HFMA Gulf Coast Chapter Webinar
Innovative Solutions for Hospital/Physician Alignment

September 17, 2013

Agenda

I. Introduction and Session Objectives
II. Market Trends
III. Market Reactions
IV. Traditional Alignment Options
V. Physician Employment Trends
VI. Clinical Integration
I. Introduction and Session Objectives

Mr. Joshua D. Halverson, Principal

- Has over 15 years of experience in healthcare strategic and business planning, mergers and acquisitions, and finance.
- Has extensive knowledge of strategic, operational, and financial best practices among large physician groups and their integration within health systems.
- Specializes in economic alignment between physicians and hospitals involving acquisition, group development, compensation planning, and operations improvement.
- Leads ECG Management Consultants, Inc.’s Dallas, Texas, office.

- Since 1973, ECG has completed thousands of major consulting engagements for our clients, which include:
  - More than 400 hospitals and 100 health systems.
  - Hundreds of large, multispecialty physician groups and faculty practice plans.
  - Over 120 of the nation’s medical schools and more than 250 teaching hospitals.
I. Introduction and Session Objectives (continued)

1. Briefly highlight/recap major market trends that are influencing care delivery.
2. Define and review traditional hospital/physician alignment strategies.
3. Outline innovative approaches to facilitate alignment.

II. Market Trends
II. Market Trends

Anatomy of a Crisis

The healthcare system in the United States is on the trajectory of insolvency.

- Budgetary constraints of federal and state programs are compressing reimbursement to providers.
- The consolidation of commercial payors and their resulting market power contribute to minimal revenue growth.
- As a result, operating margins of integrated healthcare systems across the country are under pressure.
- The sustainability of the current configuration of physician organizations without structural change is being questioned.

II. Market Trends

The Budget

Healthcare spending represents the largest proportion of governmental spending. Unchecked, healthcare could amount to nearly one-third of the gross domestic product (GDP) in 25 years.

Components of Mandatory Expenditures

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<table>
<thead>
<tr>
<th>Year</th>
<th>Actual</th>
<th>Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>1977</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>1984</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>1991</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>1998</td>
<td>22</td>
<td>23</td>
</tr>
</tbody>
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Source: Congressional Budget Office, The Long-Term Budget Outlook, June 30, 2010.

“We don’t have a budget problem. We have a healthcare problem!” Healthcare will fully consume government spending and crowd out other priorities.
II. Market Trends
The Healthcare Bubble

Analysis indicates that the majority of cost growth is due to utilization of services and new treatments (e.g., pharmaceuticals, medical device costs).

Sources of Growth in Healthcare Spending

When Does the Healthcare Bubble Pop?

• Relative to excess cost growth, the effect of the aging population is secondary.
• The magnitude of federal and state budget imbalances creates intense pressure for Congress to control costs.

Congress has three tools to manage healthcare costs:
• Reduce provider reimbursement.
• Limit governmental liability.
• Raise taxes.

NOTES:
Excess cost growth refers to the number of percentage points by which the growth of spending on Medicare, Medicaid, or healthcare generally (per beneficiary or per capita) exceeded the growth of nominal GDP (per capita). Figures are annual averages.

II. Market Trends
Seeking Value

CMS and other payors are simultaneously seeking both a reduction in healthcare expenditures and an improvement in the quality of care.

Key ACO Reforms:
CMS establishes the Center for Medicare and Medicaid Innovation (CMMI) to evaluate new payment structures.

Medicare value-based purchasing program begins for specific conditions.
Voluntary ACO payment program begins and expands.
Physician registration for federal electronic health record (EHR) incentive program begins.
EHR meaningful use incentive payments begin.

Payments reduced for high readmission rates and hospital-acquired conditions.


II. Market Trends

Conclusions

As more risk is introduced into payment methodologies, providers will need greater integration and scale to efficiently develop capabilities for value-based models.

