PAYMENT REFORM, CARE REDESIGN, AND THE "NEW" HEALTHCARE DELIVERY ORGANIZATION

THE GOVERNANCE INSTITUTE'S 2012 SIGNATURE PUBLICATION

THE GOVERNANCE INSTITUTE

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AS TREMENDOUS CHANGE HITS THE HEALTHCARE LANDSCAPE, A "NEW" HEALTHCARE DELIVERY ORGANIZATION IS EMERGING WITH DIFFERENT PAYMENT MODELS AND AN INCREASED FOCUS ON HOSPITAL-PHYSICIAN INTEGRATION. IN THIS PUBLICATION, WE EXPLORE NEW PAYMENT MODEL OPTIONS, VARIOUS MODELS AND STRUCTURES FOR HOSPITAL-PHYSICIAN INTEGRATION, AND CRITICAL SUCCESS FACTORS FOR MOVING FROM A PROVIDER TO AN INTEGRATED DELIVERY SYSTEM.

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FOREWORD

The hospital–physician integration models of the future go beyond simple alignment of goals and economic incentives. We believe true *integration* takes into account how the care delivery system should work from the ground up, to fully integrate the actions of all care providers, staff, administrators, and leaders towards the common goal of enhancing the health of the patient population, by providing the right care, at the right time, in the right setting.

Of course, not every healthcare organization can (or should) become a Mayo or a Geisinger. Each of our nation's hospitals and health systems are dealing with unique market positions, distinctive economic challenges, different relationships with physicians and payers, and varied patient/population needs.

We feel it is critical today and will become even more critical in an evolving competitive market to understand who the customer is and how they wish to receive their care. As more of the healthcare expense is paid by consumers and pricing and quality become more transparent, it will become absolutely essential to keep in touch with the customer at every point along the transformation to integrated care delivery.

In the foreword of *Really Governing: How Health System and Hospital Boards Can Make More of a Difference,* a book coauthored by Governance Institute Founder Charles M. Ewell, Ph.D. in 1994, which still remains a foundational resource for governance best practices, we find the following quote from J.W. Marriott, Jr.:

> "Directors and their organizations must be more customer focused, realizing that no time is better spent than listening to customers and responding to their needs. Directors must also look outside the boardroom and insist on continuous quality improvement in both products and services. Times are too tough and customers are too demanding to settle for less."

Times may be changing, but some things will always remain the "main" thing.

This publication serves as an in-depth integration guide for various types of organizations at any point on the hospital–physician integration continuum. It describes each integration model, its leadership and governance structure, and the role of physician leaders; each section concludes with a list of key considerations and questions for board members. We trust this publication will better enable hospital and health system leaders to drive their organizations further down the hospital–physician integration path by discovering unique, customer-focused solutions that can be tailored to each individual organization.

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EXECUTIVE SUMMARY

New models of physician–hospital relationships and integration strategies have been emerging in the past few years as a result of numerous factors including rising healthcare costs leading to healthcare reform, an unstable economy, changes in consumer demand, advances in technology, and generational differences in physician work/life balance, among others. Increasingly, physicians are looking to hospitals, health plans, and large, multispecialty medical groups for economic stability while hospitals and health systems are looking to primary care providers and certain specialists to gain market share and respond to payment reform. At the same time, hospitals and physicians have become more acutely aware of other drivers of change, such as consumer demand for more transparency and improved quality, cultural preferences, and technological influences, prompting changes to practice styles. As a result, these new relationships are different from previous forms of integration in that they include a broader spectrum of contractual and employment relationships, have a greater focus on clinical outcomes, and typically comprise a greater percentage of community physicians than ever before.

In order to optimize the healthcare dollar and improve health outcomes, both governmental and private payers are gradually shifting from volume-based reimbursement (traditional fee-for-service or FFS) to value-based reimbursement models. Payment reform will change the cost structure, focusing hospitals on population health, case management, and new alignment models with physicians to reduce lengths-of-stay, decrease readmission rates, and improve the health of the population as a whole. Much remains to be seen as physicians and hospitals continue to align in new structures; pilot projects conducted over the years are demonstrating promising results, yet it remains to be seen if it will be enough to alter the U.S. consumption of healthcare.

Emerging Payment Models

A key provision of the healthcare reform legislation (PPACA) is the focus on developing alternative payment models that achieve the "triple aim"—improved quality of care, reduced costs, and improved patient experience. The PPACA includes several payment reform initiatives that encourage hospital–physician integration, including accountable care organizations (ACOs), bundled payments, value-based payments, and the patient-centered medical home (PCMH). Each model addresses payment reform differently, but they all facilitate hospital–physician integration.

Over the past decade, pay-for-performance (P4P) has been one of the first steps away from the traditional FFS model, serving as a starting point for provider groups contracting with payers for gainsharing or a portion of shared savings. The price of entry into P4P is low, requiring only contracting effort and a willing payer, but succeeding at P4P takes concentrated effort by the organization of providers to meet the thresholds on the chosen metrics for the group and/or individual providers to earn the financial incentives.

The next step is to move beyond P4P and to focus on value-driven healthcare that rewards healthcare providers for delivering patient-centered, high-quality services that are proven to be effective.

On January 7, 2011, CMS established a value-based purchasing program (VBP) for acute care hospitals that are paid under the Medicare Inpatient Prospective Payment System. The VBP provides hospitals with value-based incentive payments beginning in FY 2013. The plan includes a set of quality measures currently reported by hospitals and adds patient perception (HCAHPS®) scores to determine overall hospital quality. According to CMS, value-based purchasing will transform Medicare from a passive payer based on volume to an active purchaser based on quality.

In addition to the P4P and VBP plans for hospitals, Medicare created the Physician Quality Reporting System (PQRS), which

provides an incentive payment for eligible professionals who report data on specific quality measures. Commercial payers are also looking at value-based payments through initiatives such as value-based insurance design (VBID), which reduces barriers to care for services where the clinical benefits exceed the costs, in effect requiring patients to pay less for services that have demonstrated clinical effectiveness.

Payment reform mechanisms such as P4P and PQRS have been effective at improving quality and reducing costs and have made significant strides in moving the healthcare landscape away from a FFS environment. The next step is to move beyond P4P and to focus on value-driven healthcare that rewards healthcare providers for delivering patient-centered, high-quality services that are proven to be effective.

Bundled payment is a method of fee-for-episode payment that focuses on the entire continuum of care for a particular condition or procedure. This method of payment creates a single reimbursement for an episode of care, which holds all providers accountable for delivering high-quality care in a cost-effective manner.

Commercial payers are also showing interest in contracting for hospital and physician services using a bundled payment methodology to bend the cost curve, and interest continues to increase around several DRGs.

The PPACA's establishment of ACOs has generated considerable excitement around hospital–physician integration, as it calls for a national voluntary shared savings program involving the collaboration of healthcare providers across the continuum. These collectives of providers assume full responsibility for the cost and quality of healthcare for a defined population of patients. As defined by the PPACA, ACOs are legal entities composed of provider organizations that use primary care physicians and care management processes to efficiently meet the healthcare needs of Medicare beneficiaries.

Another model that is gaining momentum and creating renewed interest is the next evolution of capitation: global payments. Simply defined, global payments represent fixed-dollar payments for the care patients may receive in a given time period. The goal of global payments is to reduce the use of unnecessary services and encourage coordination of services among providers, the result being reduced costs and improved quality. Global payments essentially establish a "budget" for healthcare services, which serves to place providers at financial risk for both the occurrence of medical conditions as well as the management of those conditions.

The concept of global payments is not new and currently exists in the form of capitation arrangements in many parts of the U.S. Proponents argue that global payment models will align incentives and promote a focus on cost and quality. In addition, many feel that global payments will reward healthcare providers for keeping their patients healthy rather than for reacting to their ailments. However, others feel that global payments could incentivize providers to withhold necessary care and avoid patients with chronic conditions. Global payments also require advanced administrative and technical capabilities to effectively manage payments and financial risk, putting smaller providers at a major disadvantage (or preventing them from participating at all).

The degree to which risk-based reimbursement requires boards, CEOs, and physician leaders to integrate strategy and operations is unprecedented. For organizations to be successful in a shared savings program, senior executives need to objectively assess their organizations, prioritizing their clinical reform and infrastructure development activities with an eye to what their competitors are doing in their markets.

Models and Structures for Hospital–Physician Integration

Value is rapidly becoming the new measure for success in healthcare reform and is driving emerging strategies to integrate providers. This new landscape of hospital–physician integration is markedly different from previous attempts because the major emphasis and rewards focus on the health outcomes achieved for individuals and populations as a whole. Previous attempts at integration have resulted in project-by-project and point-in-care improvements but may not be sufficient to meet the evolving demands of patients, employers, communities, and regulators into the future. To meet these demands, physicians and hospitals need to fundamentally change the way they work together in order to motivate physicians and hospitals to achieve the desired results. Co-management, clinical integration (CI), and ACOs are integration models that, if structured correctly, can shift the purpose from volume to value.

Co-management arrangements are frequently used as a means to build integrated relationships with critical service line specialists without formal employment arrangements. In a simple arrangement, the hospital contracts with a physician organization, under which the physicians are granted input and managerial authority to design and enforce clinical and operational standards. Generally, the physicians provide only their time and have limited risk in the arrangement. Under this arrangement, the physician entity assigns a physician as the executive physician director, and the hospital assigns a service line/department director to serve on a co-management committee. Sub-committees or councils may be developed under the co-management committee to coordinate sub-specialty areas as needed. In terms of governance, the physician executive retains a major role in establishing and

maintaining key items such as policies and procedures and quality and efficiency standards. The hospital retains all reserve powers and day-to-day management is provided by the service line/department director.

A more complex co-management structure involves dual ownership of a management company by both a hospital and physicians. The equity split is typically 50/50, but is not required. The goal is to create an attractive arrangement for both the physicians and the hospital. In both simple and complex structures, the physician organization or management company enters into a management services agreement with the hospital to manage the designated service line(s). The management services agreement typically includes a multi-faceted compensation structure including a base compensation for medical direction and administrative duties and a P4P incentive component based on the attainment of specified quality goals.

The degree to which risk-based reimbursement requires boards, CEOs, and physician leaders to integrate strategy and operations is unprecedented.

Clinical integration (CI) aims to integrate the healthcare landscape by bringing together providers across the continuum under a single structure. Clinically integrated organizations for physicians mean accountability for clinical results, adherence to care plans and protocols, and shared clinical information. CI for patients means access to individualized care plans, engagement in their care process, and a collaborative treatment team led by their primary care physician (medical home). In CI, hospitals are now members of a team of care providers and now share responsibility for care with physicians and other members of the continuum.

There are several CI models that have evolved over the last few years: CI through information technology; a wholly-owned subsidiary model; and a joint venture model. Each provides a vehicle for physicians and hospitals to share information and create the infrastructure required to begin to address quality and efficiency through population management.

ACOs provide the structure and the incentives for physicians and hospital to build a shared culture around outcomes-based medicine and cost-effectiveness. A well-structured, physician-led ACO creates interdependence and cooperation between a hospital or health system, private practices, employed physicians, and a health plan that creates value for patients. While ACOs do not need to be newly created entities, they are required to have formal legal structures for receiving and distributing shared savings payments or accepting risk. Regardless of the payer relationships, ACOs should be developed with governance and organizational structures that best fit the organization, including strong physician leadership and infrastructure support, the latter of which may be acquired through a management services organization (MSO) agreement. ACOs must also have patient-centered processes that involve patients in their care and methods to coordinate care across the delivery network.

There are several critical success factors that organizations need to consider when putting together an ACO. Hospitals/health systems should ensure that they are working with a willing payer and that incentives are built in for shared savings and shared risk. The care delivery network needs to include a full spectrum of physician specialties, hospital and sub-acute care providers, diagnostic/treatment services, and case management providers. Considerable attention needs to be paid to the infrastructure of the organization, ensuring that the structure has data warehousing and population management capabilities, an ability to capture financial and clinical data, and a contracting mechanism with a method for distributing payments. Most critically, the structure must be physician led and driven.

Movement towards any of the new integration strategies or payment models, whether in an ACO, co-management, CI, or P4P arrangement requires strong physician leadership. Organizations that have built collaborative, healthy physician relationships and have existing contractual alignment can leverage these arrangements to develop the structural and governance models that support an ACO or other alignment vehicle.

Critical Success Factors: Moving from Provider to Integrated Delivery System

Many healthcare organizations today include all of the components of an integrated delivery system: multiple hospitals, employed physicians, joint-ventured diagnostic centers, ambulatory surgery centers, home health services, post-acute, community health, etc. The distinction to make between these systems and those that are truly functioning as integrated delivery systems (or, some might say, ACOs) is the degree to which each business unit is integrated and supports the performance of others.

This necessitates a "focused factory" approach for each venue of care: maximize the performance of each business unit based on the manner in which reimbursement is paid

(e.g., *per diem*, per case or DRG, cost-based, per visit or procedure, etc.). As payers begin to expect and pay based on value as defined by quality, efficiencies, and cost savings across the continuum of care (inpatient, outpatient, post-acute), the need for business units to integrate and collaborate grows in importance. It also increases the need for clinical and administrative leadership to co-lead many managemet aspects of the integrated organization.

The following are key steps to create a culture and capability for success as an integrated delivery system:

- Establish the vision
- Articulate and build the culture
- Create the structure
- Develop the resources and tools
- Access and allocate capital
- Align performance measures and incentives
- Develop the leadership structure and talent

Leadership and Governance Implications: Questions, Issues, and Options

The board and senior leadership team must be effectively and proactively responding to the evolving healthcare reform environment. Leaders who are keeping pace with change recognize the need to constantly examine new and different methods to address the strategic/competitive positioning, policy, financial, clinical, and operational aspects of their organizations. Many boards are also proactively assessing board structure, composition, and other governance issues to ensure the board is up to the task to develop a clinically integrated organization.

The advent of healthcare reform has made it clear that boards and senior leadership teams must involve physicians and other clinicians in discussions of policy and strategy regarding clinical care delivery and process redesign. This involvement also extends to governance and senior leadership team levels. More organizations are expanding the involvement of physicians in governance and leadership roles through membership on boards, key governance-related committees, senior leadership teams, and in other high-level advisory capacities. The successful new physician leader is one who fosters collaboration and cooperation, with the vision to look to the future and navigate the system, physicians, and teams through the challenges of healthcare transformation to the next level and beyond.

Discussion Questions for Board Members

The following list of questions can be found throughout this publication. For more information and the complete lists of questions, please refer to the appropriate sections in this publication.

1. The economy is improving slowly, yet remains fragile; expect further pressure on balance sheets, operating margins, and reimbursement reduction from government payer sources. Are you seeing an erosion of operation margin performance? Do you need to consider affiliation options to improve performance?
2. Despite a slow economy, leadership must find ways to selectively grow market share. Is your organization evaluating opportunities to grow market share through a strategic alliance or acquisition of a group or organization with a specific expertise, skill, or brand niche?
3. It will be critical to be profitable on Medicare patients by 2014. What steps have you taken to determine your

Medicare profitability into the future, and have you implemented an action plan to start closing the gap?

4. It will be important to stay current on the continuous evolution of payment reform. Is your board receiving regular updates on CI and care redesign processes and effectiveness?
5. In evaluating payment reform and hospital–physician integration strategies, evaluate the best strategy to meet your mission and maximize organizational effectiveness. Are there physician specialties that should be augmented or added to increase capacity, build market awareness, and draw or increase visibility among specific population segments?
6. Whether or not you pursue an ACO or bundled payment contract this next year, preparing to accept and manage financial risk for a defined population will be a critical core competency to develop in the next three years. What steps has your organization taken to prepare for managing risk? Do you have robust data analytic software? Do you have internal capabilities to design and interpret medical informatics to assist in managing a population of patients?
7. Aligning incentives with physicians financially and clinically is more important than ever; physicians must be the champions to reduce costs and improve quality and patient outcomes. What is your organization doing to foster physician leadership?
8. What does the organization spend today on physician leadership development? What process is in place to assure that emerging leaders receive the training and coaching they need to be successful?
9. What are the venues across the organization from which physician leaders may be identified? Clinical improvement councils, medical staff organization, physician practice leads, service line co-management committees are a few of the areas to look.
10. Are performance expectations clear for physician leaders in the organization? Do they get feedback on their performance, and are there incentives in place that reward achievement of goals?
11. The future of healthcare is focused on "data" and CI. Useful, actionable data that provides direction on clinical and financial decisions is a key component in increasing revenues and decreasing expenses. Is your organization involving physicians in the early stages of IT planning and implementation to ensure relevance, usefulness, and buy-in?
12. Integrating services across the care continuum including primary care, acute care, and post-acute care coordination is a success factor for achieving CI and care-delivery redesign. How is your organization partnering with post-acute and primary care providers? Does your strategy integrate these providers in a meaningful way?
13. Does the board effectively understand and embrace the increasing complexity of the roles they are being asked to fill? Does the board feel adequately informed, educated, and kept abreast of the important issues they must understand, interpret, plan for, and act upon?
14. What is the profile of an effective physician director? (How is this different than that of any other director)?
15. What are the benefits as well as potential risks associated with physicians on the board (that are uniquely different than for non-physician directors)?

