

FROM THE TRENCHES: STRATEGIC IMPERATIVES AND ALIGNMENT SOLUTIONS

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Agenda

- > Elements of Physician Alignment
- > Alignment Business Arrangements
 - o Practice support
 - o Traditional employment
 - o Physician lease arrangements
 - o Co-management agreements
- > Alignment Outcomes
 - o Accountable care environment

“HEARD A RUMOR LATELY....”



A close working relationship between a hospital/practice and individual physicians...

that places a priority on working toward shared, patient-centered quality and economic goals, and...

that avoids conduct that damages the other.

What is driving us now?

PHYSICIANS

- > Flat or declining reimbursement
- > High malpractice costs
- > Increased regulatory/payer/IT burdens
- > Working hard, earning less
- > Need for succession
- > New graduates want lifestyle and security

PROVIDER ORGANIZATIONS

- > Secure/grow medical staff
- > Respond to specific market opportunities
- > Strengthen quality of care
- > Protect high margin services
- > Meet coverage requirements
- > Prepare for payment innovations

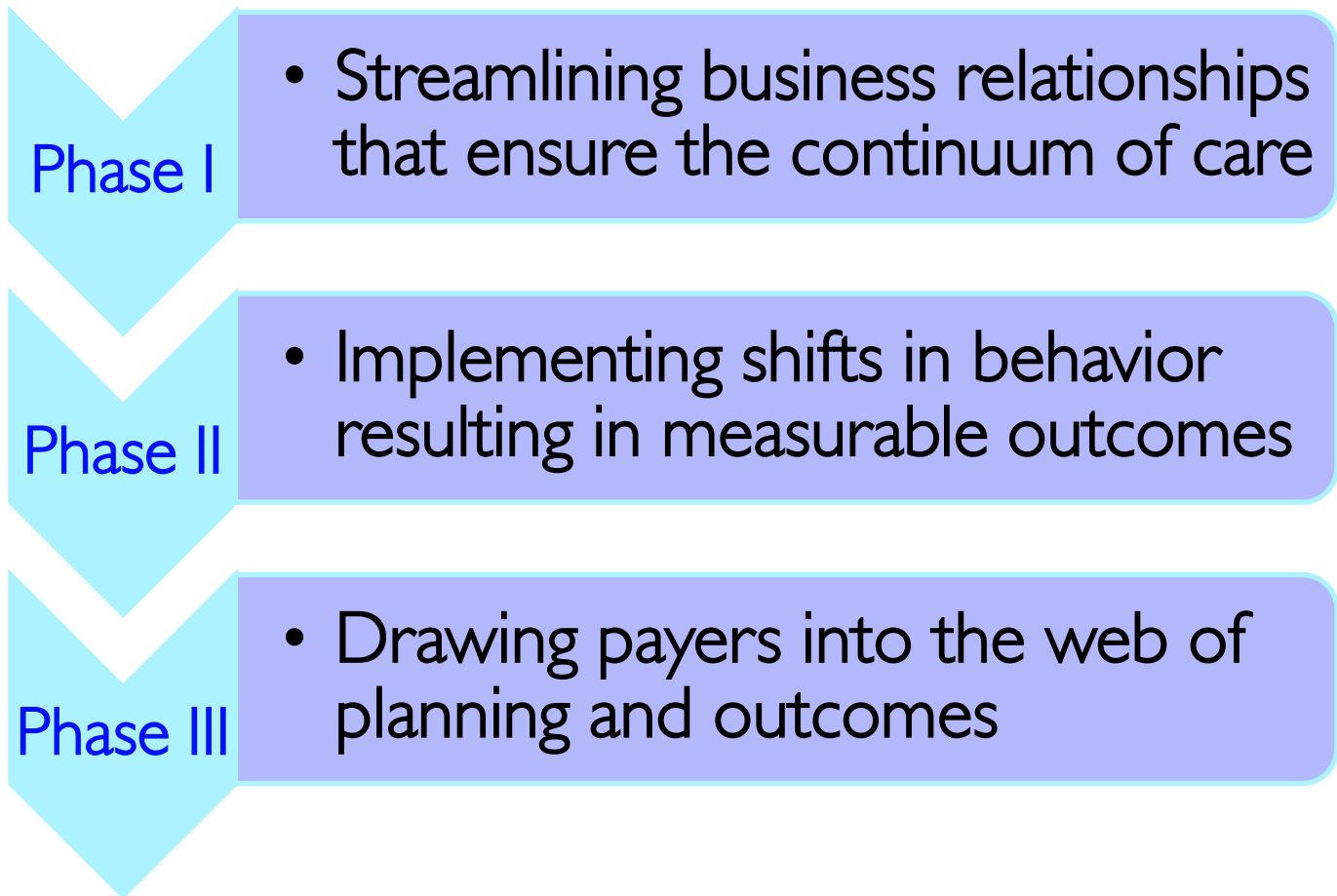
Immediate factors driving physician alignment now include:

