

Based on the results of this modeling, physicians and management can pursue compensation frameworks or “architectures” that best meet physician and hospital quality, access, service and financial goals. Detailed compensation modeling can be integrated directly into budgeting, reporting and planning activities, making adjustments as changes occur in service areas.

Physician compensation should be tied to productivity, quality, service, cost-effectiveness, access and other strategic goals, as described in the next section, and must provide physicians a fair and stable income. Different compensation arrangements are required for mid-level providers, urgent care providers, hospitalists and hospital-based physicians. These arrangements must recognize the role the provider is playing and the differing variables that are within and beyond their control.

Strategy 10. Structure effective and sustainable compensation programs for employed physicians.

Developing an effective physician compensation framework/architecture is the single most important factor driving the future performance of a hospital’s physician enterprise.

An efficient compensation design follows key principles that support organizational goals and provide physicians a fair and stable income. The most important principle is to develop consistent compensation standards and metrics and to apply these consistently across physicians, locations and specialties. Standards should cover work effort/productivity, quality, cost-effectiveness and patient access, and should support of the organization’s strategic objectives.

Another important principle in designing physician compensation programs is finding the right balance of the key metrics. Clinical work effort often represents up to 95 percent of community physicians’ work effort. So, while the industry is expected to evolve to a value-based payment system, productivity still needs to be the main factor driving compensation and the primary metric for incentive-based compensation programs. Quality, access and strategic alignment thresholds should be incorporated, but to a lesser extent. If only quality, service, patient satisfaction and other non-productivity goals are used, a measurable decline in access may occur. Recent experience demonstrates that even in a value-based care model, productivity metrics must be used or patient access measures will deteriorate. If access falls, then both quality and patient satisfaction can suffer. In a value-based care environment, productivity weighting may still need to be in the range of 50 to 70 percent, depending upon the organization’s service characteristics.

Productivity-based methods of structuring compensation programs include:

- Compensation per work relative value units (wRVUs);
- Compensation as a percentage of gross charges;
- Compensation as a percentage of net collections;
- Compensation per encounter; and
- Compensation based on panel size or panel-size equivalencies.

Of these alternatives, paying compensation per wRVU is the preferred method for a number of reasons: it is directly linked to the patient-activity level maintained by the physician and is neutral relative to patient payer mix; it is highly correlated to reimbursement for the services provided; and it is flexible enough to allow “shadow wRVUs” that can compensate physicians for items such as achievement of quality goals, support of strategic initiatives, excess travel time to cover outlying sites, participation in administrative functions, or whatever other work efforts the organization deems important.

As part of a compensation-per-wRVU framework, most leading organizations are also including quality, access, cost-effectiveness and service and patient satisfactions scores as variables that drive physician compensation. Typically, a total compensation per wRVU is set and then a portion of that total is allocated to the non-productivity metrics but is paid out on a per-wRVU basis. This requires the physicians to meet productivity goals and quality and other service-driven metrics at the same time. In general, quality is positively correlated with volume, so linking them in the compensation system makes sense.

Employment compensation agreements need to be structured competitively in a manner that is sustainable over the long term. Short-term agreements, which lead to major renegotiations after only a few years, create unnecessary conflict for the hospital or health system and the physician involved by increasing the frequency of the required renegotiations. Two- to three-year initial agreements with “evergreen” or automatic renewals are recommended. Typically the compensation metrics would be predetermined for the initial period and then would be adjusted based upon their relationship to other predetermined drivers of practice performance. If the metrics varied outside predetermined ranges, both parties would be required to renegotiate the compensation architecture.

In many successful health systems, a physician compensation committee is a standing committee that meets on an ongoing basis, not just during renegotiations. Goals related to quality, access, cost, service and other metrics are continually reviewed to determine if the goals offer the best-possible way to align the health system and physician goals.

Example: A University Health System Manages the Value Equation

As part of its clinical integration program, a university health system established a value management committee, with responsibility for defining:

- Quality and other value metrics related to infrastructure incentives, improved outcomes, improved quality and reduced clinical costs; and
- Clinical initiatives to drive value.

The selection of quality and other value metrics established consistency among all payers and a foundation for incentive payments. The committee started with a small number of metrics that were identified and approved by physicians with collective input from employers, physicians and payers. The number of metrics will grow and be reviewed annually. The university health system examined more than 400 clinical metrics from sources including:

- Other hospitals and health systems;
- Regulatory and accreditation agencies: meaningful use objective measures, Agency for Healthcare Research and Quality measures, proposed ACO measures, CMS core measures and value-based purchasing guidelines; and
- Internal sources (e.g., metrics in organizational balanced scorecards).