INTRODUCTION

New models of physician–hospital relationships and integration strategies have been emerging in the past few years as a result of numerous factors including rising healthcare costs leading to healthcare reform, an unstable economy, changes in consumer demand, advances in technology, generational differences in work/life balance, and others. Increasingly, physicians are looking to hospitals, health plans, and large, multispecialty medical groups for economic stability while hospitals and health systems are looking to primary care providers and certain specialists to gain market share and respond to payment reform. At the same time, hospitals and physicians have become more acutely aware of other drivers of change, such as consumer demand for more transparency and improved quality, cultural preferences, and technological influences, prompting changes to practice styles. As a result, these new relationships are different from previous forms of integration in that they include a broader spectrum of contractual and employment relationships, have a greater focus on clinical outcomes, and typically comprise a greater percentage of community physicians than ever before.

As hospitals and health systems navigate the various models and options for integrating with physicians, it can be daunting to determine which choices to make for success in a new environment of value-based healthcare. Most healthcare organizations today are at some point along the integration spectrum and considering options to begin integrating, enhance existing integration efforts, or completely transform themselves into a fully integrated delivery system.

Most healthcare organizations today are at some point along the integration spectrum and considering options to begin integrating, enhance existing integration efforts, or completely transform themselves into a fully integrated delivery system.

This publication describes the drivers of change that have brought provider organizations to this point, explains emerging payment models contributing to this drive, and explores the various models and structures for integrating physicians and hospitals. Each section includes key questions for board members to consider as well as implications for changes in the organization and leadership structure necessary for integration success. It includes case studies of provider organizations that have integrated in different ways, critical success factors in order to move from a provider to an integrated delivery system, and concludes with a section on leadership and governance implications.

I. DRIVERS OF CHANGE

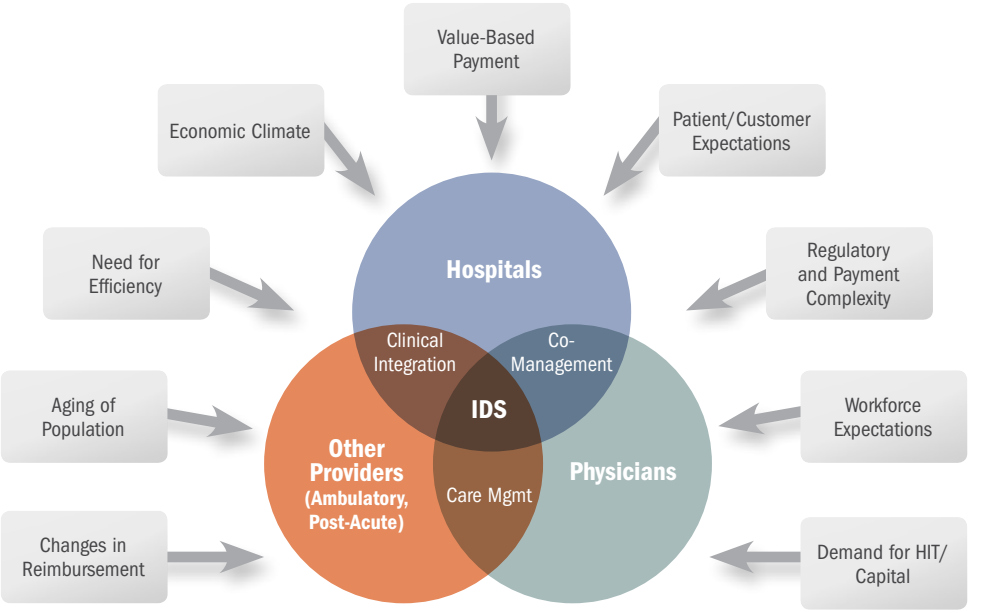
In order to better appreciate the rapid change in physician–hospital integration as a result of payment reform, it is important to understand the underlying trends and dynamics that have led us to this point. (See **Exhibit 1** for a visual overview of some of the trends and dynamics discussed in this section.)

Healthcare Costs and Reform Legislation

The U.S. spends more money on healthcare per person than any other nation and realizes fewer benefits for this investment in comparison, as measured by quality of care, patient satisfaction, and life expectancy. Statistics compiled by the Organization for Economic Co-operation and Development (OECD) demonstrate wide variability in healthcare spending by country as a share of gross domestic product (GDP). The U.S. continues to outspend all other OECD countries by a wide margin.[1]

The cost of healthcare in the U.S. has trended on an unsustainable pattern of growth above the annual inflationary rate, presenting a number of challenges for the public and private sector. Total spending for healthcare increased in 2010 to almost $2.6 trillion, more than 10 times the $256 billion spent in 1980.[2] The U.S. spent $7,960 per resident on healthcare

Exhibit 1: Drivers of Greater Integration



Source: The Camden Group.

1 OECD Health Data, 2011.

2 Adara Beamesderfer and Usha Ranji, "U.S. Health Care Costs" (Background Brief), Kaiser Family Foundation, last updated March 2010. Available at www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx.

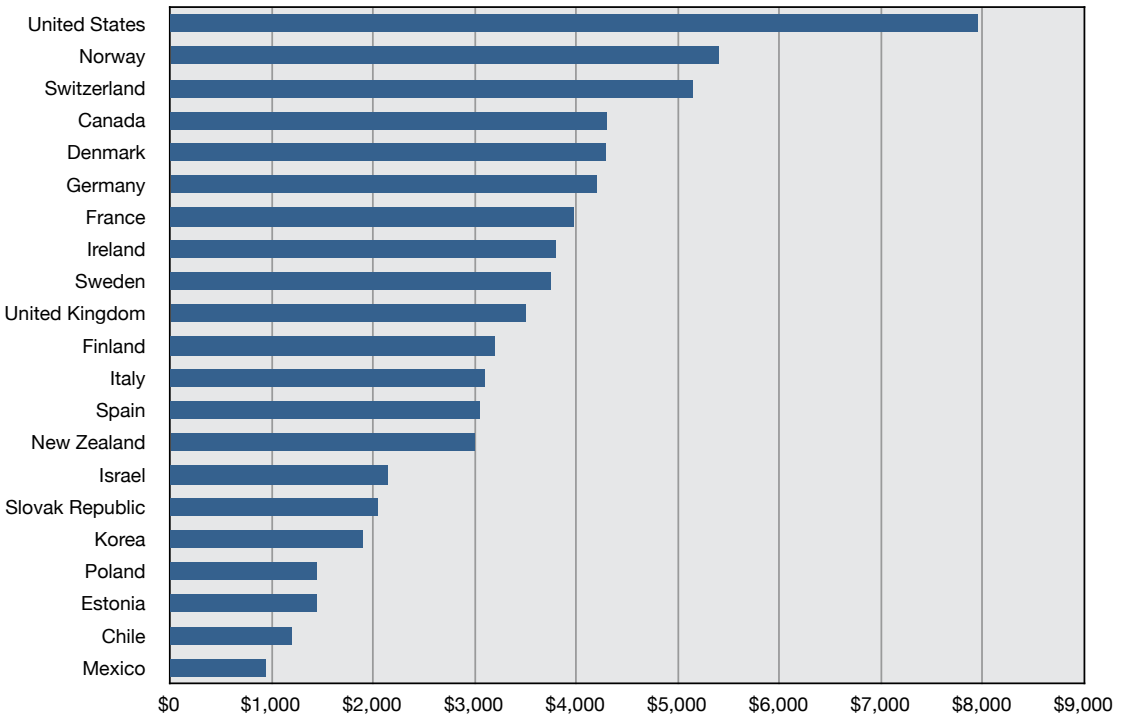
services in 2009, accounting for 17.4 percent of the nation's GDP, the highest of all industrialized countries.[3] (See **Exhibit 2**.)

The drivers of healthcare costs include increased expenses related to new technology and prescription drugs, increased prevalence of chronic disease including obesity, aging of the population, lack of care coordination and the resulting inefficiencies in care, and a perplexing array of administrative processes associated with the complexity of payment systems and regulatory requirements. Physicians continue to experience rising costs of doing business with lagging revenue increases. Hospital costs have been rising steadily as a result of increased use of inpatient, outpatient, and emergency department services, as well as the higher price of doing business. This includes capital costs for new technology and use, increased wage pressures, competition within the market, construction of new facilities to meet state regulations, use of pharmaceuticals, and lower reimbursement for government programs including Medicare and Medicaid.

While there is significant benefit to investment in healthcare services and technology, the increase in spending, combined with poor economic forces and a rising federal deficit, is placing a strain on the U.S. healthcare system, particularly on private, employer-sponsored health plans and public plans such as Medicare and Medicaid. As insurance plans pass on increased costs to employers, employers in turn are forced to increase premiums for their employees. Many in the workforce are finding it difficult to take on their share of insurance premiums, resulting in a trend to purchase high-deductible, low-premium health plans. High-deductible plans offer lower up-front costs but put more risk on employees and their families if they suffer an illness or injury.

The consequences associated with rising healthcare costs include individuals avoiding what they perceive to be discretionary healthcare expenses, such as preventive care visits with physicians, dental care, or prescriptions refills for a medication. According to the Kaiser Family Foundation,[4] 53 percent of families have experienced care-related consequences from rising healthcare costs. A survey conducted by the National Research Corporation found that 21.5 percent of consumers deferred healthcare in 2011. Top reasons included perceived inability to pay, lack of insurance, and concern about spending and the economy. Both the insured and uninsured put off care, with 24.9 percent of uninsured consumers deferring and 20.8 percent of insured consumers deferring.[5]

Exhibit 2: Total Health Expenditure per Capita (U.S. $), 2009



Source: OECD Health Data, 2011.

3 OECD Health Data, 2011.

4 Kaiser Family Foundation, "Trends in Health Care Costs and Spending," (Fact Sheet, March 2009). Available at www.kff.org/insurance/upload/7692_02.pdf.

5 2011 Ticker Survey, National Research Corporation (representing 278,824 survey respondents).

Growth in healthcare spending is expected to continue to increase, absent any changes in healthcare reform. For years, the Centers for Medicare & Medicaid Services (CMS) has identified the underfunding or overspending of the Medicare Trust Fund as a crucial matter for the sustainability of this foundational program of social service in the U.S. Medicare is one of the two largest mandatory federal programs supported by payroll taxes and general reserves. Due to rising healthcare costs, a poor economy, high unemployment, and an increase in retirees, the current tax base is insufficient to support the program. The Medicare Board of Trustees has projected that the Medicare Trust Fund will run out of funds to pay for insured services by 2024.[6]

The concern over the sustainability of the Medicare program, poor economic forces, and the federal debt crisis has led to the passage of healthcare reform and the subsequent restructuring of the payment and delivery models in both the public and private sectors. Efforts by private and public payers to control healthcare costs have been borne out through policy, programmatic, and reform initiatives, most recently the passage of H.R. 3200, America's Affordable Health Choices Act (AAHCA) of 2009, and the Patient Protection and Affordable Care Act of 2010 (PPACA). These initiatives represent legislative efforts by the federal government to reduce healthcare costs, increase access, improve the value of care, and put in place mechanisms to develop new funding and delivery models in support of system reform. **Exhibit 3** outlines major legislative initiatives that have significantly impacted the healthcare landscape, driving the need for greater hospital–physician integration and new models for such strategies.

Exhibit 3: The Evolution of Healthcare Reform and Its Impact on Hospital–Physician Integration in the U.S.

	1990s Capitation	1999–2004 Shake-Out Retrenchment	2005–2009 Focus on Market Share	2010 & Beyond Payment Reform
Legislative Efforts	► Pres. Clinton introduces universal coverage but fails to gain support ► Health Insurance Portability and Accountability Act (HIPAA) passed: restricts use of pre-existing conditions and sets standards for patient privacy	► Medicare legislation creates health savings accounts, allowing pre-tax dollars to be set aside for current/future health expenses ► Medicare Drug, Improvement Modernization Act (MMA) created a subsidized prescription drug benefit under Medicare	► American Reinvestment and Recovery Act (ARRA): substantial investment to develop health information exchange, and expand primary care workforce	► **Patient Protection and Affordable Care Act (PPACA) passed** » Expands coverage under Medicaid » Creates state-based health insurance exchanges to be operational in 2014 » Prevents health plans from denying coverage for any condition » Young adults can be covered under their parent's plan up to age 26 » Defines ACO concept and value-based payment » Funded by the CMS Innovation Center
Provider Economic Factors	► Managed care with focus on capitation ► Physician Practice Management (PPM) companies go public	► Hospital losses due to risk contracting and pressures on health insurance premiums ► Losses in hospital and PPM-sponsored medical groups	► Medicare Advantage rates improve ► Declining HMO enrollees as HSAs and affordable PPOs are introduced ► Consolidation of health plans into national companies	► Changes in payment methodologies away from traditional fee-for-service ► Changes in reimbursement and regulations affect specialists negatively
Provider Market Dynamics	► Competition among physician groups, hospitals, PPMs, and health plans for primary care physicians ► Hospitals largely profitable ► HMO market expanding	► Collapse of national PPM companies ► HMOs in disfavor among general public	► Competition for market share ► Impact of physician generational differences begin to rise ► Consolidation of specialty groups and expansion of physician-owned ancillaries	► Collaboration pursued to achieve quality and cost-reduction goals ► Clinical integration required ► ACOs, bundled payments, co-management arrangements begin to emerge and expand

Source: The Camden Group.

6 Social Security and Medicare Board of Trustees, "A Summary of the 2012 Annual Reports," available at www.ssa.gov/oact/TRSUM/index.html.

Impact of Economic Trends on Healthcare

Increase in Uninsured and Underinsured

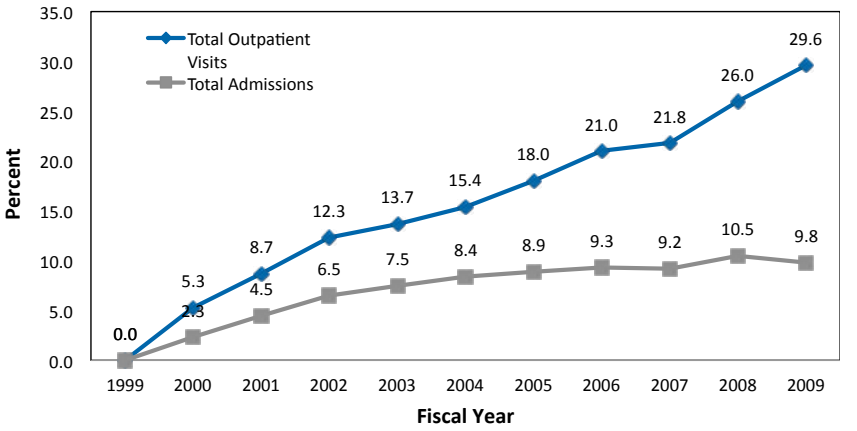
The recent lagging economy has played a huge factor in the emergence of new models of hospital–physician relationships and integration strategies. Between 2008 and 2011, the U.S. experienced a time of economic recession not seen since the Great Depression, with unemployment rates above 10 percent across the country. Given that private health insurance coverage in the U.S. is primarily an employment-related benefit, individuals lose coverage as their employment situation changes, or their temporary Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage expires. The low economic growth and unstable financial climate resulted in an increase in the number of uninsured and underinsured, a higher rate of self-pay or non-pay patients, and pressure from businesses, insurers, and government payers to curtail the historical increases of health expenditures. According to a Census Bureau report released in 2010, the number of people with health insurance dropped from 255.1 million in 2008 to 253.6 million in 2009, making this the first year since 1987 that the number of insured declined. The report also noted an increase in the number of people covered by government insurance from 87.4 million in 2008 to 93.2 million in 2009.[7]

Migration to Outpatient Settings

Another notable change in the consumption of healthcare resources is the shift from inpatient to outpatient services. The Medicare Payment Advisory Commission (MedPAC) reported a cumulative percent change in hospital admissions from 2008 to 2009 of 0.7 percentage points (or 230,000 admissions)—the single largest decline in the past 10 years. Conversely, the cumulative percent change in outpatient visits increased four percentage points or nearly 18 million visits in the same period.[8] (See **Exhibit 4**.)

From 2004 to 2009, hospital fee-for-service (FFS) discharges per Medicare beneficiary decreased 4.2 percent while the number of outpatient services per beneficiary increased more than 23 percent. These two trends clearly represent the shift

Exhibit 4: Cumulative Change in Total Admissions and Total Outpatient Visits, 1999–2009



Note: Cumulative change is the total percent increase from 1999 through 2009. Data are admissions (all payers) and outpatient visits at about 5,000 community hospitals.