- > Payment differentials for ancillary services
- > Declining negotiating leverage
- > Desire to secure volume
- > Prepare for health reform (payment innovations)
 - o ACOs, bundled payments, leverage with health plans

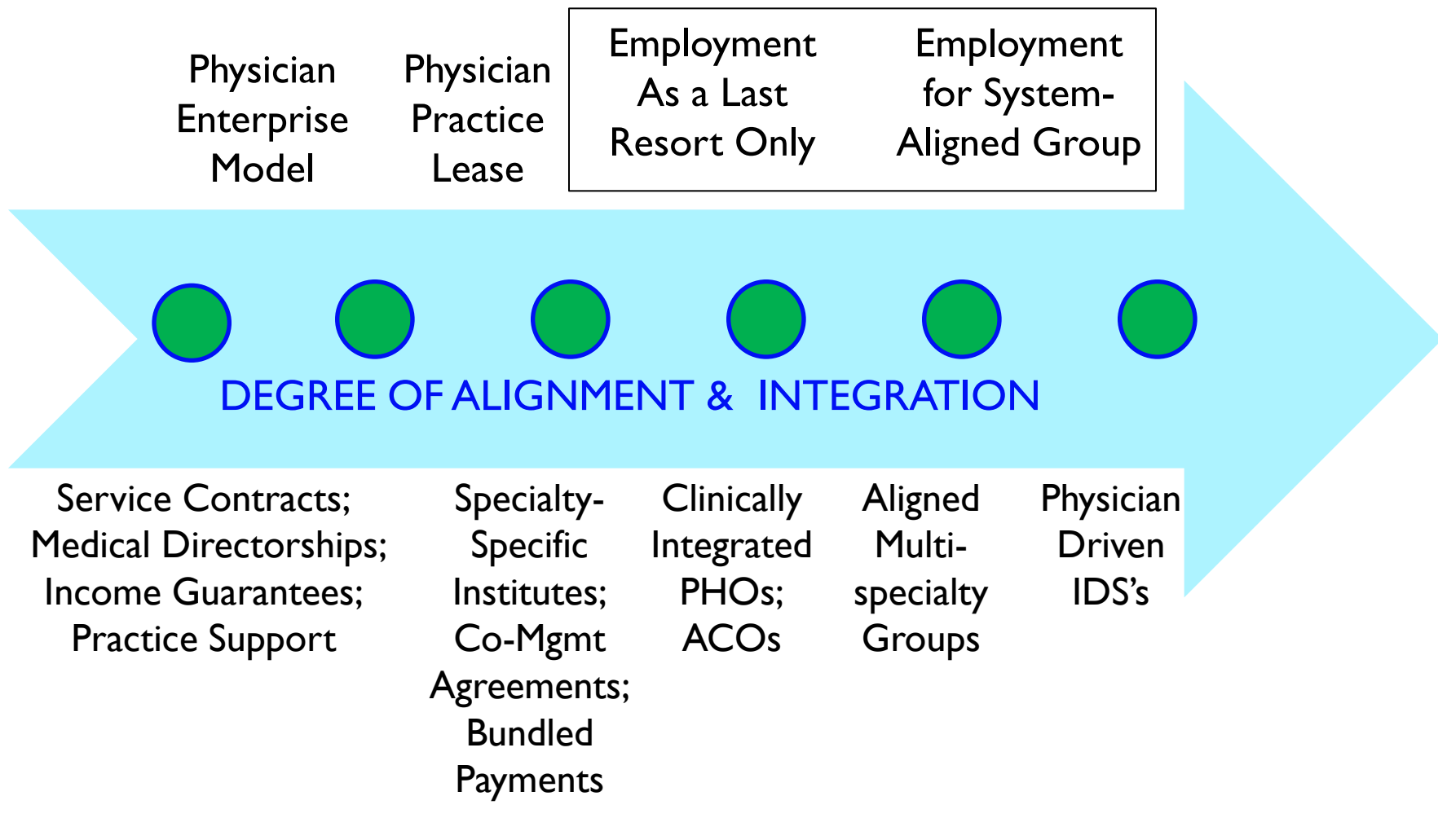
PRINCIPLES OF ALIGNMENT

- > Trust, transparency and communication
 - o Reduce the inefficiencies of stymied communication
- > Physician-Hospital Interdependence
 - o Achieve respective economic and clinical goals through collaboration and integration
- > Aligned financial incentives
 - o Deliver cost-effective, high-quality care consistent with best practices to produce shared incentives
- > Quality
 - o Identify and measure relevant indicators
- > Shared leadership
 - o Physician-driven and professionally managed clinical enterprise

Alignment components

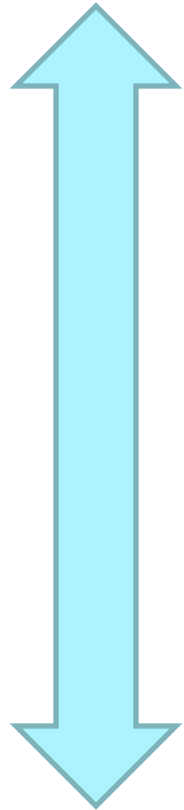


Phase I: Business arrangement alignment models



Alignment models to consider

Individual



- > Targeted practice support
- > Traditional employment
- > Physician/Practice lease arrangements
- > Co-management agreements
- > Accountable Care Organizations (ACOs)

Entity

OPTIONS TO MEET GOALS

Goals	Coordinate with Existing Practices	Business Support to Existing Practices	Income Guarantees, Practice Support	Directorships, AS&T Relationships	Co-management, Joint Ventures	Employment	Physician Enterprises: ACOs, Institutes
Physician-Oriented Goals							
Improve Revenue / Economic Security	●	●	●	●	●	●	●
Balanced Lifestyle	●	●	●	●	●	●	●
Protect Voluntary Practices	●	●	●	●	●	●	●
Decision-Making Influence	●	●	●	●	●	●	●
Hospital-Oriented Goals							
Gain Market Share & Margin	●	●	●	●	●	●	●
Growing Medical Staff	●	●	●	●	●	●	●
Pursue Clinical Quality	●	●	●	●	●	●	●
Shared Goals							
Comp, Recruitment, Retention	●	●	●	●	●	●	●
Health Reform and Regulatory Req.	●	●	●	●	●	●	●