The rigorous evaluation process examined cultural feasibility (i.e., the likelihood of acceptance, receptivity to process change and credibility) and technical feasibility (i.e., the ability to collect the data and produce credible results). Through this process, the university health system selected 112 metrics to implement in its first program year.

Measurement is a key ingredient of managing value, but also necessary are appropriate resources and planning related to clinical initiatives that make performance targets achievable. The university health system defined three major clinical programs related to managing value across the continuum of care—managing chronic disease, improving generic prescribing and reducing overall hospital days—and defined specific and detailed plans to implement comprehensive programs in each area.

Strategy 11. Manage employed physicians to achieve goals.

Hospitals and health systems with high-performing physician enterprises actively track and monitor the performance of their employed physicians, using both internal and published benchmarks to identify and address performance strengths and weaknesses. Indicators for employed physicians should focus on financial performance, quality, outcomes, service, patient satisfaction, cost and other operational metrics. Indicators must be specific, measurable, attainable, relevant and time bound. They also must be reviewed on a frequent and ongoing basis.

On the revenue side, two areas require particularly close performance monitoring, review and proactive intervention when needed.

- *Physician revenue cycle performance.* This must be a top priority if the organization is committed to physician employment. If the organization cannot effectively manage the physician revenue cycle, the organization should outsource this function to a proven firm that can improve collection metrics and reduce collection costs.
- *Treatment of technical revenues post acquisition.* There are regulatory reasons that technical revenues cannot tie directly to physician compensation. However, many organizations shift technical revenues from the practice to the hospital to reflect the fact that the revenues are being billed at hospital rates. This creates a large revenue loss for the practice, even though the practice is creating value for the hospital. To hold physicians accountable to benchmark performance levels based on survey data, these revenues should remain in the practice at least at the operating reporting level before being removed during consolidation.

Cost-effectiveness will be a key issue in a value-based business environment. Figure 10 illustrates a simple performance dashboard that serves as an important practice management reporting tool. This dashboard allows individual physicians, practice administrators and organizational leadership to track productivity, staffing efficiency, revenue and expenses by physician, site or in total. The level of detail is indicative of what is required. Prompt identification of areas of underperformance and the development of concrete improvement strategies better enable the organization to attain performance targets.

Figure 10. Physician Practice Budget Dashboard by Region

Physician Network			
Budget Summary for Region 1			
FY2012 Budget			
	FY10	FY11 PROJ	FY12 BUD
Physician Productivity			
Physician FTEs	0.00	0.00	0.00
Mid-Level Provider FTEs	0.00	0.00	0.00
Total Provider FTEs	0.00	0.00	0.00
Office Visits (IP and OP)	000,000	000,000	000,000
% Growth		0%	0%
Office Visits per Provider	0,000	0,000	0,000
Office Visits per Day per Provider	0	0	0
Staff Efficiency			
Staff FTEs (exclude Mid-Level Prov.)	0.00	0.00	0.00
Ratio of Staff FTEs to Provider FTEs	0.00	0.00	0.00
Office Visits per Staff FTE	0,000.00	0,000.00	0,000.00
Average Hourly Wage	0.00	0.00	0.00
% Increase Average Hourly Wage		0.00%	0.00%
Revenue Analysis			
Net Patient Revenue per Visit	0.00	0.00	0.00
% Increase per Visit		0%	0%
Net Revenue per Provider	0	0	0
Expense Analysis			
Non-Provider Expense per Provider	0	0	0
% Increase		0%	0%
Rent Expense/Provider	0	0	0
Operating Expense per Visit	0.00	0.00	0.00

Source: Kaufman, Hall & Associates, Inc. Used with permission.

Evaluation of Physician Integration Options

Evaluation of physician integration options involves a thorough and fact-based analysis of the community-based advantages, capital requirements, operating impact and quality implications of each option. Hospitals and health systems must be able to answer the question, “What are the costs and impacts of each option in the integration continuum, from customer service arrangements to practice acquisitions and employment?” Ultimately, the alignment models encouraged by payers, employers and patients require a transformational change in the health care business model from facility-based silos to systems-level thinking.

Whatever the form of integration, the litmus test for an approach’s effectiveness will be its ability to align hospital and physician goals related to utilization, cost, service, access and quality, while maintaining or increasing the level of physician and patient satisfaction. Without achieving target levels of physician and patient satisfaction, none of these options are sustainable.