Source: American Hospital Association, AHA Hospital Statistics.

7 Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60–238, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, U.S. Government Printing Office, 2010.

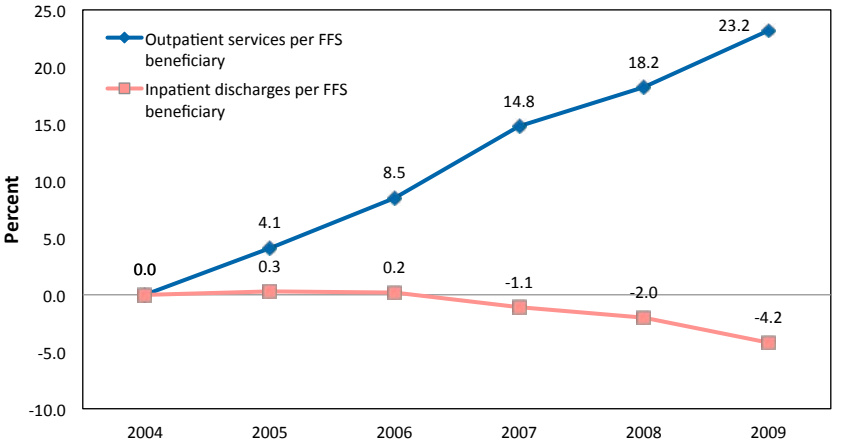
8 Medicare Payment Advisory Commission (MedPAC), *Healthcare Spending and the Medicare Program, Acute Inpatient Services* (Data Book), June 2011. Available at www.medpac.gov/documents/Jun11DataBookEntireReport.pdf.

in emphasis from inpatient to outpatient delivery modalities, exacerbating this shift in delivery setting that began decades ago.[9] (See Exhibit 5.)

Declining Medicare Margins and Financial Pressures on Physicians

In addition to the shift from inpatient to outpatient services, which was largely attributable to changes in Medicare's payment policies aimed at cost reduction, as well as changes in technology and the impact of pharmaceutical advances, hospitals also experienced a significant decline in their overall Medicare margin, reaching a low of –7.1 percent in 2008.[10] Hospitals were able to make up the difference in the declining Medicare margin due in part to favorable contractual rates with commercial payers. However, many suffered from the economic recession, the impact of which included declining overall volumes and substantial investment losses that further restricted cash flow and capital investment opportunities, resulting in layoffs as well as freezes in wage rates and hiring. (See Exhibit 6.)

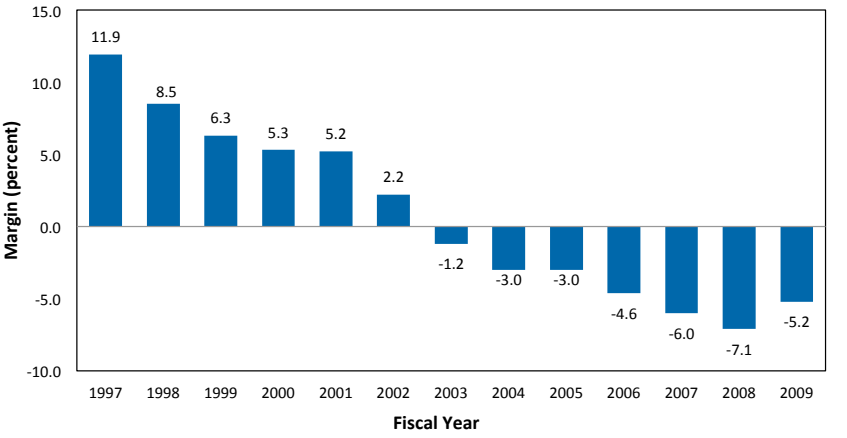
Exhibit 5: Cumulative Change in Medicare Outpatient Services and Inpatient Discharges per FFS Beneficiary, 2004–2009



Note: Data are for short-term general and surgical hospitals, including critical access and children's hospitals.

Source: MedPAC analysis of MedPAR and hospital outpatient claims data from CMS.

Exhibit 6: Overall Medicare Margin, 1997–2009 per FFS Beneficiary, 2004–2009



Source: MedPAC analysis of Medicare cost report data (August 2010) from CMS.

9 MedPac, June 2011.

10 *Ibid.*

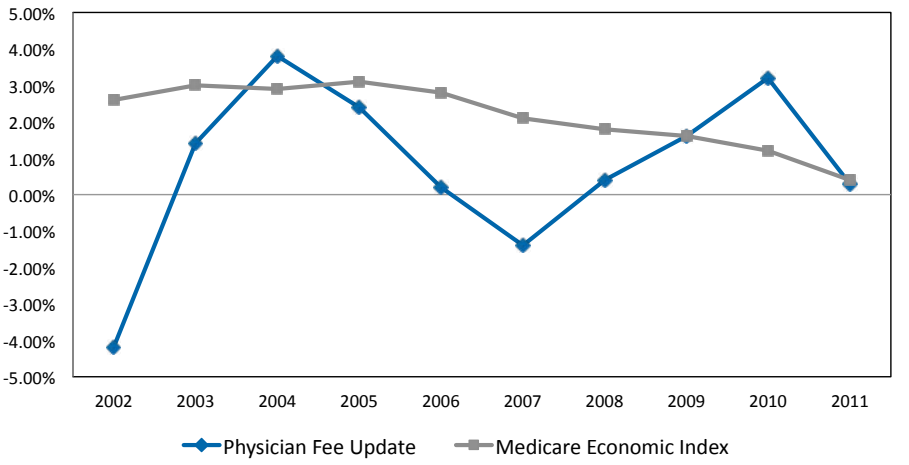
Physicians are also experiencing a decline in reimbursement rates as evidenced by Medicare's annual update to the physician fee schedule trending at or below Medicare's Economic Index, a measure of physician practice operating costs, for most years between 2002 and 2011.[11] (See **Exhibit 7**.)

Further, physicians are seeing a steady erosion in their gross FFS collection percentage as a result of increasing contractual discounts provided to payers and increasing bad debt due to the economic crisis (with patients losing their health coverage or switching to high-deductible health plans). At this same time, physician practices are experiencing increases in expenses as a result of implementing electronic medical records (EMRs), increased administrative and employee costs due to the complexity of regulatory and payer requirements, and an increase in supply costs. Operating costs as a percent of revenue reached 62.4 percent in 2009 up from 54.9 percent in 1994. In addition, physicians are spending more time implementing government regulations with the passage of the Health Insurance Portability and Accountability Act (HIPAA), ePrescribing, and other regulatory initiatives, as well as implementing quality reporting processes with the Physician Quality Reporting System (PQRS). To implement these initiatives successfully requires more sophisticated technology and workflow processes, which requires more skilled management, additional time burdens, and cost.

Demographic Trends Impact Delivery of Care

In addition to economic trends, hospitals and physicians will be further impacted by an aging population. The baby boomer population (those born in the post-WWII period between 1946 and 1960) represents more than 75 million people or more than one-third of the U.S. population, presenting a number of challenges to the future consumption of healthcare resources. A report released by the American Hospital Association depicts the challenges of managing a large population likely plagued by chronic conditions. The report estimates that 8.6 million baby boomers today (one in 10) are managing multiple chronic conditions; this is expected to grow to 37 million by 2030.[12] In less than 20 years, nearly one in four (14 million) will be living with diabetes, one in two (26 million) with arthritis, and over

Exhibit 7: Annual Medicare Physician Fee Schedule Payment Updates, 2002–2011 (%)



Note: Physician fee schedule update figures include all legislation impacting payment updates, excludes updates due to risk adjustment.

Sources: 2011 Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds; The Camden Group.

11 The Boards of Trustees, *Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,* 2011 Annual Report, May 13, 2011. Available at www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf.

12 American Hospital Association (AHA), *When I'm 64: How Boomers Will Change Health Care*, May 2007. Available at www.aha.org/content/00-10/070508-boomerreport.pdf.

21 million will be managing obesity. With chronic conditions contributing to the leading cause of death and disability in the U.S., and treatment of patients with co-morbid conditions costing up to seven times more than those with only one chronic condition, the cost burden of the boomer population is predicted to be significant.[13] (See **Exhibit 8.**)

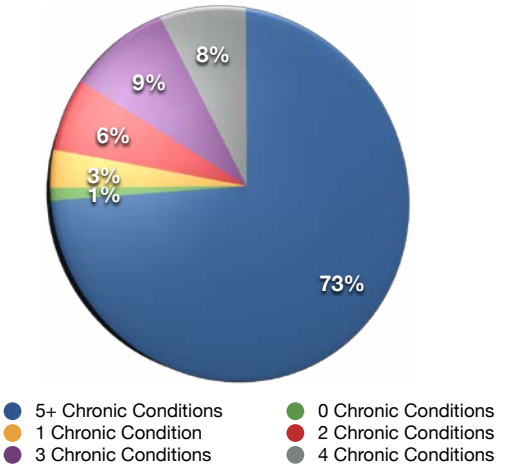
Fundamental changes will need to be made to the way healthcare is delivered to manage the influx of baby boomers with multiple healthcare needs. Hospitals will need to collaborate more effectively with physicians and community providers and increase their focus on outpatient services.

However, it is anticipated that the supply for physician services required to support the aging baby boomer population will not meet demand in certain specialties such as primary care, geriatrics, internal medicine, cardiology, and orthopedic surgery. As a result, healthcare reform includes a number of provisions to assist in increasing the number of primary care physicians in order to anticipate future demand. The PPACA provides funding to expand the number of residency slots with priority given to primary care, and creates teaching health centers, defined as community-based, ambulatory care centers, including federally qualified health centers (FQHCs), which are eligible for Medicare payments for expenses associated with residency programs. Additional support is provided to primary care providers through a 10 percent bonus payment by Medicare from 2011 to 2015 and to general surgeons who practice in a designated health professional shortage area. While these efforts are intended to mitigate the physician shortage concern, many are looking to mid-level practitioners, including nurse practitioners and physician assistants, to help meet the increased demand. (See **Exhibit 9.**)

Consumer Demands and Expectations for Healthcare

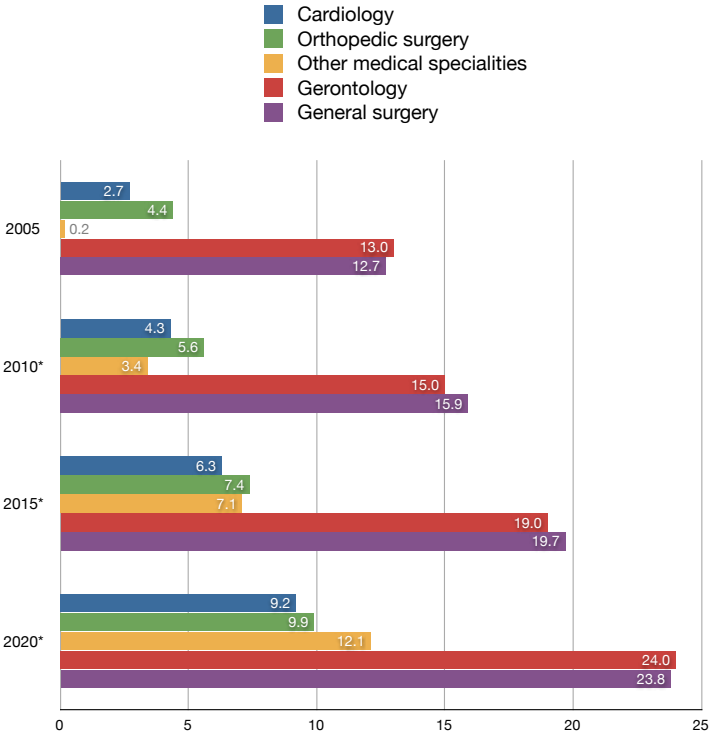
Consumer demands and expectations are also changing how care is provided as consumers are becoming more informed and more technologically equipped. The demand for greater choice and convenience is rapidly changing how consumers engage in their healthcare, from selection of benefit plans to scheduling office visits. Consumer demand for such items as prescription drugs has increased due to advertising by pharmaceutical companies, the emergence and use of more lifestyle drugs, and the increased promotion of drugs by physicians such as those used to reduce cardiovascular disease. Spending on drugs by Americans has more than doubled over the last

Exhibit 8: Two-Thirds of Medicare Spending Is for People with Five or More Chronic Conditions



Source: Medicare Standard Analytic File, 2007.

Exhibit 9: Physician Shortage by Specialty (in Thousands)



*Projected

Sources: Physician Supply and Demand; Projections to 2020, HRSA, October 2006; "Research Shows Rapid Decline in Geriatric Medicine Students," Press Release, University of Cincinnati, April 4, 2007; "Aging Boomers Face a Doctor Shortage," CBS News, March 4, 2003.

13 Agency for Healthcare Research and Quality (AHRQ), Research in Action, Issue #19. The High Concentration of U.S. Health Care Expenditures, June 2006.

decade to more than $234 billion on prescription drugs in 2008, up from $104.6 billion in 1999.[14]

Also impacting consumer demand for healthcare is the coming of the digital age—consumers have ready access to multiple sources of medical information, research, and data through Web sites, blogs, and publicly available medical literature, in addition to traditional sources. The Deloitte Survey of Health Care Consumers indicates that 42 percent of consumers surveyed are interested in establishing an electronic personal health record to connect online with their physician, and 55 percent want the ability to communicate with their physician via email.[15] While traditional healthcare providers are still the main source of information, non-traditional sources such as the Internet and an individual's family and friends are beginning to represent a significant source of healthcare information in the U.S. In a study recently conducted by the Pew Research Center, 80 percent of Internet users surveyed had looked online for health information, and 34 percent have read someone else's commentary or experience about health or medical issues on an online news group, Web site, or blog.[16]

Non-traditional healthcare companies are entering the healthcare landscape to offer consumers opportunities to connect with each other through social media, blogs, and healthcare portals. Through these sites, consumers ask and answer health-related questions, rate physicians, and participate in online discussions. An example of such a company is Revolution Health, originally founded in 2005 by Steve Case, cofounder of AOL. Conversely, many healthcare organizations are embracing social media as a means to engage with their patients and consumers. According to National Research Corporation, 18.1 percent of consumers have used social media sites for healthcare information purposes. Of those healthcare consumers, 39 percent highly trust the medium as a source and 30.9 percent use social media to help shape their future healthcare decisions.[17]

Another trend that will continue into 2012 is the use of new mobile health applications and devices to help consumers prevent, improve, monitor, and manage their health. The research company Technavio predicts that the global mobile health applications market will reach $4.1 billion by 2014, up from $1.7 billion in 2010.[18] Mobile applications currently in use already have a variety of capabilities and functions. For example, some allow the consumer to scan and monitor moles over time and alert the user if a visit to the doctor is needed; blood pressure monitoring devices track data and automatically upload information to a physician's office; and car manufacturers are including Applink software to enable drivers access to applications that track chronic conditions.

Physicians and other healthcare providers can expect patients to engage in more personal healthcare monitoring and may begin to see patient care visits as a result of these mobile applications. Healthcare providers are rapidly implementing EMRs as a result of the passage of the American Reinvestment and Recovery Act (ARRA), which provided financial incentives to help physicians and hospitals implement health information technology. EMRs will allow healthcare providers to stay connected to their patients as the digital age continues to evolve at a rapid pace.

Healthcare spending in the U.S. is the highest in the world, with significant regional variability; the difference in spending between the lowest- and highest-spending regions is more than double.

Ethnic and Cultural Changes

Research over the past three decades reveals that health status and utilization of healthcare services depend on a variety of factors beyond insurance coverage including age, race, gender, socio-economic status, living situation, and education level. These cultural differences have been used to predict a person's probability to get routine annual care, to be screened for

14 Nicholas Bakalar, "Prescription Drug Use Soared in Past Decade," Vital Statistics, *The New York Times,* October 18, 2010.

15 Bernie Monegain, "Consumer Demand for Healthcare IT 'never stronger' Survey," *HealthcareITNews,* April 14, 2009.

16 "The Social Life of Health Information," Pew Research Center's Internet & American Life Project. Available at http://pewinternet.org/Reports/2011/Social-Life-of-Health-Info.aspx.