The Risk Continuum Associated With Various Reimbursement Structures

- **FFS**: Medical Home\(^1\)
- **P4P**: Bundled Payment
- **Payment for Episodes of Care**
- **Gain Sharing**
- **Global Payment With Performance Risk and P4P**
- **Global Payment With Financial Risk**

**Clinical and Financial Integration**

**Complexity/Broader Capabilities Required**

**Greater Risk/Potential Upside**

Integration Over Aggregation


\(^1\) Medical homes that receive extra dollars for patient management.

III. Market Reactions
III. Market Reactions

**Hospital Industry Consolidation**

Economic pressures and uncertainty with respect to future reimbursement are driving an increase in provider mergers and acquisitions and other affiliation arrangements.

**Hospitals Involved in Mergers and Acquisitions**

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospitals</th>
<th>Dollars Committed (In Billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>60</td>
<td>$2.6</td>
</tr>
<tr>
<td>2009</td>
<td>51</td>
<td>$1.7</td>
</tr>
<tr>
<td>2010</td>
<td>73</td>
<td>$12.8</td>
</tr>
<tr>
<td>2011</td>
<td>92</td>
<td>$8.3</td>
</tr>
<tr>
<td>2012</td>
<td>94</td>
<td>$1.9</td>
</tr>
</tbody>
</table>

Source: Irving Levin Associates, Inc.

**2012 Largest Not-for-Profit Health Systems**

<table>
<thead>
<tr>
<th>Not-for-Profit Health System</th>
<th>Number of Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ascension Health</td>
<td>81</td>
</tr>
<tr>
<td>Catholic Health Initiatives</td>
<td>76</td>
</tr>
<tr>
<td>Trinity Health</td>
<td>49</td>
</tr>
<tr>
<td>Adventist Health System</td>
<td>41</td>
</tr>
<tr>
<td>Dignity Health</td>
<td>40</td>
</tr>
<tr>
<td>Kaiser Foundation Hospitals</td>
<td>36</td>
</tr>
<tr>
<td>Catholic Health East</td>
<td>35</td>
</tr>
</tbody>
</table>

Source: Becker’s Hospital Review, July 2012.

1 Trinity Health and Catholic Health East merged in 2013.

**How big is big enough?** Many of the larger health systems have continued to increase in size through mergers and acquisitions.

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III. Market Reactions

**Private Practices Dwindle**

As professional service reimbursement flattens or falls and uncertainty over reform continues, physicians are increasingly becoming employed by hospitals and health systems.

**Growing Trend**

- Newly trained physicians see health systems as a “safe haven” from uncertainty.
- Health systems see primary care as a necessary investment to lock in future business.
- Smaller multispecialty groups are dissolving as select specialties pursue hospital employment to improve compensation levels.

“More than half of practicing U.S. physicians are now employed by hospitals or integrated delivery systems, a trend fueled by the intended creation of accountable care organizations and the prospect of more risk-based payment approaches.” – New England Journal of Medicine, May 2011.
III. Market Reactions

**Commercial Payor Response**

The consolidation of health plans has led to a negotiating imbalance between fragmented providers and a few, large insurers.

### Large Payors Continue to Grow

<table>
<thead>
<tr>
<th>Healthcare Payor Consolidation, 1992 – Present</th>
<th>Result</th>
<th>Reported Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>QualChoice, Atrium, WellChoice, Lumenis, Anthem (nine others, including seven BGUS plans), WellPoint (Cuban/United Wisconsin RightChoice, five others).</td>
<td>WellPoint, Inc.</td>
<td>34 Million</td>
</tr>
<tr>
<td>FIServ Health, Sierra Health, Aetna, John Duran, PacificCare (including Pacific Life), Oxford Health, Great Lakes, Infinity, MAMSI, Golden Rule, 12 others.</td>
<td>UnitedHealthcare</td>
<td>28 Million</td>
</tr>
<tr>
<td>HMS Health (PPOM, Sierra’s Lake, Mountain Medical), Chickering, New York Life (NYLCare), Prudential HealthCare, US Healthcare, four others.</td>
<td>Aetna Inc.</td>
<td>16 Million</td>
</tr>
<tr>
<td>KMG America, CHA, CorpHealth, Memorial Hermann, ChoiceCare, PCA, Emphasis, Care Network, Group Health.</td>
<td>Humana</td>
<td>11 Million</td>
</tr>
<tr>
<td>GreatWest, Sugarmore Health Network, ChoiceOne, Managed Care Consultants, Healthsource (CYN, Provident, Centramass).</td>
<td>Cigna</td>
<td>10 Million</td>
</tr>
</tbody>
</table>