● Most benefit






● Some benefit

● No benefit

EXAMPLES OF PRACTICE SUPPORT

Alignment Opportunity	Annual Dollars Involved	Pros	Cons
Directorship	\$80,000 - \$100,000	<ul style="list-style-type: none"> • Medical directorship remains filled • Possible expansion into a co-management arrangement • Strengthens relationship with voluntary physician(s) • Physician involvement in quality efforts 	<ul style="list-style-type: none"> • May be unfair to other physicians holding administrative duties
On-Call	\$130,000 - \$160,000	<ul style="list-style-type: none"> • Call coverage requirements will be met 	<ul style="list-style-type: none"> • May be unfair to other physicians taking call; only transfers cash
Medicaid Subsidy	\$60,000 based on current on Medicaid volume	<ul style="list-style-type: none"> • Allows hospital to meet the community's need • Possible savings to the Hospital 	<ul style="list-style-type: none"> • May be unfair to other practices that provide care to Medicaid patients
Recruitment Assistance	\$150,000 - \$200,000 depending on cost estimates	<ul style="list-style-type: none"> • Growth in medical staff without employment • Protects and secures relationship with voluntary practices 	<ul style="list-style-type: none"> • May need to demonstrate community need

EXAMPLES OF OBJECTIVES

- > Hospital's operational needs?  On-call
- > Clinical leadership?  Directorship
- > Practice support?  Subsidy
- > Expand service capacity?  Recruiting
- > Community access?  Medicaid mission

Simplicity: Traditional employment



- > Popular for primary care physicians; trend is increasing for specialists as well
- > Lower regulatory burden and scrutiny than other models
- > Requires governance and operational infrastructure
- > Part-time: more complex