17 2011 Ticker Survey, National Research Corporation (representing 278,824 survey respondents)

18 Technavio, *Global Mobile Health Applications Market 2010–2014,* Aug 15, 2011. Available at www.technavio.com/content/global-mobile-health-applications-market-2010-2014.

preventive purposes, and to be informed about and effectively manage chronic health conditions. Cultural differences also correlate to an individual's exposure to environmental factors and behaviors that may increase their health risk. At a baseline then, each individual has a different health risk profile unique to his or her particular circumstances, family history, and cultural identity. According to the Centers for Disease Control and Prevention, the health disparities associated with chronic diseases such as cancer, cardiovascular disease, and diabetes, experienced by difference ethnic groups and the change in population growth expected in those groups represent a compelling reason to address the issue. For example, incidence of diabetes in African-Americans is roughly 70 percent higher than in Caucasians, while the incidence in Hispanics is nearly double. Similarly, the cancer death rate is 35 percent higher for African-American men and women than that of Caucasians.[19]

As the U.S. becomes more diverse, healthcare providers will continue to see patients with a varying degree of perspectives regarding health. Patients may have different thresholds for obtaining care, have limited English proficiency, and represent their illness in a variety of ways. Cultural competency is gaining momentum with employers, providers, and payers as a strategy to improve or eliminate racial/ethnic disparities and improve quality. Kaiser Permanente, Aetna, and Blue Cross and Blue Shield of Texas and Florida are examples of payers that provide cross-cultural communications trainings for clinicians who care for their members. Many hospitals have integrated cultural competency training to physicians and staff to be responsive to the unique demographics of their patient populations.

Regional Variability

The level of healthcare spending in the U.S. is the highest in the world, with significant regional variability; the difference in spending between the lowest- and highest-spending regions is more than double.[20] This variation has been largely attributed to the FFS payment environment, which is not designed to encourage or incentivize the use of clinical guidelines or evidence-based medicine to standardize clinical practice and supports discretionary decisions made by providers at the point of care. Variation is also attributed to differences in the use of a hospital as a site of care versus an alternative provider such as hospice, nursing home, or a physician's office. Over time, the variation in growth rates of spending across regions in the U.S. has created significant differences in the utilization of healthcare resources without any commensurate increase in healthcare outcomes. Proposals to address this variation involve transitioning from a FFS payment structure while developing more organized and integrated systems of care delivery.[21] Atul Gawande's article on a small-impoverished Texas town clearly articulates the regional variation in healthcare spending because of incentivized medical culture. Gawande writes that McAllen, Texas, "is one of the most

19 Office of the Associate Director for Program, "Eliminating Racial and Ethnic Disparities: Eliminating Health Disparities in Chronic Disease," FY 2000 Performance Plan–Revised Final FY 1999 Performance Plan, Centers for Disease Control and Prevention. Available at www.cdc.gov/program/performance/fy2000plan/2000xvchronic.htm.

20 Brenda Sirovich, Patricia M. Gallagher, David E. Wennberg, and Elliott S. Fisher, "Discretionary Decision Making by Primary Care Physicians and the Cost of U.S. Health Care," *Health Affairs*, Vol. 27, No. 3, May/June 2008; pp. 813–823.

21 Elliott Fisher, Julie Bynum, and Jonathan Skinner, "Slowing the Growth of Health Care Costs—Lessons from Regional Variation," *The New England Journal of Medicine*, Vol. 360 (2009); pp. 849–852.

expensive healthcare markets in the country. Only Miami—which has much higher labor and living costs—spends more per person on healthcare. In 2006, Medicare spent $15,000 per enrollee here, almost twice the national average. The income per capita is $12,000. In other words, Medicare spends three thousand dollars more per person than the average person earns."[22]

States have reacted differently to the pressures they are facing with rising healthcare costs. For example, Massachusetts passed legislation in 2006 to provide healthcare coverage to almost all residents of the state, mandating residents to purchase health insurance. The basic tenant of the legislation was to create a model of shared financial accountability among the residents, employers, and government.

The Massachusetts Experience

Passed in 2001, Massachusetts healthcare reform served as a model for the PPACA. Due to healthcare reform, Massachusetts has by far the lowest rate of uninsured residents in the nation (coverage has been expanded to 98.1 percent of residents since the law was enacted, with children covered at a rate of 99.8 percent). Since both the Massachusetts and PPACA reform laws use similar approaches to expand coverage, many people view the commonwealth as a useful model for analyzing the potential impact of a fully implemented PPACA.

Enacted in 2006, Massachusetts health reform now has five years of results available for analysis. Two areas that have received a lot of focus, and remain primary areas of concern for many, are 1) the impact of the individual mandate on emergency department (ED) utilization (a primary driver of high healthcare costs) and, 2) protection against the negative consequences associated with adverse selection.

In regards to ED utilization, a September 2011 report from *The New England Journal of Medicine* (NEJM) found that Massachusetts reform did not change the state's trend in total ED utilization relative to that in states where no such reform was enacted.[23] While ED use increased in Massachusetts after reform, it also increased by similar amounts in New Hampshire and Vermont, states that did not implement insurance expansions. The article concluded that, at least for now, physicians' and lawmakers' fears that the PPACA will increase ED visits (due to increased difficulty in getting appointments for outpatient physician visits) may be unfounded.

In a separate article from January 2011, NEJM looked at the impact of mandates on insurance premiums. The authors looked at the characteristics of the subsidized insurance pool before and after the mandate went into effect to assess how much of an additive effect the mandate had over that of simply offering subsidized, community-rated insurance. They found that the mandate initially brought many more healthy people than non-healthy into the risk pool when enacted (with the gap shrinking to pre-mandate levels over time as the remaining uninsured residents complied with the mandate). According to the report, the initial large jump in healthy enrollees suggests that the mandate had a causal role in *improving* risk selection. Also, the smaller PPACA subsidies would suggest that mandating coverage "might well play an even larger role in encouraging the healthy to participate in health insurance markets nationally than it has in Massachusetts."[24]

22 Michael Ricciardelli, "Atul Gawande: Why McAllen, Texas Can't Be the Answer to Health Reform," Health Reform Watch, June 14, 2009.

23 Christopher Chen, B.A., Gabriel Scheffler, B.A., and Amitabh Chandra, Ph.D. "Massachusetts' Health Care Reform and Emergency Department Utilization," *The New England Journal of Medicine,* Perspective, Vol. 365, No. e25, September 22, 2011. Available at www.nejm.org/doi/full/10.1056/NEJMp1109273.

24 Amitabh Chandra, Ph.D., Jonathan Gruber, Ph.D., and Robin McKnight, Ph.D., "The Importance of the Individual Mandate—Evidence from Massachusetts," *The New England Journal of Medicine,* Perspective, Vol. 364, January 27, 2011; pp. 293–295. Available at www.nejm.org/doi/full/10.1056/NEJMp1013067.

Maryland is the only state with a Health Services Cost Review Commission (HSCRC), an independent state agency, which is charged with the task of establishing hospital rates to promote cost containment, access to care, and ensure financial stability.[25] Based on a state waiver granted over 40 years ago, Maryland is exempted from adhering to the Medicare and Medicaid fee schedule. The HSCRC establishes reimbursement rates for all payers, and CMS reimburses care based on the HSCRC-established rates. Maryland is credited with slowing the rate of growth below that of other hospitals across the country and is looking at new measures to further incentivize cost containment.

Payment reform will change the cost structure, focusing hospitals on population health, case management, and new alignment models with physicians.

Oregon implemented what is known as the Oregon Health Plan (OHP), a plan for low-income residents that was intended to increase access and control costs through the provision of an established set of benefits based on a prioritized list of health services. Oregon received a waiver to implement the plan from the federal government in 1994, expanding eligibility for Medicaid recipients. In the first year of the plan, 120,000 new members joined and bad debt dropped at Portland hospitals by 16 percent. OHP has subsequently seen an increase in costs resulting in a shortfall to the plan's financial performance; state legislators hope a new law will save $240 million by the middle of 2013.[26] The new law requires OHP enrollees to join a coordinated care organization, which will be composed of teams of providers who will have accountability for health outcomes of enrollees and will have opportunities for shared savings.[27]

As described in this section, increased spending on healthcare services, a poor economic climate, changing consumer demand, and variations in the demographic landscape are primary drivers affecting healthcare legislation and the organization and delivery of healthcare into the future. In order to optimize the healthcare dollar and improve health outcomes, both governmental and private payers are gradually shifting from volume-based reimbursement (traditional FFS) to value-based reimbursement models. Payment reform will change the cost structure, focusing hospitals on population health, case management, and new alignment models with physicians to reduce lengths-of-stay, decrease readmission rates, and improve the health of the population as a whole. Much remains to be seen as physicians and hospitals continue to align in new structures; pilot projects conducted over the years are demonstrating promising results, yet it remains to be seen if it will be enough to alter the U.S. consumption of healthcare.

Key Considerations for Board Members

- The economy is improving slowly, yet remains fragile; expect further pressure on balance sheets, operating margins, and reimbursement reduction from government payer sources. Are you seeing an erosion of operation margin performance? Do you need to consider affiliation options to improve performance?
- It is expected that per-unit revenues will increase at a rate below cost trends, with Medicare payments increasing less than 2 percent and commercial payers holding rates between 4 to 6 percent. Has your finance staff provided the board with scenario modeling to test the impact of potential reimbursement cuts?
- It will be critical to be profitable on Medicare patients by 2014. What steps have you taken to determine your Medicare profitability into the future, and have you implemented an action plan to start closing the gap?

25 Health Services Cost Review Commission, Baltimore, MD (www.hscrc.state.md.us).

26 Betsy Q. Cliff, "Coordinated Care May Lower Costs," *The Bulletin,* September 2011.

27 Oregon Health Policy Board, "Transforming the Oregon Health Plan," Oregon Health Authority, September/Oct 2011. Available at www.oregon.gov/OHA/OHPB/health-reform/docs/transforming-ohp.pdf?ga=t.

II. EMERGING PAYMENT MODELS

With the passage of healthcare reform legislation, physicians and hospitals must increasingly look to new reimbursement models as a means to position themselves favorably in the new healthcare market. FFS models remain attractive for many providers because economic models for most providers are built on this historical method of payment; the fact that it carries minimal financial risk compared to other emerging models is also key. However, FFS models do not reward providers for keeping patients healthy and avoiding unnecessary care; on the contrary, providers are penalized financially by reducing volume. A key provision of the PPACA is the focus on developing alternative payment models that achieve the "triple aim"—improved quality of care, reduced costs, and improved patient experience. The PPACA includes several payment reform initiatives that encourage hospital–physician integration, including accountable care organizations (ACOs), bundled payments, value-based payments, and the patient-centered medical home (PCMH). Each model addresses payment reform differently, but they all facilitate hospital–physician integration.

Under the PPACA, CMS created the Center for Medicare & Medicaid Innovation. The CMS Innovation Center offers CMS an opportunity to spread rapidly promising new pilot payment programs without requiring Congressional approval.[28] Through more engagement and a rapid response system, CMS can help identify meaningful changes in both payment models and delivery organization design that will create the savings potential of healthcare reform. Its mission is "better care and better health at reduced costs through improvement."[29] Medicaid, other public programs, and private payers are included in the pilots in order to maximize the effectiveness of the incentives across different payers, reduce administrative burdens, and address unwarranted variation among payers.[30] Current initiatives include:

- Bundled Payment Models 1–4
- Pioneer ACO
- ACO: Advance Payment Model
- Comprehensive Primary Care Initiative (Advanced Payment Model)
- FQHC Advanced Primary Care Practice Demonstration (medical home)
- Health Care Innovation Challenge (to support identification, testing, and implementation of compelling new delivery and payment models, as well as workforce development and deployment)
- Innovation Advisors Program (creates a network of individuals trained in a common vision of better care, better health, and lower costs and will train up to 200 individuals in year one)
- Partnership for Patients (acute care hospitals improving processes for care transitions and/or partnering with community-based organizations to improve care transitions)
- State Engagement Models (for integration of dual eligible individuals)

28 Meredith B. Rosenthal, "Hard choices—Alternatives for reining in Medicare and Medicaid spending," *The New England Journal of Medicine*, Vol. 364, No. 20 (May 2011); pp.1887–1890.

29 Center for Medicare and Medicaid Innovation Web site: http://innovations.cms.gov.

30 Stuart Guterman and H. Drake, "Developing Innovative Payment Approaches: Finding the Path to High Performance," Commonwealth Fund, Issue Brief, Vol. 87, June 8, 2010.

The Center for Medicare and Medicaid Innovation

The CMS Innovation Center began full-scale operations in 2011. The center's purpose is to "test innovative payment and delivery system models that show important promise for maintaining or improving the quality of care in Medicare, Medicaid, and the Children's Health Insurance Program, while slowing the rate of growth in program costs. The center is to give priority to 20 models specified in the health reform law, including medical homes, all-payer payment reform, and arrangements that transition from fee-for-service reimbursement to global fees and salary-based payment."[31]

A critical underlying factor of each of these emerging models is that they all require increased infrastructure and financial risk for hospital and physicians. Insurance companies will also face significant infrastructure challenges, as their claims processing systems and protocols are primarily designed for the FFS payment environment. Under these emerging models, payment will no longer be linked solely to the provision of services. Quality outcomes and cost of care will also be core factors in determining reimbursement payments.

A key provision of the PPACA is the focus on developing alternative payment models that achieve the "triple aim"—improved quality of care, reduced costs, and improved patient experience.

The Current Landscape

CMS established the Prospective Payment System (PPS) for hospitals in 1982 as an initial attempt to control spending that had escalated under the previous cost-based reimbursement system. The payment model creates a per-case reimbursement mechanism for inpatient admissions categorized as diagnosis-related groups (DRGs). Under this system, hospitals are paid a flat rate per case, which incentivizes hospitals to manage costs and become more efficient. The payment reflects the costs an efficient hospital incurs; highly effective hospitals serve to prosper under this model, while inefficient hospitals continue to struggle.

Diagnosis-Related Group (DRG): A unit of measure used to classify patients by diagnosis, average length of stay, and therapy provided. The result is used to determine the amount of payment healthcare providers will receive for future procedures and services, primarily for inpatient care.

Early on, Congress exempted specialized hospitals, such as children's, psychiatric, rehabilitation, and long-term care hospitals from the PPS. However, the PPS has recently expanded to include many of these specialty hospitals. DRG payments were implemented in long-term care facilities in 2002 and are slated for implementation in children's hospitals in July 2012. Congress also included a provision in the PPS payment model for disproportionate share hospitals, which treat a high share of low-income Medicaid and Medicare patients. CMS makes additional allocations to these hospitals to account for the cost and to encourage these hospitals to continue to treat this patient population.

31 S. Guterman, K. Davis, K. Stremikis, and H. Drake, "Innovation in Medicare and Medicaid Will Be Central to Health Reform's Success," *Health Affairs,* Vol. 29, No. 6, June 2010; pp. 1188–1193.

Long-Term Care Providers

Value-based purchasing (VBP), bundled payments, and ACOs are becoming regular lexicons for hospitals and integrated healthcare organizations. As these payment models begin to unfold and take hold in redefining our healthcare system, it is important to consider the implications to community providers, including specialty hospitals, long-term care providers, and other specialty service providers.

Over the years, the post-acute care market has been largely driven by changes in Medicare reimbursement and will again be provided with opportunities and challenges as Medicare moves to a value-based payment methodology, in which payments cover the entire continuum of care from admission to discharge to recovery. Under this climate, post-acute care providers are anticipating an acceleration of partnerships with ACOs and integrated health systems looking to manage high-acuity patients post-discharge or without a hospital admission.

In response to these changes, leading-edge, post-acute care providers have begun forming care continuums, merging single-venue entities into care networks. These networks are acquiring or partnering with service providers such as home health, hospice, assisted living, adult day care, pharmacy, diagnostic ancillaries, and inpatient/outpatient rehabilitation providers. Programs have begun to emerge in which post-acute care networks accept full risk for these high-acuity patients, helping them to manage their care at home or in lower-cost settings through the program's network of providers.[32] The result is a patient-centered program that provides the right care in the right setting while reducing admissions, readmissions, and emergency room visits.

In order to manage these highly complex and acute patients effectively, post-acute providers are investing in clinical expertise in the form of R.N. case managers, higher nurse ratios, physician extenders, and leadership development. Providers are also implementing clinical protocols based on evidence-based medicine and utilizing technology to assist in data collection, care monitoring, and trend reporting. The ability to monitor performance and demonstrate value will continue to increase as preferred provider networks are formed.

Resource-Based Relative Value Scale (RBRVS): A scale that ranks physician services by the labor required to deliver the services.

The shift to PPS represented a significant change in how risk is managed and has served as a model for commercial payers looking to shift risk to providers. Under the PPS, efficient hospitals were able to maintain a reasonable margin on their Medicare book of business, but they looked to commercial payers with negotiated rates based on a percent of charges (POC) as their primary source of revenue. Hospitals continued to feel financial pressure as healthcare costs escalated, and the quest for increased commercial patients—particularly preferred provider organization (PPO) patients—led many hospitals to increase their outreach efforts into new markets to attract this new payer source. Hospitals also continued to increase their charges year over year, which put payers who maintained full risk at a disadvantage with a growing financial obligation. Subsequently payers began to negotiate discounted POC rates and implement inpatient *per diem* rates. In this model, payers and providers share risk by negotiating a daily payment rate for each type of hospital stay. This mechanism encourages hospitals to manage utilization and control costs and leaves the payer at risk for the length-of-stay.