IV. Traditional Alignment Options

- Deeper Contracted Discounts to Dominant Plan
- Lower Costs for Dominant Plan
- Greater Number of Provider Claims Reimbursed at Deeper Discounts
- Diminishing Commercial Revenue Stream
- Weaker Provider Negotiating Power
- Dominant Plan Offers More Attractive Fees to Purchasers
There is a range of alignment options that allow for varying degrees of financial and operational integration between physicians and the hospital.

Loosely Integrated  
Degree of Physician/Hospital Integration  
Tightly Integrated

IV. Traditional Alignment Options

Overview

PSA, comanagement, and employment are becoming the most common methods of alignment.

IV. Traditional Alignment Options

PSA

Under the PSA model, the hospital would contract for professional services from the physician group.

Hospital  
PSA  
Physician Group

Clinical Services

Compensation

- Contracting.
- Billing.
- Managed care administration.
- Recruiting.
- Research/education support.
- IT support.
- Staffing and management.
- Clinic operations.
- Asset ownership.

Considerations
- Group governance.
- Physician hiring/termination.
- Clinical coordination.
- Internal compensation distribution plan.

- Allow for professional/practice autonomy.
- Maintain efficient clinic operations and leverage the expertise of both parties.
- Enhance the coordination of care and related services.
- Provide flexibility and nimbleness in business development.
The PSA model allows hospitals and physicians to work together to build a program while maintaining a high level of autonomy for the physicians.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physicians retain control of group governance and physician income distribution.</td>
<td>• Physicians are not relieved of clinical management responsibilities.</td>
</tr>
<tr>
<td>• The PSA structure may enable the group to leverage financial opportunities (e.g., economies of scale, GPO contract rates) from the hospital, without becoming employed.</td>
<td>• Typically, designing and negotiating these arrangements is a complex and arduous process.</td>
</tr>
<tr>
<td>• Aligning with a hospital often enables physicians to access capital that they might not otherwise deem possible.</td>
<td>• The economic opportunity for physicians may be limited, depending on their current financial performance relative to FMV benchmarks.</td>
</tr>
</tbody>
</table>

IV. Traditional Alignment Options

**PSA (continued)**

With a PSA and MSA, the physicians would be contracted to provide both the professional and management services.

**PSA and MSA Description**

- The contracts would define compensation, the services provided by both parties, and the governance mechanism for decision making.
- Physicians would be paid FMV compensation for clinical activities and program development through the PSA.
- The physician group would be compensated at FMV for the management of the clinic, the lease of specific staff, and potential quality and/or performance improvement incentives under the management terms.
- The practice’s ownership and infrastructure would remain independent and under the control of the physicians.
IV. Traditional Alignment Options

Comanagement Arrangement

Under the comanagement model, a management company is formed for the purpose of managing a service line or program.

1. Physicians/Physician Group Investors
   - Initial minimal start-up capital.
   - Equity distributions.

2. Management Company (LLC or Other Structure)
   - Service line management and oversight.

3. Governing Board
   - May include committee structure.
   - Participation from both physicians and hospital.
   - Number of committees will be dependent upon complexity of arrangement.

4. Hospital
   - Fixed/variable payments.

The Governing Board of the service line reports up through the management company with a dotted-line relationship to the hospital.

Ownership/Operating Agreement – The management company is typically a JV LLC between the independent providers who are participating. The initial capital contribution must be proportionate to ownership interest.

MSA – The management company is contracted to provide management services to the hospital and is compensated through a base fee and incentive bonus. The scope of services as well as performance metrics are defined in the MSA.

Governing Board – The Governing Board consists of comanagement investors. The Governing Board will ensure that the company delivers the management services to the hospital by securing subcontracts with physician champion(s) and other administrative personnel.