Strategic & Financial Considerations

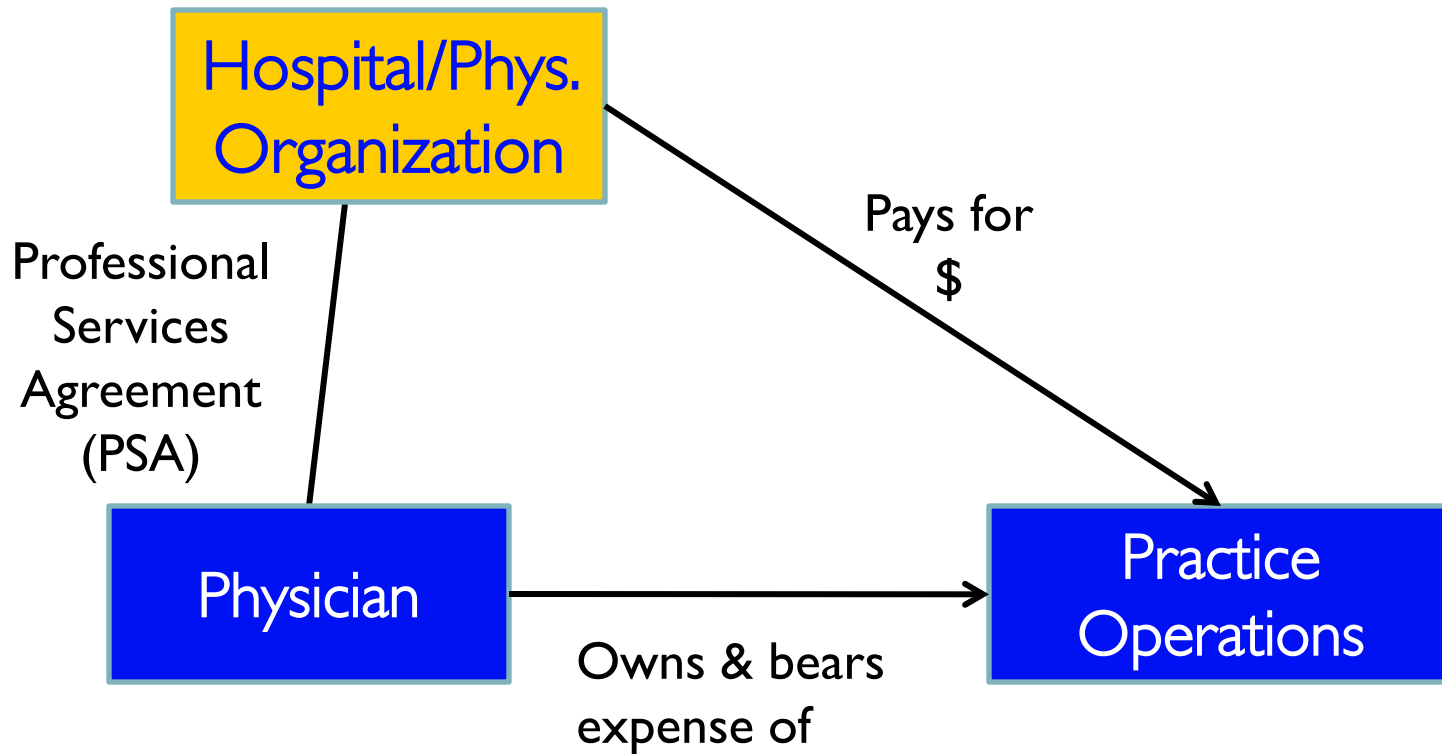
> Strategic

- Hospitals should have governance structures that give physicians significant authority over clinical decision making, operational efficiency, and strategy development

> Financial

- Sometimes a more expensive strategy for hospital
- Compensation design is critical
- Significant initial investment if practice purchase and goodwill is included (less common now)

Practice Lease and PSA



- > Optimal when hospital and physicians seek to exchange services and maintain independence