Misalignment of economic incentives has created the need to move to a more evolved and collaborative process based on performance, value, and outcomes.

Physicians over the past two decades have continued to be paid largely on an FFS or discounted FFS basis. In 1992, Medicare implemented a fee schedule in which payment for individual services are based on measures of the relative resources (resource-based relative value scale [RBRVS]) used to provide those services. The intent of the program was to redistribute funds among various providers—not necessarily to reduce spending. In most cases, commercial payers established fee schedules based on Medicare's RBRVS and physicians negotiate payments with insurers as a POC or as a percent of the Medicare fee schedule.

32 Kathleen Griffin, Peter Longo, et al., *Building a Post-Acute Network: Care Management and ACOs,* Health Dimensions Group, May 2011.

A portion of this payment methodology includes a factor known as the sustainable growth rate (SGR), which has been a source of considerable debate over the past several years. In effect, the SGR was established to ensure that Medicare spending did not exceed growth in the economy. If payments to physicians were less than the SGR, the physicians would receive an increase the following year, and conversely, if payments were higher, the physicians would sustain a reduction. Payments have continued to exceed the economic growth rate, but Congress has not allowed for a rate decrease since 2003, creating a cumulative effect of higher payments and the need for greater cost reductions.[33]

This FFS environment has resulted in a fragmented and more costly healthcare system. Reductions in the SGR are met with resistance from physician organizations who are already feeling the pressures of increased costs and declining reimbursements. Negotiations with commercial payers based on FFS payments have forced physicians and physician groups to negotiate and provide services independently from other healthcare providers. Hospitals are trying to manage utilization and costs without a payment mechanism that involves physicians, and physicians are incentivized by the system to provide more services. This misalignment of economic incentives has created the need to move to a more evolved and collaborative process based on performance, value, and outcomes. (See **Exhibit 10**.)

Exhibit 10: Past and Emerging Models of Accountability in Provider Payments

Supporting Better Performance		Paying for Better Performance		Paying for Higher Value	
Pay for reporting. Payment for reporting on specific measures of care. Data primarily claims-based.	**Payment for coordination.** Case management fee based on practice capabilities to support preventive and chronic disease care (e.g., medical home, interoperable HIT capacity).	**Pay for performance.** Provider fees tied to one or more objective measures of performance (e.g., guideline-based payment, non-payment for preventable complications).	**Episode-based payments.** Case payment for particular procedures or conditions based on quality and cost.	**Shared savings with quality improvement.** Providers share in savings due to better care coordination and disease management.	**Partial or full capitation with quality improvement.** Systems of care assume responsibility for patients across providers and settings over time.

Source: Mark McClellan, Engelberg Center for Health Care Reform, The Brookings Institution, September 2009.

33 Congressional Budget Office, "The Sustainable Growth Rate Formula for Setting Medicare's Physician Payment Rates, Economic and Budget," Issue Brief, September 6, 2006.

The New Landscape: Value-Based Purchasing

Recognizing the unsustainability of the current payment system—based largely on quantity versus quality—public and private healthcare entities have looked to new ways to become purchasers of value, leading to the development of new, value-based payment methodologies.

Pay-for-Performance (P4P): A healthcare payment system in which providers receive incentives for meeting or exceeding quality and cost benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of P4P programs is to improve the quality of care over time.[35]

Pay-for-Performance

California developed its pay-for-performance (P4P) program in 2001 as a result of the negative public reaction to managed care in the 1990s. California's program, currently the largest non-governmental incentive program in the country, is administered by the Integrated Healthcare Association, representing eight health plans, 10 million insured individuals, 35,000 physicians, and over 220 physician groups. It is responsible for aggregating, standardizing, and reporting data across diverse regions. While California's P4P program has largely focused on quality of care, recent trends in escalating healthcare costs have contributed to the creation of the value-based P4P program, with a focus on cost control and affordability in addition to quality.[34]

CMS launched the Premier Hospital Quality Demonstration Project in collaboration with Premier Healthcare Alliance on October 1, 2003, which was the first national P4P project. This demonstration project tested the theory that using financial incentives would improve hospital quality performance, thus improving patient outcomes and ultimately driving down utilization and cost of care. The project rewarded top-performing hospitals in more than 30 nationally recognized evidence-based quality measures. The top-performing hospitals in each condition received bonuses of 1 to 2 percent of their Medicare DRG payments for the associated condition. Hospitals also received penalties in year three if performance did not exceed baseline. The results of the project clearly demonstrated that providing financial incentives improves care delivery and outcomes; CMS extended the project for three additional years to test the effectiveness of new incentive models.

The significance of P4P in the present healthcare environment is that it serves as a starting point for provider groups contracting with payers for gainsharing or a portion of shared savings without necessarily taking on "down-side" risk or investing in sophisticated IT infrastructure. The price of entry into P4P is low, requiring only contracting effort and a willing payer, but succeeding at P4P takes concentrated effort by the organization of providers to meet the thresholds on the chosen metrics for the group and/or individual providers to earn the financial incentives.

Agreeing on the metrics and thresholds is not always easy. Quality metrics will appeal to most providers and will hopefully also lead to savings for the payers, which can then be shared with the providers. Process measures, like getting diabetics to have an A1c every six months, can be achieved by most providers in the first year, particularly if there is some type of disease registry available. Improvement in outcome measures, such as getting A1cs into an acceptable range, will likely take more than a year. Choosing the wrong metrics could result in no incentives for providers and/or no savings for the payer, discouraging expansion, or even continuance, of the P4P program. Groups that succeed at P4P are better positioned to become clinically integrated, establish an ACO, and/or to accept capitated risk.

A recent survey was conducted of members of The Governance Institute regarding integration strategies and payment models organizations are pursuing or plan to pursue in order to meet the challenges of healthcare reform. The survey demonstrated that, of the 115 members who responded, 77 percent are implementing or have implemented P4P. While other alternative models are being pursued, specifically bundled payments, ACO/shared savings, and global payment, these all dramatically fall short in comparison to P4P.

34 Integrated Healthcare Association, "California Pay for Performance Overview" (Web page): www.iha.org/p4p_california.html.

35 The Henry J. Kaiser Family Foundation, *Focus on Health Reform: Glossary of Key Health Reform Terms*, September 9, 2010. Available at www.kff.org/healthreform/upload/7909.pdf.

Value-Based Payment

On January 7, 2011, CMS issued a proposed rule that established a value-based purchasing program (VBP) for acute care hospitals that are paid under the Medicare Inpatient Prospective Payment System. The VBP provides hospitals with value-based incentive payments beginning in FY 2013 or October 1, 2012 discharges. The plan includes a set of quality measures currently reported by hospitals and adds patient perception (HCAHPS®) scores to determine overall hospital quality. According to CMS, value-based purchasing will "transform Medicare from a passive payer of claims based on volume of care to an active purchaser of care based on the quality of services its beneficiaries receive."[36] CMS also introduced the framework for the Hospital Readmission Reduction Act program, established under the PPACA. The rule is designed to reduce Medicare inpatient payments for acute care hospitals with higher than expected risk-adjusted readmission rates for certain conditions. CMS will cap the Medicare payment reduction at 1 percent beginning in fiscal year 2013, with potential increases over time; acute myocardial infarction, heart failure, and pneumonia will be the only applicable conditions for the first two years of the program.

Groups that succeed at P4P are better positioned to become clinically integrated, establish an ACO, and/or to accept capitated risk.

In addition to the P4P and VBP plans for hospitals, Medicare created the Physician Quality Reporting System (PQRS), which provides an incentive payment for eligible professionals who report data on specific quality measures. The program is currently voluntary with physicians receiving a 1 percent incentive payment of their total Medicare Part B payment in 2011 and half a percent increase from 2012 until 2014. In 2015, CMS is implementing a penalty of 1.5 percent for non-participation. The non-participation penalty, coupled with a potential reduction in the Medicare fee schedule, is prompting many physicians to participate voluntarily in the program.

Commercial payers are also looking at value-based payments through initiatives such as value-based insurance design (VBID). VBID plans reduce barriers to care for services where the clinical benefits exceed the costs, in effect requiring patients to pay less for services that have demonstrated clinical effectiveness. In some instances, insurance companies are selecting patients with specific diagnoses or conditions and are lowering copayments for high-value medications such as beta-blockers and ACE inhibitors. Other companies are looking at ways to integrate VBID with wellness programs that motivate patients to follow their treatment guidelines by providing incentives in the form of free services and medications, reduced copayments, and wellness coaches. The patients benefit from improved health outcomes at a lower out-of-pocket cost while employers receive improved productivity, fewer disability claims, and lower premiums. The ability to identify evidence-based, high-value services and track patient compliance through data warehousing technology and electronic health records is helping propel VBIDs forward.

Value-Based Insurance Design (VBID)

VBID is a mechanism gaining traction in the commercial insurance market to better align patient copayments and premiums with the value of healthcare services. VBID plans reduce out-of-pocket expenses for consumers for high-value treatments, drugs, and services that are proven to prevent or manage disease.

In an effort to control costs and pay for value-based services, insurance companies are also looking towards implementing reference pricing and narrow or "tiered" networks, and are often using tiered pricing to provide patient choice. Reference pricing is a patient cost-sharing method that insurance companies use to cover only low-cost generic medications that have similar efficacies as their brand-name counterparts. Patients can opt for the higher-priced substitute and will pay the difference between the retail price and the reference price the insurance company allows. This same concept is being applied to certain procedures, such as total knee replacements or outpatient surgery. Narrow networks are a throwback from the managed care era in which service providers were included in networks based on their ability to provide large discounts to payers. New models have emerged that are including providers based on their ability to manage cost and improve outcomes. Setting different rates for different classifications of drugs or services is known as tiered pricing. Tiered pharmaceutical benefits set copayments at different rates for generic, brand name, and non-formulary drugs. Tiered networks provide patients with financial incentives

36 Medicare Program: Hospital Inpatient Value-Based Purchasing Program, Proposed Rule, 76 Fed. Reg. 2454, Jan 13, 2011. Available at http://edocket.access.gpo.gov/2011/pdf/2011-454.pdf.

for choosing more cost-effective physicians and hospitals. In essence, insurance companies are trying to find the highest-quality, lowest-cost providers, while still allowing patient choice (at a cost).

Recognizing the unsustainability of the current payment system—based largely on quantity versus quality—public and private healthcare entities have looked to new ways to become purchasers of value.

Bundled Payment

Payment reform mechanisms such as P4P and PQRS have been effective at improving quality and reducing costs and have made significant strides in moving the healthcare landscape away from a FFS environment. The next step is to move beyond P4P and to focus on value-driven healthcare that rewards healthcare providers for delivering patient-centered quality services that are proven to be effective.

Bundled payment is a method of fee-for-episode payment that focuses on the entire continuum of care for a particular condition or procedure. This method of payment creates a single reimbursement for an episode of care, which holds all providers accountable for delivering high-quality care in a cost-effective manner.

Prometheus is one of several bundled payment models being tested nationally and includes a collaboration of payers, healthcare delivery organizations, and self-insured employers who volunteered to participate in the pilot. The pilot was designed to pay for all of the care required to treat a defined clinical episode based on established clinical guidelines. Budgets are developed for each condition, and all services are bundled into what is called an evidence-informed case rate (ECR). To date, ECRs have been created for a number of acute and chronic conditions, including heart attacks, hip and knee replacements, diabetes, asthma, congestive heart failure, and hypertension.[37]

One of the highlights of the Prometheus model is the focus on care coordination among providers through the use of a performance scorecard. Providers are measured based on their compliance with clinical guidelines, patient satisfaction, and patient outcomes. In order to ensure clinical collaboration, the plan includes a withhold, which is distributed to the provider in part based on the individual physician's performance, with the remainder determined on the performance of the team as a whole. The model also includes a budget for potentially avoidable complications (PACs), which is reserved and paid out to the care team if PACs are reduced or eliminated. According to Prometheus, up to 40 cents of every dollar spent on chronic conditions, and 15 to 20 cents of every dollar spent on acute hospitalization and procedures, are attributable to PACs.[38] To date, the Prometheus payment model appears to be a viable model, resulting in cost savings while improving patient outcomes.

PROMETHEUS Payment® (Provider Payment Reform for Outcomes, Margins, Evidence, Transparency, Hassle Reduction, Excellence, Understandability, and Sustainability)

Sponsored by the Health Care Incentives Improvement Institute and funded in part by grants from the Robert Wood Johnson Foundation and The Commonwealth Fund.

37 Prometheus Payment, Inc., "What is Prometheus Payment? An Evidence-Informed Model for Payment Reform," Robert Wood Johnson Foundation, June 10, 2009. Available at www.rwjf.org/files/research/prometheusmodeljune09.pdf.

38 Prometheus Payment, Inc., 2009.

Acute Care Episodes

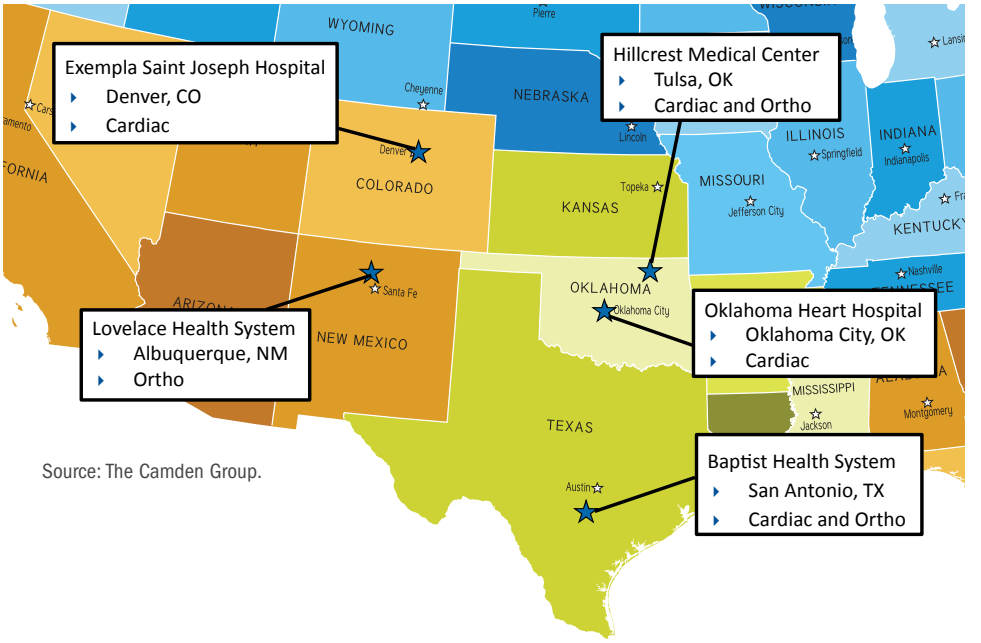
CMS has also developed Acute Care Episodes (ACE), a bundled payment demonstration project that encompasses five hospitals in the Southwest. The current ACE demonstration project includes paying bundled rates specifically for 28 cardiovascular and nine orthopedic DRGs, with other diseases also being considered. ACE combines the Medicare Part A and Part B payments for hospitals and physicians into a single payment, which the providers share. By sharing the payment and potential risk pool, physicians and hospitals must work together to ensure the most efficient care is delivered at the highest quality. Hospitals that have participated in the demonstration project are reporting increased collaboration with physicians to identify cost saving opportunities and improve efficiencies. (See **Exhibit 11**.)

CMS has established its ACE bundles to cover all providers and services across the continuum of care, including skilled nursing, rehabilitation, and home health; thus integrated health systems are well poised to serve as contracting organizations. Other entities interested in participating will need to evaluate the requirements and risks and ensure that they can form strategic partnerships to meet the requirements. The PPACA includes provisions to expand the bundled payment demonstrations scheduled to launch in January 2013.