Management Services – The management services, as defined in the MSA, are the services for which the hospital will compensate the management company with a base fee. These services are provided by the Governing Board, physician champion(s), and designated committees.

Compensation for Management Services – The base compensation is the predetermined fee provided to the management company for contracted services. This fee is typically an hourly rate for committee involvement and physician champion time.

Incentive Bonus – The incentive bonus is a predetermined amount of payment that is contingent upon the level of achievement related to key performance metrics, as outlined in the MSA. It represents extra earnings to the company to be returned as equity based on ownership percentage.
IV. Traditional Alignment Options

Comanagement Arrangement (continued)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• This option provides a venue for joint hospital/physician strategic planning.</td>
<td>• This model is more complicated to implement.</td>
</tr>
<tr>
<td>• It offers base compensation plus incentive payment arrangements (based on predetermined measures) that can be used to align the incentives of the hospital and physicians.</td>
<td>• Additional time will be required outside of clinical practice to manage administrative activities.</td>
</tr>
<tr>
<td>• The financial upside associated with comanagement is greater than with the Leadership Council.</td>
<td>• If multiple groups are present, determining who participates can be political.</td>
</tr>
</tbody>
</table>
V. Physician Employment Trends
Organizational Models

Organizations with aligned/employed physicians are seeking to reorganize themselves in order to establish high-functioning systems of care that create value by demonstrably improving quality outcomes and reducing costs.

Federated Model
- Limited Central Governance and Management

Integrated Model
- Strong Central Governance and Management

Multispecialty Model
- Common Governance, Management, and Finances

The market appears to recognize that high-functioning, integrated multispecialty group practices are most likely to be successful in a value-based reimbursement system.

V. Physician Employment Trends
Mechanisms for Group Integration

Physician group integration is achieved through the following elements:

<table>
<thead>
<tr>
<th>Structure</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance and Management</td>
<td>• Common vision and shared direction with physician participation.</td>
</tr>
<tr>
<td></td>
<td>• Clearly articulated roles and authorities of governing bodies.</td>
</tr>
<tr>
<td></td>
<td>• Delegated leadership with a strengthened governance structure to facilitate efficient and</td>
</tr>
<tr>
<td></td>
<td>effective decision making.</td>
</tr>
<tr>
<td></td>
<td>• Consolidated leadership for key functions and overall physician enterprise.</td>
</tr>
<tr>
<td>Operations</td>
<td>• Implementation/enforcement of standards for patient care processes, practice characteristics,</td>
</tr>
<tr>
<td></td>
<td>and administrative functions.</td>
</tr>
<tr>
<td></td>
<td>• Electronic medical records (EMRs) that provide a common platform to collect information and</td>
</tr>
<tr>
<td></td>
<td>coordinate care.</td>
</tr>
<tr>
<td>Financial Arrangements</td>
<td>• Consolidation of compensation methods.</td>
</tr>
<tr>
<td></td>
<td>• Consistent incentives among physicians.</td>
</tr>
<tr>
<td></td>
<td>• Financial alignment between providers of care (i.e., hospitals and physicians).</td>
</tr>
</tbody>
</table>
VI. Clinical Integration

Overview

There are a variety of circumstances in which providers may implement clinical integration programs while minimizing antitrust risk, including the following:

- The creation of a network with both specialists and primary care physicians (PCPs) to provide seamless care with the requirement of in-network referrals.
- Established clinical protocols for a broad spectrum of diseases and disorders.
- Integrated IT.
  - Network participants can efficiently exchange information regarding patients and practice experience.
  - Utilization and claims information can be gathered, analyzed, and communicated in order to improve treatment quality, rates of utilization, and cost containment.
  - Physician compliance and performance, in accordance with collective, physician-authored benchmarks and standards, may be measured.