Strategic & Financial Considerations

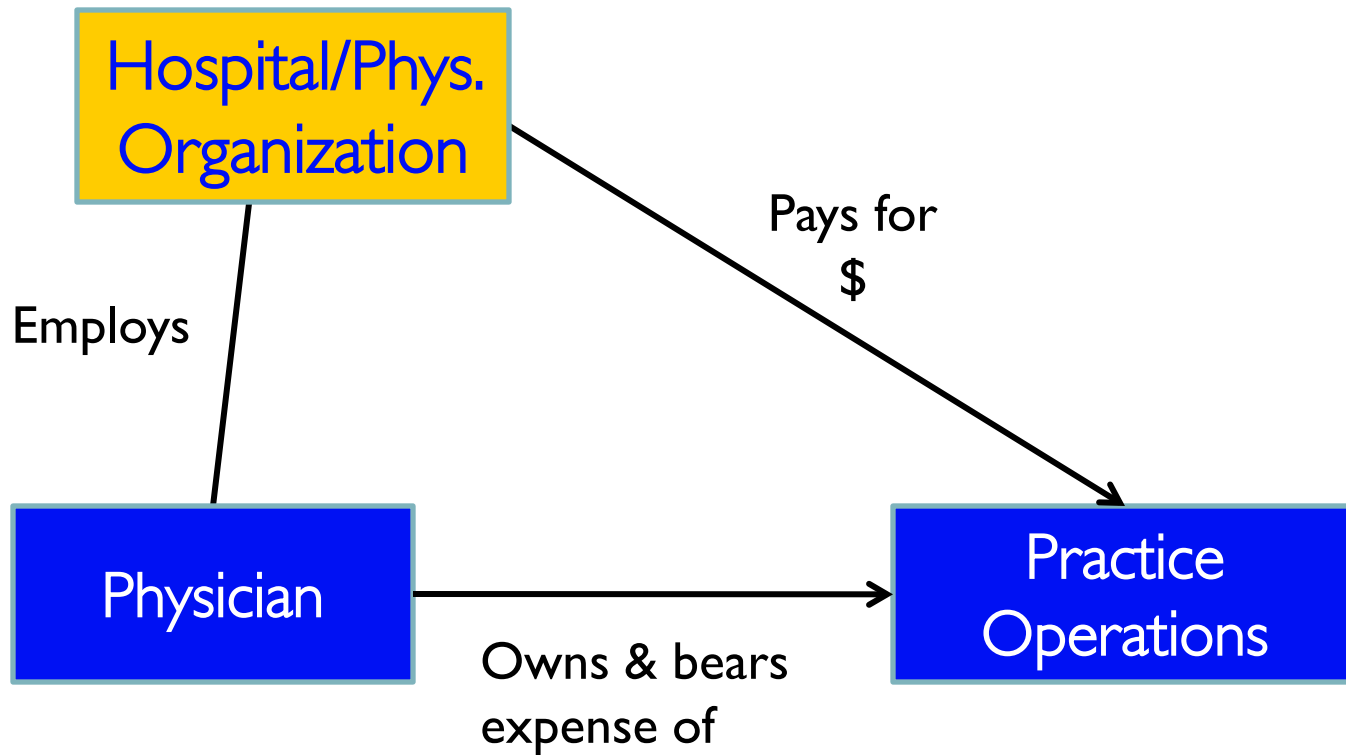
> Strategic

- Engaging physicians fully can be difficult
- Should standardize transactions and arrangements across entire organization

> Financial

- Physicians often seek higher payment than would be supported by FMV analysis
- Allows for limited relationship with relatively low cost

Physician Employment and Practice Lease



- > Optimal when hospital seeks benefit of physician employment but physicians want to maintain option to unwind the relationship

Strategic and Financial Considerations

> Strategic

- More complicated than employment
- Intermediary step toward employment and integration
- Hospital can influence physician behavior
- Physicians can participate in hospital incentive-based compensation