Bundled Payment for Care Improvement Initiative

The CMS Innovation Center announced its new Bundled Payment for Care Improvement Initiative in August 2011, a voluntary program focused on encouraging acute and post-acute care hospitals and other providers to effectively manage the utilization of services and care delivery costs through collaboration with physicians and providers. With this initiative, CMS has "jump-started" the expansion of ACE-like bundled payment programs. Providers are compensated through either prospective or retrospective bundling, but in effect receive a single "bundled" payment for services provided for an entire episode of care. The main benefit to participation for hospitals is the opportunity to collaborate with physicians to improve quality and reduce costs, without the risk of violating gainsharing regulations, which are being waived for this program. This is a promising model for hospitals to integrate with independent physicians in the community, improve operational performance, and drive down cost. It is possible under this model

Exhibit 11: ACE Demonstration Project Sites

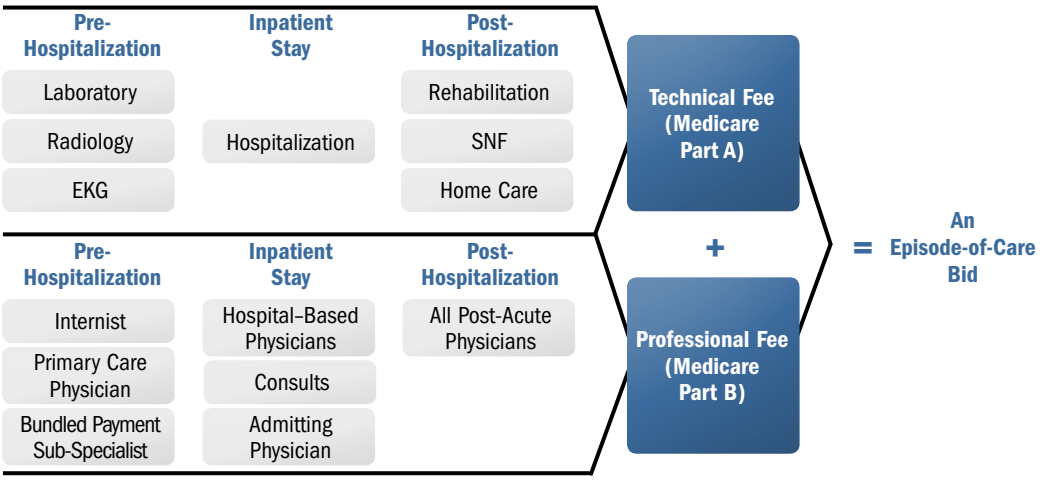


Source: The Camden Group.

to establish bundled prices based on historical readmission rates and improve readmission performance, increasing the shared savings pool.[39]

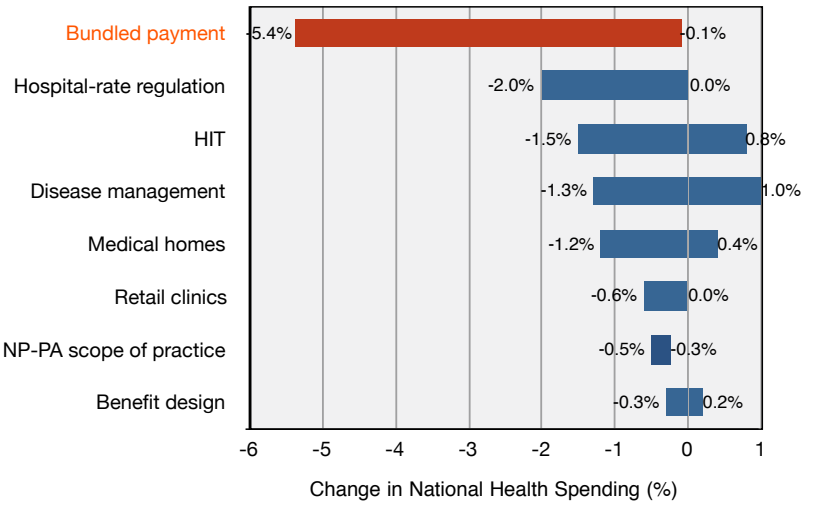
There are several key elements in assembling a bundled payment. The payment must contain both pre- and post-hospitalization technical and professional fees (Medicare Parts A and B) and identify all caregivers in the episode of care and quantify their fees, and the data must be used to contract with independent physicians. (See **Exhibits 12** and **13**.)

Exhibit 12: Assembling a Bundled Payment



Source: The Camden Group.

Exhibit 13: Bundled Payment: Greatest Opportunity to Bend the Cost Curve



Notes: Estimated cumulative percentage changes in national healthcare expenditures, 2010 through 2019. HIT denotes health information technology, NP nurse practitioner, and PA physician assistant.

Source: P. Hussey, et al., *New England Journal of Medicine,* Vol. 361 (2009); pp. 2109–2111.

39 Rob Lezerow, "Top 10 Questions About the Bundled Payments for Care Improvement Initiative," The Advisory Board Company, October 2011.

Commercial payers are also showing interest in contracting for hospital and physician services using a bundled payment methodology to bend the cost curve, and interest continues to increase around the following DRGs:

- Percutaneous coronary intervention
- Electrophysiology procedures (defibrillators and pacemakers)
- Major joint replacement
- Hip fractures
- Coronary artery bypass graft
- Valve replacement
- Congestive heart failure
- Pneumonia

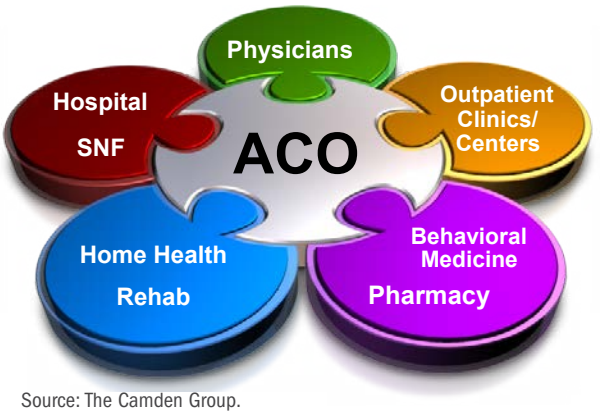
Commercial payers are also showing interest in contracting for hospital and physician services using a bundled payment methodology to bend the cost curve.

Respondents to The Governance Institute survey reported a strong interest in pursuing bundled payments over the next two years, with 69 percent of responding members planning to pursue this payment methodology. While pay-for-performance will remain a strong second, additional models gaining significant momentum include ACO or shared savings, and global payment or capitation.

Accountable Care Organizations

The PPACA's establishment of ACOs has generated considerable excitement around hospital–physician integration, as it calls for a national, voluntary shared savings program involving the collaboration of healthcare providers across the continuum. These collectives of providers assume full responsibility for the cost and quality of healthcare for a defined population of patients. Of The Governance Institute member organizations surveyed for this publication, 57 percent reported that they will be exploring opportunities to engage in ACOs within the next two years, with 25 percent actively pursuing this model now. (See **Exhibit 14**.)

Exhibit 14: Accountable Care Continuum



Source: The Camden Group.

As defined by the PPACA, ACOs are legal entities composed of provider organizations that use primary care physicians and care management processes to efficiently meet the healthcare needs of Medicare beneficiaries. CMS has recognized a number of organizational structures that may be appropriate candidates for participation as ACOs, including:

- Independent physician practice networks
- Medical group practices
- Acute care hospitals that employ ACO-eligible physicians
- Joint venture arrangements between hospitals and professionals
- Critical access hospitals
- Rural health clinics
- Federally-qualified health clinics

Beginning in 2012, providers may qualify to participate in two programs: 1) Pioneer ACO and 2) Medicare Shared Savings Program.

Pioneer ACO

The Pioneer ACO was developed by the CMS Innovation Center and intended for provider organizations that have robust processes of care and the organizational infrastructure and experience necessary to eventually assume responsibility for enrolled Medicare beneficiaries in a population-based payment model. Participating ACOs must meet quality reporting requirements and other organizational requirements of the Medicare Shared Savings Program (SSP). Compared to the SSP, the Pioneer ACO program has higher shared savings and loss rates. It also includes movement to a population-based payment model that comprises 50 percent of the total FFS payment rate. This program is managed by the CMS Innovation Center, which has selected up to 30 organizations across the nation to participate based on their perceived readiness to take on additional risk and larger populations (at least 15,000). (See **Exhibit 15**.)

Medicare Shared Savings Program

The SSP is intended for provider organizations that might have less care coordination and patient management experience but who still have the ability to coordinate care and meet quality reporting requirements. The SSP has two shared savings tracks for ACOs to choose from: Track One offers only upside shared savings; Track Two offers sharing in both the upside savings and downside losses which may be experienced by the ACO through the three years of program participation.

Exhibit 15: First Glance: Shared Savings Program vs. Pioneer ACO

	SSP Final ACO Regulations	Pioneer ACO
Number of ACOs	Between 50 and 270 (expected)	About 30 organizations
Minimum Beneficiaries	5,000 Medicare FFS	15,000 Medicare FFS (5,000 rural)
Governing Body	75% representation from participating members plus beneficiary representative	Similar to SSP plus consumer advocate
Patient Assignment	► Preliminary prospective assignment with final retrospective reconciliation (updated quarterly) ► Prospective assignment: patients initially assigned through physicians who directly rendered primary care services in most recent 12 months	► Prospective and retrospective ► Prospective assignment: based on last three years of FFS claims data, weighted for the most recent year; patients can opt in
Eligible Specialties	► PCPs (first step), any physician, or NP/PA/CNS based on who provided the plurality of allowed charges for primary care services (based on HCPCS codes)	► PCPs plus nephrology, oncology, rheumatology, endocrinology, pulmonology, neurology, and cardiology (for patients with allowable E & M charges of <10%)
Expected Start Date	Potential start dates (minimum 3-year term): ► April 1, 2012 (3 years and 9 months) ► July 1, 2012 (3 years and 6 months) ► January 1 of 2013 and later years	January 1, 2012
Quality Measures	33 measures; overlap with PQRS and other existing quality reporting measures	
Risk Adjustment	Adjusted by HCC scores (initial benchmark plus new individuals)	Adjusted by age/sex on matched cohort
Length of Agreement	Three years or longer	Up to five years if ACO meets certain conditions first two years; otherwise terminated after three
IT Eligibility Requirements	► Meaningful use compliance not a requirement of participation ► EHR measure included in quality data reporting (weighted)	At least 50% of PCPs must meet requirements for meaningful use of EHR for receipt of payments through the Medicare and Medicaid EHR incentive programs
Physician Exclusivity	Physicians with dependent beneficiary assignments must be exclusive.	Physicians with dependent beneficiary assignments must be exclusive
Payment Arrangement	► Shared savings, years 1–3 ► One-sided option: shared savings only ► Two-sided option: shared savings and losses ► Share in first dollar savings/losses after minimums met ► FFS payment only	► Shared savings with two-sided risk in period 1–2, partial population-based payment in period 3 ► If minimum savings thresholds are achieved in periods 1 and 2, transition from FFS to population-based payment in period 3 ► Share in first dollar savings/losses after minimums met
Limits on Financial Risk	Exclude beneficiary expenditures above the 99th percentile national per capita expenditures	

Source: The Camden Group.

Current State of Development

Throughout 2011, CMS sought the input of stakeholders to the initial draft regulations for ACOs, releasing their final rules in October and setting the stage for formal applications to CMS in January 2012. Across the U.S., commercial insurance payers in particular markets are supporting the development of ACO-like organizations for commercially insured populations through partnerships, development grants, infrastructure development support, and by contracting with such entities through pilots for shared savings and population management initiatives. Commercial ACOs will differ in terms of the clinical needs of the populations under contract, the approach to patient attribution, which may be very contract-specific, and the level of risk or shared savings opportunity determined between the payer and the organization. However, commercial payers are cognizant that the infrastructure, analytic capability, and considerable reporting requirements established under CMS regulation should be leveraged to support the mirror priorities for quality improvement, patient satisfaction, and cost reduction non-public insurers value.

Blue Cross Blue Shield of Massachusetts led the way with the development of their Alternative Quality Contract (AQC). Under the AQC, physicians and hospitals contracted together as a "system" to control cost growth and improve quality, safety, and outcomes. The "system" of providers negotiated a global payment for care provided across the continuum and incentives were used to eliminate clinically wasteful care.[40] Many of the features put in place under the AQC have prepared network providers well for the move to ACOs.

In 2010, Blue Cross Blue Shield of Illinois, the state's largest health insurer, and Advocate Health Care, one of the nation's top 10 health systems, signed an agreement that holds the health system accountable to established performance measures and quality outcomes. The agreement established a shared risk pool in which Advocate's physicians and hospitals will share in savings resulting from improved care at reduced costs. According to Dr. Lee Sacks, Advocate's chief medical officer, "By innovatively collaborating with health insurance companies…we will be able to afford the infrastructure investments and incentives for physicians to better coordinate care across the continuum. This will allow for elimination of waste and inefficiency found in more traditional approaches to care delivery."[41]

Medicaid

The Medicaid program is also undergoing a transformation to contain escalating costs, support increased enrollment, and prepare for the expansion of low-income beneficiaries predicted for 2014 under the PPACA legislation. States are increasingly worried about the cost of care for the increase in the Medicaid population and are implementing cost containment measures. The National Association of State Budget Officers' 2009 State Expenditure Report estimated Medicaid spending in fiscal year 2010 at $354 billion, representing the largest component of state spending, higher than elementary and secondary education.[42] In response to these pressures, states are considering a number of options, including freezing or reducing provider payments, with an estimated 33 percent of states having implemented rate restrictions in their 2012 budgets.[43]

Additional methods for cost containment include expansion of the Medicaid managed care programs, the use of the medical-home model for patients with chronic conditions, bundled payments for management of chronic disease, decreased utilization through increased copayments on beneficiaries, restrictions on prescription drugs, and a reorientation of long-term care from institutions to community-based settings.

Many states are pursuing Section 1115 Medicaid Demonstration Waivers to make program changes that are not otherwise allowed under federal Medicaid law. States with existing waivers are implementing programs focused on provider payment reform targeting individuals with disabilities or special healthcare needs.

Medicaid 1115 Waiver: Waivers are vehicles that states can use to test new programs and healthcare delivery mechanisms under the Medicaid program. States can apply for program flexibility that meets their state's healthcare goals.

40 Christopher Collins, *Alternative Quality Contract,* Blue Cross Blue Shield of Massachusetts. Available at www.ehcca.com/presentations/hosppayreform1/collins_2.pdf.

41 Bruce Japsen, "Blue Cross, Advocate raise bar on accountability," *Chicago Breaking Business,* October 6, 2010.

42 The National Association of State Budget Officers (NASBO), Medicaid Cost Containment: Recent Proposals and Trends, April 13, 2011.

43 NASBO, 2011.

Children's Hospitals

The healthcare reform bill included several provisions that expand comprehensive health coverage for children, insuring up to 95 percent of all children in the U.S. Short-term gains in Medicaid payments to primary care physicians for preventative care may be overshadowed by higher-than-expected costs of expanding access to care to new populations. The potential to positively affect children's healthcare is significant but will be contingent on the ability of states and local communities to implement new models of cost-efficient care delivery.

While much of the attention around ACOs has focused on Medicare and an aging adult population, pediatric ACOs are being launched across the country. Children's hospitals are looking for ways to align with pediatricians and specialists to enhance care coordination in the movement towards value-based care.

Pediatric Medicaid ACOs, similar to those established under the Medicare ACO pilot program, are in development in participating states. The Medicaid pilots provide incentives to participating providers to reduce expenditure growth while improving the outcomes of a defined population. Providers must demonstrate the ability to care for the overall health of a defined population, have a legal structure in place to obtain and distribute shared savings, and promote patient-centered care and evidence-based medicine.[44]

California Children's Services (CCS), a program that provides diagnostic and treatment services to children with chronic medical conditions, has initiated four pilot demonstration programs with California children's hospitals that began on on January 1, 2012. Models range from a focus on outpatient care through a primary care case management model with incentives for inpatient care to an ACO model in which eligibility is determined by defined health conditions. CCS will monitor the pilots to determine such factors as improvement in care coordination, quality of care provided, patient and provider satisfaction, and the growth rate of expenditures.

Other pediatric ACOs across the country have created structures to align incentives between hospitals, employed and independent community physicians, and health plans. In all cases, the pediatrician is playing a central role in the development of primary care medical homes, clinical protocols, governance, and incentive distribution models.

Federally Qualified Healthcare Center (FQHC): An FQHC is a non-profit entity whose primary objective is to provide care to the uninsured or underinsured in medically underserved areas (MUAs) or medically underserved populations (MUPs). FQHCs are paid by Medicare and Medicaid on a cost-basis and are eligible for federal and private grant funding. FQHCs often serve as safety net providers for their communities.

FQHC and Community Clinic Involvement

FQHCs and community clinics are teaming up with hospitals and integrated healthcare systems to help systems reduce costs and expand their primary care coverage. Major elements of the PPACA legislation was designed to include a larger role for primary care providers, improve care coordination among providers through the use of electronic medical records, and increase patient involvement in the care they receive. The ability of FQHCs and community clinics to effectively manage the low-income, uninsured, and underinsured population is of significant benefit in managing the total healthcare dollar and future expenditures as this population is often at risk for adverse outcomes and often contribute to a significant portion of emergency room visits. Hospitals and health systems are partnering with FQHCs and community clinics as part of ACOs and other demonstration projects towards this end.