Ultimately, an organization’s arrangements with physicians must provide the platform for organizational growth. Many hospitals and health systems are responding reactively to

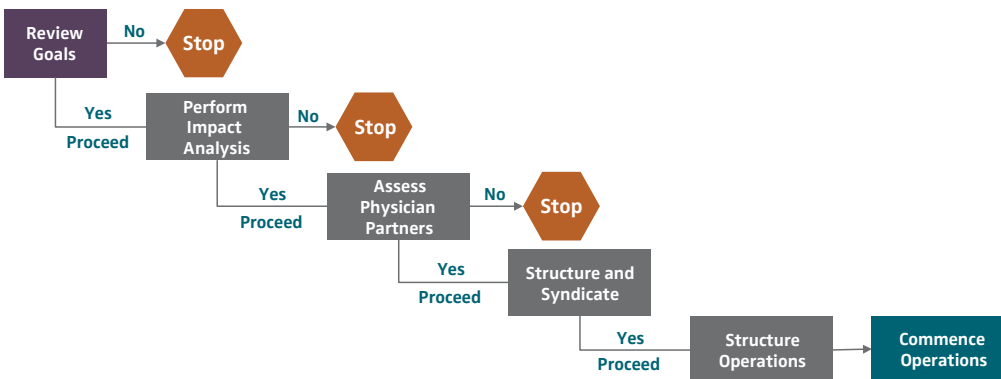
integration options as they evolve. But a better approach is to proactively identify, evaluate and select physician-integration options that represent a win/win opportunity—meeting physicians’ needs while positioning the overall organization for success. Timing is often critical. Nationally, the trend is service areas that moved from experiencing little physician practice consolidation to being fully “in play” in a matter of months.

Regulatory and compliance issues are numerous, so hospitals need to be knowledgeable and guided by legal counsel in these areas.

Strategy 12. Use a structured process to ensure creation of a sustainable venture and consistency over time.

As described in the previous section for physician-employment opportunities, hospitals and health systems should use a comprehensive process to ensure that they are creating a sustainable venture that is aligned with their “go-forward” strategy. Figure 11 illustrates this process.

Figure 11. Process for Creating Sustainable Integration



Source: Kaufman, Hall & Associates, Inc. Used with permission.

Review goals: Before initiating collaborative discussions and setting physician expectations, the organization must review its strategic goals and determine how or if the venture would support such goals.

Perform an impact analysis: An impact analysis quantifies the effect the collaboration would have on existing and proposed operations, financial performance, patient access, tax status, contracting and a host of other factors. One of three outcomes are possible from the perspective of physicians, the hospital or the patient: 1) the collaboration creates value; 2) the collaboration preserves value, meaning that the collaboration may be a needed defensive strategy to maintain the current level of value; or 3) the collaboration erodes value, which indicates that the collaboration should never be pursued, even if it meets one or more tactical goals.

Assess physician partners: Selecting the right physician partners has the biggest impact on creating value and driving quality. Key questions that must be addressed include: Is the arrangement with individual physicians or with a group or legal entity? If it is with a physician group, does the entire group meet the organization’s quality expectations? What will be the competitive response from non-participating physicians? How will the organization build in succession plans, future offerings and other considerations with relatively modest initial capitalization requirements? What will be the specific change to acute operations (e.g., volumes, payer mix, charity care) based on the specific physician partners? How will the organization handle different physician groups (e.g. faculty practice plans versus voluntary physicians)?

Structure and syndicate the venture and operations: This phase typically has two concurrent work streams, which include structuring the venture and operations and syndicating the venture, as appropriate. As described previously, there are numerous ways to structure a partnership. To create value for all stakeholders, operations must be structured for optimal efficiency and should include physicians in key leadership roles. Appropriate for shared joint-equity arrangements, the goal of syndicating a venture is to attract physicians as equity investors at a price that ensures viability of the venture and meets regulatory requirements but does not create too great a financial hurdle for interested physicians.

Commence operations: This phase requires start-up planning and implementation that is as thorough and seamless as possible. Continuous monitoring of progress toward meeting strategic financial goals and development of plans to address performance shortfalls are critical.

Concluding Comments

Hospitals and health systems must achieve effective hospital-physician alignment to remain competitively positioned. There is no one integration plan that works for all organizations or all physicians. Service areas and physician needs are diverse, so hospitals and health systems must be prepared to offer multiple engagement options, serving multiple physician constituencies.

Models selected for use must align organizational and physician goals related to improved quality, efficiency and access within the constraints of current organizational capital resources. Finding a sustainable balance of strategic and clinical needs, capital constraints, operation capabilities and management competencies is critical.

The organizations most likely to gain and retain close integration with physicians have common attributes that include deep management expertise, shared hospital-physician leadership and a well-developed integration infrastructure. Health care boards and executives should be taking purposeful steps to align their organizations with physicians for sustainable success under a very different care and payment system going forward. Organizations whose leaders act early to build these attributes based on solid planning and monitoring are poised for future success in their communities.

About the Authors

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Founded in 1985, Kaufman, Hall & Associates, Inc. is an independent management consulting firm, providing services and software to hospitals, health systems and other health care organizations nationwide.

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