- Physician services are reimbursed at hospital negotiated rates
- Physicians need to be engaged like other employed physicians
- Harder to generate benefits like shared EMR and scheduling integration

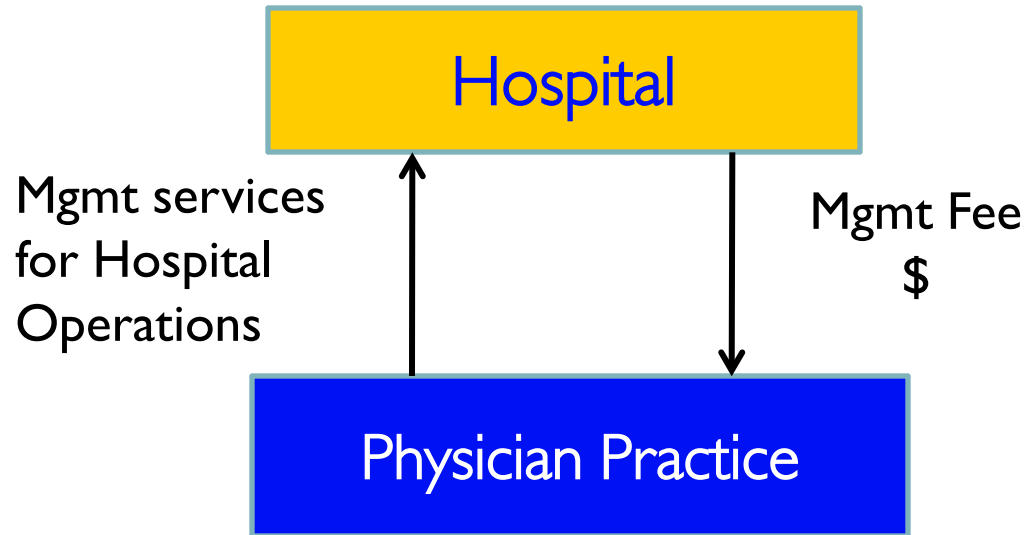
Strategic and Financial Considerations

(continued)

> Financial

- Size of investment is relatively small
- Since all payments are FMV, it is unlikely that any parties will have windfall profits
- Physicians must be efficient managers of their practices
- Physicians are guaranteed a revenue stream outside of compensation
- Agreements need to specify changes in equipment and provider levels

Co-management agreements



- > Large single specialty group or cooperation across groups
- > Broad opportunity to improve hospital quality and cost across service line
- > JV alternative
- > May include facility management