The legislation also provided $11 billion in funding to community clinics that operate as FQHCs, which represents a 500 percent increase, to be used to increase primary care services and support the medical home model for the uninsured.[45] FQHCs receive cost-based reimbursement, which allows them to implement many of the elements of the medical home model that are not currently reimbursable by public or private payers, including case management, social services, and psychiatric support. FQHCs have also been able to tap into grants and hospital sponsored clinical integration strategies to implement EMRs that promote care coordination across the continuum.

On June 6, 2011, CMS launched the Medicare FQHC Advanced Primary Care Demonstration Project. The demonstration project is being piloted in 500 health center sites across the country with the goal of transforming these sites into an NCQA Level 3 Primary Care Medical Home by the end of three years. The project will evaluate the impact of the advanced primary care practice model on the accessibility, quality, and cost of care provided by FQHCs.

The degree to which risk-based reimbursement requires boards, CEOs, and physician leaders to integrate strategy and operations is unprecedented.

44 California Department of Health Care Services, "California Children's Services Demonstration Projects Request for Proposal," November 3, 2011 (Web page), www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/OMCPccsDemoRFPHome.aspx.

45 Gary Lewins, "Physician Integration: the Community Health Center Collaboration Option," *hfm,* Vol. 65, No. 1, January 2011; pp. 72–76.

Patient-Centered Medical Home

The current conversation about value-based patient care models is focused on ACOs, bundled payment, and clinical integration. However, long before these models came into prominence, patient-centered medical homes (PCMHs) were being developed as a response to a fragmented healthcare delivery system, especially for patients with chronic diseases.

The PCMH is a primary care model designed to deliver comprehensive and coordinated care to patients of all ages. The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In 2007, the American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association teamed up with the AAP in endorsing the concept and issuing joint principles of the patient-centered medical home.[46] The principles include:

- Each patient has an ongoing relationship with a personal physician.
- The personal physician leads a team of individuals who collectively take responsibility for the care of patients.
- The personal physician cares for the "whole person" and is responsible for providing for all of the patient's healthcare needs or appropriately arranging care with other qualified professionals.
- Care is coordinated across the entire healthcare system.
- Quality and safety are hallmarks of the model.
- Enhanced access to care is available.
- Payment appropriately recognizes the added value provided to patients.

Because quality and safety are key underpinnings of the PCMH model, evidence-based protocols and information technology to support clinical decision making are used to ensure patients receive timely and appropriate care. In addition, patient involvement is seen as vital to obtaining optimal outcomes.

Patient involvement is fostered through the use of care plans and education as well as offering a variety of ways to interact with the care team. Enhanced access, through both face-to-face visits and other electronic means, such as secure email and patient portals, is also essential to the PCMH. By allowing patients to interact with their provider how and when they would like, it is more likely that patients will be engaged in their care and maintain a strong relationship with their care team.

Several organizations have developed accreditation or recognition processes that evaluate physician practices according to the joint principles. In recognition of the additional care coordination time and technology investment needed, physician practices designated as patient-centered medical homes are often eligible for enhanced payments from payers. This payment may be in the form of higher fee-for-service rates, or they may receive a separate care coordination fee based on the number of patients in the medical home.

One such program is the National Center for Quality Assurance's (NCQA) Primary Care Medical Home Recognition Program. This program emphasizes systematic use of patient-centered, coordinated care management processes. Practices that achieve recognition are posed to receive bonuses from payers and employers. NCQA has established three levels of recognition based on 10 must-pass elements. Level 1 recognition requires compliance with at least five of these elements, while Level 3 requires compliance with all 10. The elements are included in nine standard categories including access and communication, patient tracking and registry functions, care management, patient self-management and support, electronic prescribing, test tracking, referral tracking, performance reporting and improvement, and advanced electronic communication.[47]

Payers are willing to provide increased reimbursement because data shows that medical homes do a better job of reducing emergency department utilization and preventing admissions than conventional practices, especially for patients with chronic diseases. A 2010 Harvard Medical School study of seven prominent medical homes across the country showed reductions in hospitalization up to 19 percent and reductions in ER utilization up to 29 percent.[48]

46 Patient-Centered Primary Care Collaborative (www.pcpcc.net).

47 National Center for Quality Assurance, PCMH brochure. Available at www.ncqa.org/Portals/0/PCMH%20brochure-web.pdf.

48 D. Fields, E. Leshen, and K. Patel, "Driving Quality Gains and Cost Savings through Adoption of Medical Homes," *Health Affairs*, Vol. 29, No. 5, May 2010; pp. 819–27.

Global Payment and Capitation

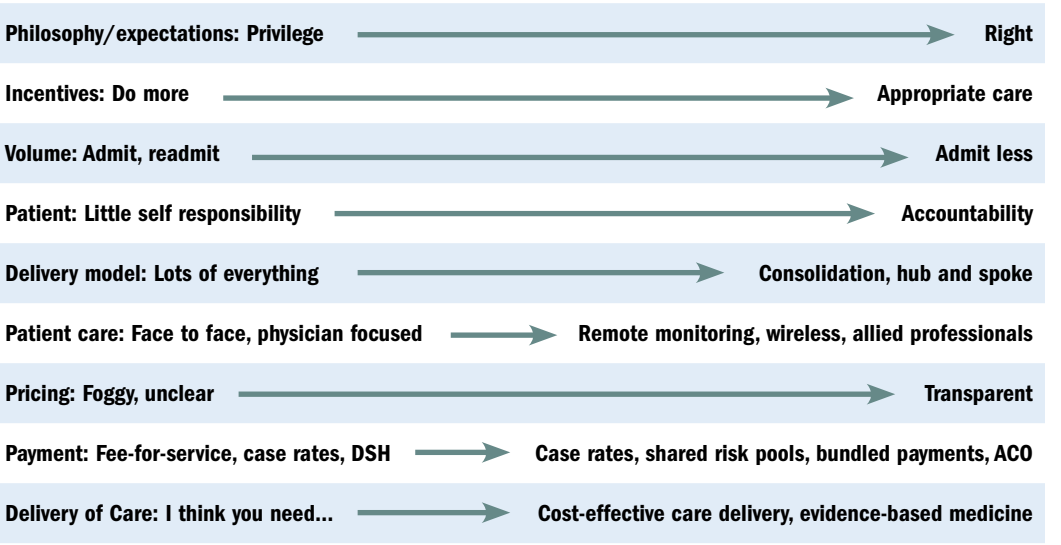
Another model that is gaining momentum and creating renewed interest is the next evolution of capitation: global payments.

Simply defined, global payments represent fixed-dollar payments for the care that patients *may* receive in a given time period. The goal of global payments is to reduce the use of unnecessary services and encourage coordination of services among providers, the result being reduced costs and improved quality. Global payments essentially establish a "budget" for healthcare services, which serves to place providers at financial risk for both the occurrence of medical conditions as well as the management of those conditions.

The concept of global payments is not new and currently exists in the form of capitation arrangements in many parts of the U.S. Proponents argue that global payment models will align incentives and promote a focus on cost and quality. In addition, many feel that global payments will reward healthcare providers for keeping their patients healthy rather than for reacting to their ailments.

However, others feel that global payments could incentivize providers to withhold necessary care and to avoid patients with chronic conditions. Global payments also require advanced administrative and technical capabilities to effectively manage payments and financial risk, putting smaller providers at a major disadvantage (or preventing them from participating at all). (See **Exhibit 16**.)

Exhibit 16: Paradigm Shift of Payment Reform



Source: The Camden Group.

The California Experience

California is home to a global payment and capitation model that has unique characteristics not seen in other parts of the U.S. This payment model developed during the rise of managed care in the 1980s and has helped contributed to the growth of large physician organizations throughout the state. First and foremost, the California model is different, in that capitation remains a widely used reimbursement model, while in other parts of the country capitation has faded or never took hold to begin with. Furthermore, capitation in California differs from other capitation models: in California, a majority of the managed care functions have been shifted from the health plans to physician groups. In this delegated risk model, large medical groups and independent practice associations (IPAs) often accept full or global risk for patients and are responsible for care management and network development functions more commonly found in health plans in other parts of the U.S.

Many see California's delegated risk structure as a model for new payment methodologies that pay physicians for proactively managing a population, rather than paying on a fee-for-service or volume-based methodology. Physician organizations in California have developed more robust care management resources that are being promoted in new care models such as the patient-centered medical home and ACOs.

Requirements for Success

For organizations to be successful in a shared savings program, senior executives need to objectively assess their organizations, prioritizing their clinical reform and infrastructure development activities with an eye to what their competitors are doing in their markets. Areas of assessment include:

- Organizational comfort with managing risk
- Integrated clinical management infrastructure (e.g., care management capability)
- Engaged physician leadership; ability to influence outcomes across the continuum of care
- Effective health information management capability including the ability to deliver, track, and document patient-centered, evidence-based care provision at the point of service
- Aligned, broad delivery network of providers with a strong primary care base who are able to participate in/connect to the IT network of the ACO (or other clinically integrated organization)

If considering global risk or partial or full capitation, in addition to shared savings factors, leaders need to assess whether their organizations have:

- Proven ability to manage risk
- A population base large enough to spread risk
- Infrastructure in place and deployed to impact quality and cost

Key elements of reform are in process, most notably forays into bundled payment, narrow network health plan products, ACOs, and value-based purchasing activities.

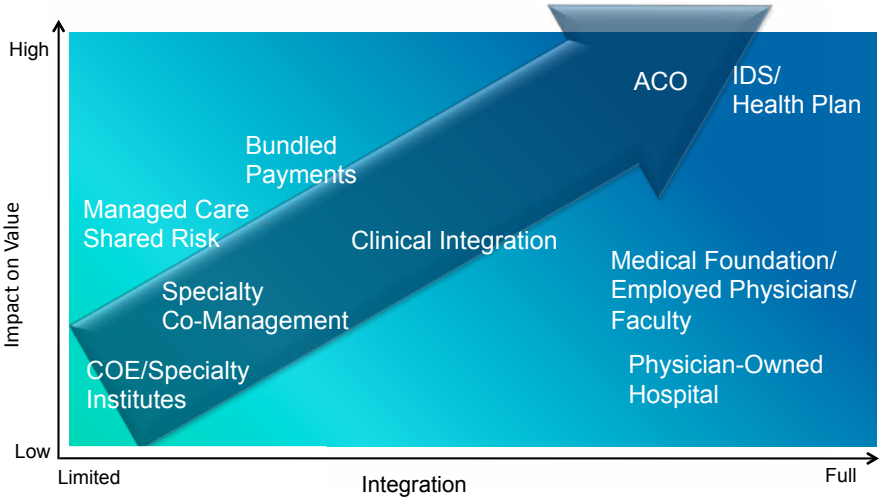
Key Considerations for Board Members

- It will be important to stay current on the continuous evolution of payment reform. Is your board receiving regular updates on CI and care redesign processes and effectiveness?
- Key elements of reform are in process, most notably forays into bundled payment, narrow network health plan products, ACOs, and value-based purchasing activities. What steps are you taking to prepare for bundled payment? Have you explored participation with Medicare versus commercial payers and determined which opportunity best fits your organization and physician partners?
- If you do not have experience managing population risk, start small by evaluating shared-risk hospital pools and creating narrow network health benefits for your employees. Do you know your organization's capacity to manage risk? Are you evaluating ways to manage risk with a small population such as your employee health benefits?

III. MODELS AND STRUCTURES FOR HOSPITAL–PHYSICIAN INTEGRATION

The traditional medical staff model is being redefined to accommodate the changing landscape; physician employment models are being reconsidered as necessary strategies, and emerging alignment models such as co-management arrangements, clinical integration (CI), and ACOs are coming to the forefront. Emerging payment models are driving the need for new hospital–physician alignment models or redesign of those used historically. **Exhibit 17** outlines many of the approaches to hospital–physician integration, with a focus on the level of hospital–physician integration required for each and the expected impact on value (which incorporates both cost and quality of care).

Exhibit 17: Hospital–Physician Integration: Driving the Value Proposition



Source: The Camden Group.

Traditional Models of Hospital–Physician Integration

The Traditional Medical Staff

Historically, hospitals have relied on voluntary physician relationships represented by the traditional medical staff model, which was developed during a time when physicians and hospitals were largely independent of each other. The medical staff structure respected the independence of the medical staff while allowing physicians to influence hospital decisions affecting the care of patients. The medical staff is specifically charged with ensuring the credentialing and recredentialing of its physician members, evaluating clinical performance, offering educational opportunities to the medical staff, and providing input on clinical issues to the governing board and administration of the hospital.[49]

As medical practice shifted to ambulatory settings, physicians became less connected to the hospital on a daily basis, and as physicians began to look for new revenue sources outside their practice, this increased the competition between physicians and hospitals. Physicians began to seek compensation for services (e.g., emergency department call coverage, medical directorships) traditionally provided as part of their medical staff duties and were less willing to accept responsibility for unassigned patients that presented to the emergency room.

Hospitalist programs emerged in in the 1990s in response to primary care physicians (PCPs) wishing to focus on outpatient care, the need to provide coverage for unassigned patients and the emergency department, and changing hospital reimbursement. Hospitalist programs began to evolve and expand their focus in improving the quality of inpatient care. They also serve as a recruitment and retention tool for community PCPs no longer interested in the management of inpatients.

According to the Society for Hospital Medicine, there are over 30,000 hospitalists practicing in 3,300 large hospitals and over half of all community hospitals.[50] However, shifting inpatient responsibility away from PCPs often created breakdowns in communication and patient management; hospitalist programs also facilitated further distancing of primary care from the hospital, including less participation in medical staff committee and leadership roles. In recognition of the need to reconnect outpatient and inpatient care to improve quality and patients' health, emerging payment models are beginning to look at opportunities to realign hospitalists and PCPs along this continuum.

Further, as the economics of medical practice have put the pressure on physicians to increase productivity in their practices in order to maintain or increase income, time has become their most precious commodity. Time required for medical staff meetings has been sacrificed in order to focus on the practical requirements of maintaining a strong private practice.

Consequently, hospitals have had to seek other means in order to align with physicians. With the renewed focus on quality and efficiency and their impact on payment, hospitals are seeking more effective ways of working collaboratively with their medical staff.

The Traditional Medical Staff

Traditional hospital medical staffs are established as independent structures within a hospital and are currently required for licensing by the Medicare Conditions of Participation for hospitals and The Joint Commission. The medical staff is governed by bylaws through a distinct organizational structure. Traditional medical staffs are operated by a medical executive committee (MEC), which serves as the staff's executive committee and is empowered to act on behalf of its membership. The MEC is responsible to ensure self-governance of the medical staff and the quality of professional services provided.

Physician Employment

Economic interests in the 1990s demanded greater alignment between hospitals and physicians, and hospitals turned to strategies that required greater integration to manage care under a capitated environment. As hospitals faced the need to recruit and retain physicians to address physician shortages and ED coverage issues, gain market share, and respond to physicians in economically fragile groups, they increasingly turned to physician employment. Further, during this period of time, the expansion of publicly traded physician practice management companies (PPMs) created increased demand for medical practices. With the public markets rewarding growth, the PPMs were motivated to acquire practices as quickly and as broadly across the country as possible. This

49 Richard E. Thompson, "Re-forming the Traditional Organization Medical Staff," *Physician Executive,* April 1995.

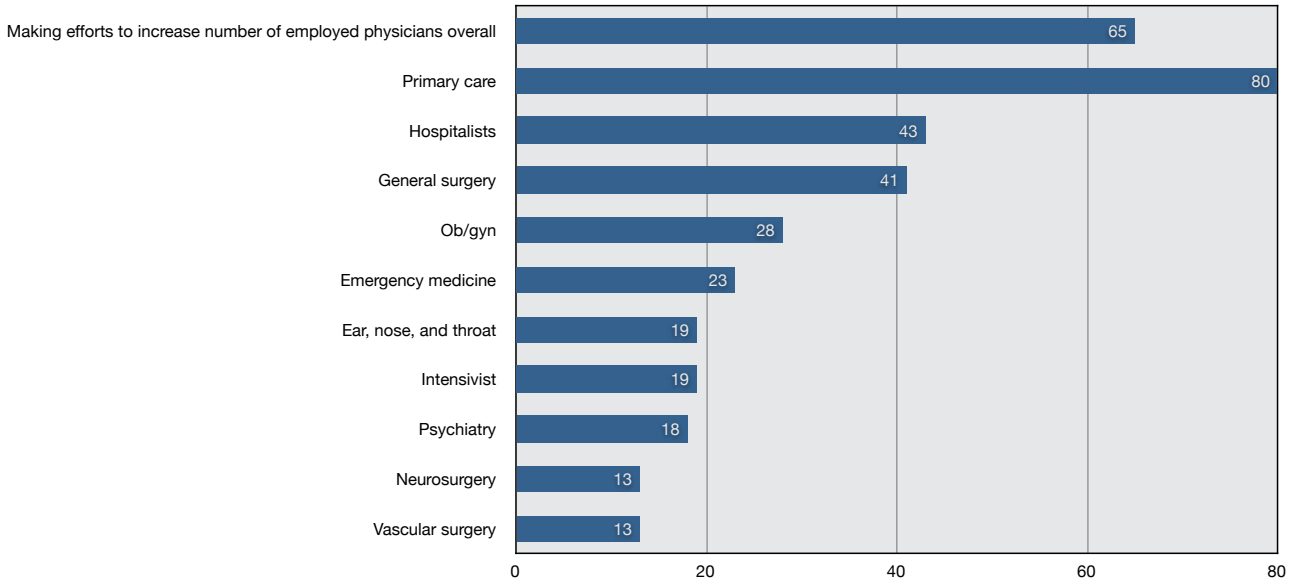
50 Society of Hospital Medicine, Philadelphia, PA, "The Society of Hospital Medicine Fact Sheet," updated July 2010. See www.hospitalmedicine.org.

created a "bubble" of increased physician practice value, since local hospitals did not want their physicians to be absorbed by an outside party that might disrupt their relationships. Hospitals were competing in this market for physician practices with not only their local competitors, but these national companies as well.