The Federal Trade Commission (FTC) requires providers to demonstrate that joint managed care contracting is necessary to achieve the efficiency and quality goals of the system.
VI. Clinical Integration

Potential Contracting Structures

<table>
<thead>
<tr>
<th>Less Integrated</th>
<th>Range of Business Relationships</th>
<th>More Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Contracting Decisions</td>
<td>Possible Collective Negotiations</td>
<td>Financial Integration</td>
</tr>
<tr>
<td>&quot;Messenger&quot; Model</td>
<td>Hospital/Physician Alignment</td>
<td>&quot;United Front&quot;</td>
</tr>
<tr>
<td>Third-Party</td>
<td>&quot;United Front&quot;</td>
<td>Coordinated Care</td>
</tr>
</tbody>
</table>

- Providers share responsibility for cost or utilization and have significant positive gain for achieving targets.
- Members or owners share financial risk directly or through membership in another organization.
- Members may not comprise more than 30% of physicians in local market.
- Care provided in accordance with quality targets.
- Quality of care reviewed and monitored.
- Providers share responsibility for cost or utilization and have significant positive gain for achieving targets.
- Members or owners share financial risk directly or through membership in another organization.
- Members may not comprise more than 30% of physicians in local market.
- System-wide efficiencies across providers.
- Centralized ownership.
- Separate, independent, and unilateral contracting decisions.
- Offers and counteroffers between individual physicians and payors conveyed by PHO messenger.
- Objective information communicated to providers regarding proposed contract terms.
- Payments based on historical activity to avoid referral incentives.
- Patient-centered care focused on common understanding of desired outcomes.
- Multispecialty network of providers.
- Integrated IT and efficient information exchange.
- Compliance with utilization review and performance standards.
- Care provided in accordance with quality targets.
- Quality of care reviewed and monitored.
- Payments based on historical activity to avoid referral incentives.

The ultimate goal of many organizations is to achieve a clinically integrated network through a phased approach.

- Medicare Advantage (MA)
- Commercial Risk
- Employee Health Plan
- Clinically Integrated Network
VI. Clinical Integration
Payor Contracting Opportunities

There are five primary contracting avenues to consider as the group moves toward value-based care.

<table>
<thead>
<tr>
<th>Employee Health Plans</th>
<th>Commercial</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Insurance Exchanges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Benefit design.</td>
<td>• Shared risk.</td>
<td>• Narrow network for MA.</td>
<td>• Medical home.</td>
<td>• Narrow network (discounts would need to be messengered).</td>
</tr>
<tr>
<td>• Network tiers.</td>
<td>• Common measurement and participation in pay-for-performance (P4P) program.</td>
<td>• Shared to full risk for MA.</td>
<td>• Innovative models for high-risk obstetrics and NICU.</td>
<td>• Shared risk (need to understand population).</td>
</tr>
<tr>
<td>• Common clinical protocols.</td>
<td>• Medical home.</td>
<td>• CMS/CMMI pilot programs.</td>
<td>• Specific programs for dual eligibles.</td>
<td>• Common medical management.</td>
</tr>
<tr>
<td>• Common medical management.</td>
<td>• Thin capitation.</td>
<td>• MSSP.</td>
<td>• Specific programs for dual eligibles.</td>
<td></td>
</tr>
<tr>
<td>• Programs for high-risk members.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Wellness.</td>
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</table>

Employee health plans offer a viable first-generation opportunity, but consideration should also be given to the sequencing of the other contracting options.

VI. Clinical Integration
First-Generation Activities

• Population Health Management Plan
  – Increase generic drug utilization – pharmacy review and standardized drug formulary.
  – Decrease inappropriate emergency room utilization through after-hours PCP access.
  – Decrease leakage from ACA system providers.
  – Decrease utilization of low-value-added interventions identified through Choosing Wisely.
• Total Joint Replacement
  – Standardized ACA order sets for inpatient care.
• Patient-Centered Medical Home
  – Health condition registries.
  – Health coaches.
  – Decrease in care gaps for diabetic care.
  – Promotion of team-based care.
• Improved Efficiencies of Scale
  – Cardiac impact device purchasing.
  – Blood products.
  – Dialysis.
  – Insurance.
  – Molecular lab.
VI. Clinical Integration
Risk Sharing

A comprehensive care delivery network, coupled with population health management capabilities, enables organizations to align reimbursement mechanisms with population health management strategies.

Questions & Answers

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