CO-MANAGEMENT MODEL

- > Physicians retain Part B collections
- > Hospital pays physicians FMV for administrative time, including:
 - QA
 - Operations oversight
 - Medical Director
 - Administrative meetings
 - Patient/case management
 - Community relations/education
 - Reporting, budgeting, planning
- > Bonus opportunity based on metrics such as:
 - Patient, employee, physician satisfaction
 - Performance improvement
 - Performance against operating/capital budgets

Strategic & Financial Considerations

> Strategic

- Can align key specialist groups with hospital
- Can help prepare for bundled payments
- Reduces silos and intra-system redundancy

> Financial

- Improving efficiency and repricing opportunities
- Physicians often seek higher payment than would be supported by FMV analysis
 - > May include on-call coverage as part of the fee paid
- Incentives for achieving quality goals may be included

SPECIFIED AND TRACKED EFFORT

- > Document allocated time monthly
- > Hospital pays on a variable (per hour) or fixed fee basis (monthly)
- > Hospital and Practice agree on expected and budgeted time
- > Fee includes FMV estimate of physician and non-physician time, benefits and malpractice

Practice Services Budgeted FTE (hypothetical)

Responsibility	Physician	Administrative Staff
Arrangement Development	0.1	0.2
Clinical Environment	0.05	0.2
Clinical Protocol Development	0.05	
Medical Director	0.15	
Medical Staff administrative activities	0.1	0.1
Physician Credentialing		0.05
Physician Coordination	0.05	0.05
Supervision of Staff	0.05	0.5
Patient Scheduling	0.05	0.05
Continuum of Care Activities	0.1	0.05
Annual Proposals, budgets	0.025	
Marketing/Community Relations/education	0.05	
Other reports	0.025	0.05
Regulatory Compliance	0.025	0.025
Provision of R&I personnel	0.025	0.05
Total FTE	0.85	1.325

Arrangements and legal concerns

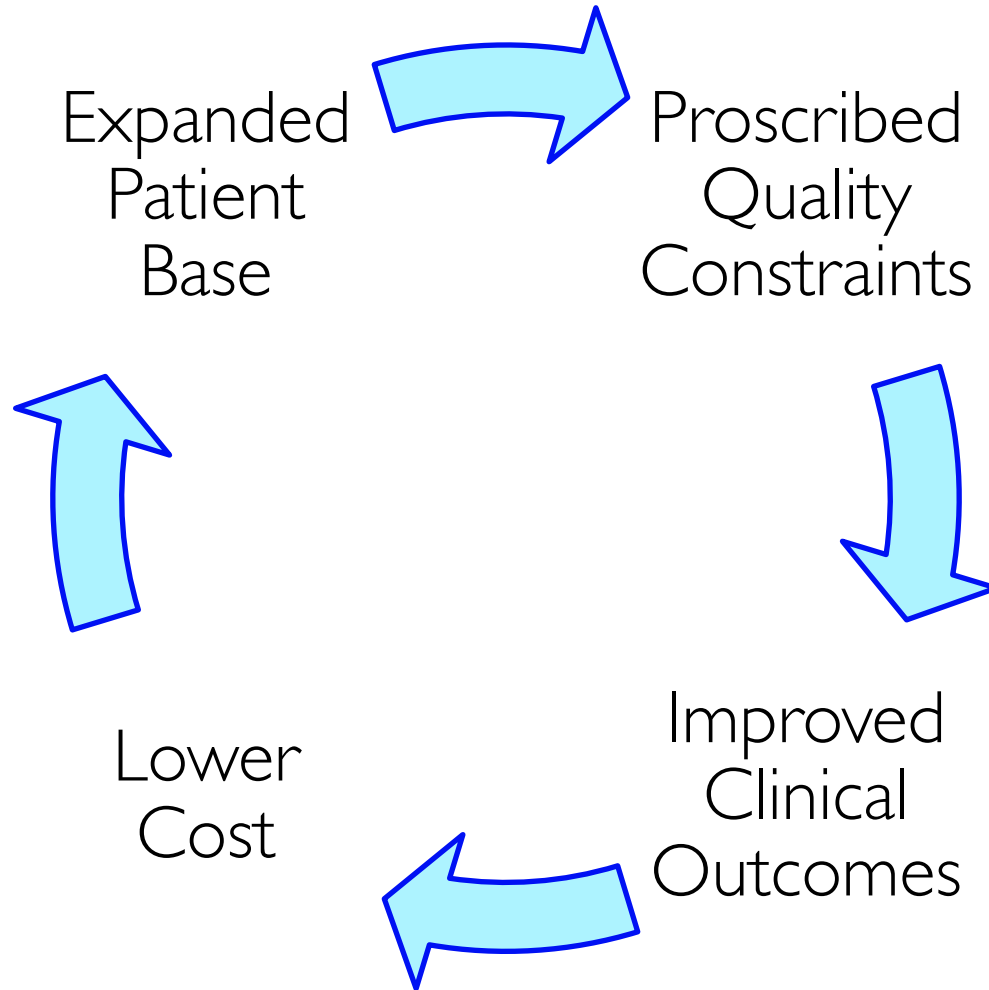
	FMV – Scrutiny for Stark and AKS	Contractual Complexity
Traditional Employment	○	○
Practice Lease Arrangements	●	●
Employment & Lease Arrangements	◐	●
Co-Management Agreement	●	◐
Physician Enterprise/Institutes	● ?	◐ ?

● High

◐ Medium

○ Low

Phase II: Alignment outcomes



Vision considerations

- > Aligned entities include consideration of independent physician groups
- > Focus is on the health system, not necessarily the hospital
- > Physician-to-physician alignment will also be critical

ALIGNMENT OUTCOMES

Like it or not...

...the numbers are hard to stay

> From www.hospitalcompare.hhs.gov

	Hospital A	Hospital B	Hospital C
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	82%	78%	64%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	55%	61%	47%

Rate of Readmission for Heart Failure Patients	Worse than U.S. National Rate	No Different than U.S. National Rate	No Different than U.S. National Rate
Rate of Readmission for Pneumonia Patients	No Different than U.S. National Rate	No Different than U.S. National Rate	Worse than U.S. National Rate

Alignment // the data

- > Patient satisfaction
- > Value based purchasing
- > Pay-for-performance (P4P)
- > Accountable Care Organization (ACOs)
- > Other FFS “tweaks”
 - o PQRI—is PQI next?
 - o Hospital acquired conditions
 - o Readmissions measures

Value-based purchasing program...

... hospital or physician driven?

- > CMS's proposal for 2014
- > Sample measures for hospital scores:
 - Air embolism
 - Pressure ulcer stages III & IV
 - Vascular Catheter-Associated Infections
 - Poor glycemic control
 - Other Agency for Healthcare Research and Quality developments (PSI, IQI)
- > Relevance of physicians to adoption cannot be overestimated

ACOs: Wolf in sheep's clothing?

- > Clinically and financially accountable for the entire continuum of care of a population
- > ACOs unique in potential to simultaneously affect:
 - Business arrangements
 - Changes in referral patterns, behavior or quality
 - Payer's interest in negotiating

Strategic alignment considerations in an accountable care environment:

- > A new competitive environment for partnering with physicians?
 - o Different regulatory standard
 - o Stronger financial ties by sharing savings on Medicare volume
- > For hospitals, market share, rather than shared savings is critical to success
 - o A potential rush to align with PCPs
 - o Reduced “leakage” to competing hospitals through the “gentle steerage” of better coordinated care
- > A closed medical staff?

As reimbursement moves toward incentives...

- > The right care at the right time in the right place
 - ...Physician behavior must be managed
- > Physicians don't make widgets
 - ...Reinserting the physician's role in managing daily care decisions
- > Facilitating physicians' relationships
 - ...to develop the efficiencies and outcomes expected in the future

Questions?

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