However, hospitals had mixed success with the employment model. Because of intense competition for physicians, purchase prices were often high, which ultimately required "write downs" in later years. Physicians were often salaried, which undermined the need for productivity. Additionally, hospitals often underestimated the expertise required to manage their employed physicians and increased practice overhead as they moved practice support staff to the hospital's higher salary and benefit systems. These actions often contributed to significant losses of $100,000 or more per year.

The expansion of capitation never really took place as predicted in many markets across the country. The PPM industry imploded, as the pace of growth outstripped the infrastructure required for successful practice management. Hospitals found themselves with underperforming practices, for the reasons identified above, in a market that no longer demanded the same degree of integration. As a result, in the early 2000s, many hospitals divested themselves of their medical groups. Those who persevered now have robust employed medical groups that provide an effective platform for the physician integration required for success in today's changing healthcare environment. Hospitals that "disassembled" their employment model a decade ago are now returning to physician employment to help them address the need to recruit to fill shortages in specialty and primary care and achieve the collaboration required to achieve improvements in quality and efficiency. Merritt Hawkins, a physician search firm, recently reported that physician searches for hospital employment settings grew from 23 percent in 2005/2006 to 51 percent in 2009/2010.[51] (See **Exhibits 18** and **19**.)

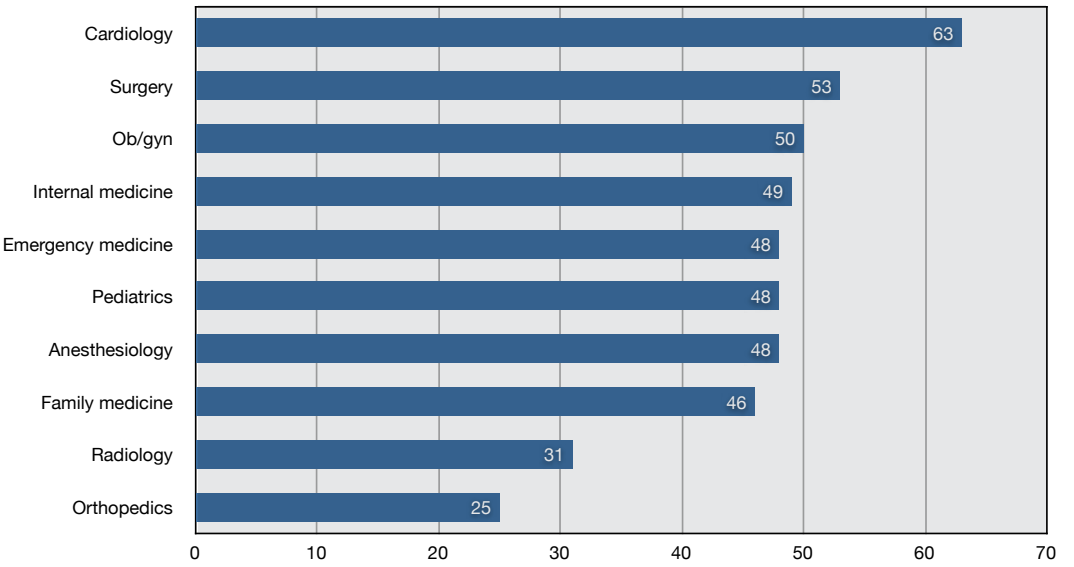
Exhibit 18: Percentage of Hospitals Increasing the Number of Employed Physicians by Type



Source: AHA Rapid Response Survey, *"Telling the Hospital Story Survey,"* March 2010.

51 Merritt Hawkins, *Review of Physicians Recruiting Incentives,* Summary Report 2010.

Exhibit 19: Physician Interest in Employment by Specialty, 2010 (%)



Source: PricewaterhouseCoopers, Health Research Institute Physician Survey, 2010.

Physicians are becoming increasingly interested in selling their private practices and becoming employed by hospitals, health systems, or payers. These options are becoming more attractive to physicians as they look for increased stability in an uncertain healthcare environment; access to healthcare IT, facilities, and equipment; opportunities to reduce the administrative burden of operating a practice; or to obtain a more manageable work week. Key differences in generational groups of physicians are also affecting how and why physicians engage in alignment strategies with hospitals, including employment. With the Traditionalist and Baby Boomer generations in retirement or heading towards retirement, hospitals will need to understand the attributes that make up Generation X and Y and how they differ from their predecessors. As can be see from the characteristics described in **Exhibit 20**, Generations X and Y are much more interested in work/life balance, which makes employment an attractive option.

Exhibit 20: Characteristics of Generational Groups of Physicians

Generation	Born	Characteristcs	Impact on Healthcare System
Traditionalist	1925–1945	Hardworking, respects authority, values personal accountability	Loyal to organizations, demand respect and appreciate hierarchical structures, retiring
Baby Boomer	1946–1964	Work-centric, independent, goal-oriented	Strong desire for leadership roles, responsive to hospital administration, transitioning to retirement
Generation X	1965–1976	Individualistic, technologically adept, flexible, value work/life balance	Expectation for improved technology and resources, values timeliness of results, looks to avoid medical politics, looking for positions with income security
Generation Y	1977–1996	Family-centric, achievement-oriented, team-oriented, looks for validation	Technology is essential, requires work/life balance, increased opportunities in non-healthcare industries, focus on job versus long-term career

Source: The Camden Group.

Employment Models

There are a number of models used by hospitals to employ physicians. Under direct employment, the physicians and hospital are considered a single entity. Hospitals can also create a separate entity to employ and manage the medical group. Foundation models are used in states with corporate practice of medicine laws that prohibit the direct employment of physicians, as well as by those systems preferring to establish a separate entity to house the "physician practice enterprise." Foundations are typically created as separate, not-for-profit affiliates of a hospital or health system and, in most cases, qualify for tax-exempt status, provided the foundation adheres to certain criteria, such as a restriction of no more than 20 percent representation by physicians on its governing board.[52] (See **Exhibit 21**.)

In California, where regulations generally ban direct employment of physicians by hospitals, foundations must meet statutory requirements that tend to favor larger hospitals and health systems: the not-for-profit foundation must contract with a group or groups comprising a minimum of 40 physicians, at least two-thirds of whom are full-time, and include at least 10 board-certified specialists who participate in research and education sponsored by the foundation. Community hospitals, rural hospitals, and specialty hospitals are now looking towards the development of joint medical foundations to support a physician employment model. Foundation bylaws and corporate membership agreements clearly define the roles of the member hospitals including board composition and structure. (See **Exhibit 21**.) In other states, where the regulations are less restrictive, foundations may be established to focus organizational resources and management on the physician enterprise.

For academic medical centers (AMCs), faculty practice plans (FPPs) are integral components with a three-fold mission of research, teaching, and clinical care. The role of an FPP is to provide billing, collections, revenue distribution, and financial services to the full-time teaching faculty of an AMC. FPPs can be organized as defined entities within the parent organization, hospital, or medical school, or as independent legal entities.

Exhibit 21: Hospital Employed Medical Group vs. Independent Entity

	Direct Employment	Separate Physician Entity
Ease of establishing a medical group	Does not require a new legal structure and can be integrated into existing human resource processes.	New legal entity must be created; requires an effective physician leader to develop the entity and recruit physicians.
Setting performance metrics and productivity goals	May be complicated by data-gathering capabilities of hospital systems and personnel requirements that allow little flexibility; however, can be easier to align incentives since all are within one organization.	Given the physician-driven focus of the entity, it is easier to establish physician-specific metrics; systems to gather and track data are designed to meet practice needs so data may be more readily available.
Consistency with compensation arrangements	Hospitals may have a harder time maintaining consistency, depending on their relationship with the employed physicians, competing demands within the hospitals, and the experience and strength of the practice manager.	Consistency may be easier to achieve since there is less distraction by demands that are unrelated directly to physician compensation.
Development of physician leadership	Hospitals may have more opportunities to develop leaders given the availability of both the medical staff and group structures.	Opportunities for leadership positions may be more limited and may be more difficult to align leadership goals between the hospital and physician entity when competing interests arise.
Managing physician expectations	Can be more difficult as hospital structures can be more cumbersome, requiring a more involved approval process and more time to reach decisions.	Occurs more rapidly, as the structure is nimble enough to respond quickly and meet expectations.
Ability to manage practice expense	Generally more difficult for hospital system because cost structure is generally higher.	Provides greater flexibility to create manageable cost structure based on revenue generated by the physician enterprise.

Source: The Camden Group.

52 Michael W. Peregrine and Louis D. Glaser, "Choosing Medical Practice Acquisition Models," *hfm*, Vol. 49, Issue 3, March 1995.

Historically, FPPs have funded clinical care through teaching and research revenue, but as funding of these areas has decreased, FPPs are now required to look for new ways to increase clinical revenue and improve operational efficiencies. FPPs are reconsidering traditional models of governance and are looking for new alignment opportunities that better balance the needs of faculty with the needs of the medical center. Further, FPPs are evaluating new models for alignment with community physicians. This includes expansion of clinical faculty to include more employed community physicians as part of the FPP, but it also may include establishing new relationships and structures with community physicians, such as those created by Partners Healthcare in Boston with their Partners Community Healthcare, Inc. network of physicians.[53] This network allowed the academic practices associated with Harvard Medical School and its affiliated academic medical centers to establish a linkage to community physicians through a management services organization (MSO) that provides support to private practices covering more than a million patients.

Hospitals and systems that achieve success with the employed model, regardless of structure, recognize the need for experienced practice managers and establish more realistic financial relationships and cost structures. Hospitals that are not successful fail to recognize the differences in operating physician practices and lack core competencies in practice management. In the past, hospitals often rushed to acquire medical groups as a defensive strategy without a long-term plan based on realistic projections of volume and expenses required to manage the practice. Hospital financial systems, including cost accounting and budgeting, were used to track performance and establish performance targets but were often incapable of effectively measuring or monitoring those factors critical to success for physician practices. In addition, hospital cost structures, including wages, benefits, facilities, and overhead were significantly higher than a traditional medical group, which inflated the cost of doing business.

Hospitals also made the error of employing physicians on salary, not recognizing the clear link between the number of patients seen and a physician's net income. Successful systems have established sustainable physician compensation models that align and incentivize behaviors that contribute to both physician and organizational success; they also recognize the need to frequently reevaluate their models to ensure that they continue to appropriately align incentives to achieve organizational goals. In the last 10 years, physician compensation models have trended largely towards productivity-based models, based on work relative value units (wRVUs).[54] With the movement towards value-based care, organizations are starting to integrate quality metrics as a percent of total compensation, though that percentage still remains relatively low. Organizations will face challenges in moving physicians from productivity-based plans to outcomes-based arrangements until reimbursement moves from the traditional FFS model to new models based on outcomes. Organizations will need to move physicians to new compensation plans gradually as the ability to monitor and report on outcomes improves and reimbursement models change.

Hospitals and systems that achieve success with the employed model, regardless of structure, recognize the need for experienced practice managers and establish more realistic financial relationships and cost structures.

Joint Ventures

As physicians sought new avenues of revenue growth and branched into traditional services provided by hospitals, hospitals began to enter into joint ventures with medical staff members, including ambulatory surgery centers (ASCs), acquisition of equipment, imaging centers, medical office buildings, cancer centers, and other specialty-driven services such as radiation oncology, partially to preempt physicians from establishing competing entities. There also has been considerable growth in physician-only joint ventures, but as a result of the poor economy, declining reimbursement, tight capital markets, and uncertainty with healthcare reform, physicians are now beginning to sell their ancillary services businesses or reconsider venture relationships with hospitals and health systems. Hospital joint ventures offer physician-owned businesses security from regulation changes, an opportunity to improve IT connectivity, an increased ability to respond to quality reporting requirements, and more opportunities to participate in new payment models such as CI and ACOs.

Joint ventures have had mixed success. While some were profitable, others were less successful. A number failed because the primary reason for the joint venture was to maintain physician allegiance and the business model was flawed. Others failed because of poor management or changes in

53 Partners Community Healthcare, Inc. (www.partners.org), accessed January 15, 2012.

54 Cat Vasko, "Physician Compensation: New Complexities and Trends," *ImagingBiz,* May 12, 2011.

reimbursement, while others did not succeed because the partners could not agree on how to run the business, or some partners felt disenfranchised. Because failed joint ventures often created increased tension with hospital medical staff members who were part of the joint venture, many hospitals have become less interested in pursuing a joint venture strategy, and physicians often have felt they would be more successful without a hospital partner.

In addition, as the number of joint ventures escalated, federal and state governments became concerned about the potential for abuse, so laws and regulations were implemented to restrict these relationships, and some joint ventures had to be discontinued. There has been significant debate over the years about whether physician-owned hospitals (POHs) adversely select the healthiest patients with the best forms of reimbursement or, as proponents argue, provide quality care at a lower cost by offering another form of competition to community-based hospitals.[55] It is this debate that led to the inclusion of provisions in the PPACA that resulted in the moratorium on the creation of new POHs and limited expansion of existing POHs, as of December 31, 2010. The PPACA restricts the expansion of existing POHs by implementing stringent criteria in expansion submission requests, which can only be submitted once every two years. In addition, a cap on the physician ownership percentage restricts further syndications to raise funds for new capital projects.[56] However, there are still more than 200 physician-owned hospitals in the U.S., including general acute care, multispecialty, rehabilitation, long-term care, cardiac, and orthopedic hospitals that were developed before the ban.

For many, the equity model, in which the physicians and hospital each own equity in the venture, and the physicians use the facility or services as an extension of their practice,[57] still remains a viable physician alignment approach. Given the changes in payment models, however, the current trend for joint ventures is to focus on quality standards and market capture. Organizations can create gainsharing relationships through effectively structured joint governance models with physicians and the incorporation of quality measures, monitoring, and carefully organized incentive pools. As can be seen in **Exhibit 22**, joint ventures are still increasing in a number of key areas because success is still possible in the current environment.

Exhibit 22: Recent Trends and Environmental Factors Affecting the Joint Venture Sectors

	Ambulatory Surgery Centers	Imaging Centers	Management Services Organizations	Cancer Centers
Environmental Factors	► Changes in ASC reimbursement may prompt further desire for partnerships or sale to mitigate potential revenue impact	► Decreases in imaging reimbursement are prompting physicians to sell existing ventures	► Difficult to generate profits since revenue comes from serving physicians who are often price-sensitive	► Often part of centers of excellence, co-management, or bundled payment strategies ► Movement to value-based reimbursement may open up new opportunities
Trends	► Health systems purchasing ASCs to increase market share ► Rise in joint ventures with anesthesia providers ► Increased mergers and consolidation among existing ASCs, and ASC management firms	► Hospital acquisition of imaging centers and establishment of outpatient off-site centers ► Increase in mergers and consolidations among existing imaging centers ► Rise in merger and acquisition activity in the teleradiology sector ► Increase in merger of radiology group practices*	► Primarily used as retention strategy for independent physicians	► Increased joint ventures between cancer centers and radiation oncology services ► Rise in joint ventures between medical centers and affiliated physicians to form new cancer centers

*Douglas G. Smith, "Trends in Mergers and Acquisitions in the Diagnostic Imaging Sector," *ImagingBiz*, June 12, 2008.

Source: The Camden Group.

55 Eric M. Peterson, "An Endangered Species: Physician-Owned Hospitals," Dorsey & Whitney LLP, January 28, 2010.

56 Jason Greis, "Exploring the Adverse Impact of Federal Healthcare Reform on Physician-Owned Hospitals," *Greis Guide to LTACHs*, (greisguide.com), April 1, 2010.

57 Beth Guest and James Mathis, "Innovative Strategies for Physician-Hospital Alignment," *HealthLeaders Media*, August 11, 2008.

Regardless of the specifics of the joint venture, the critical success factors for any joint venture continue to be the same:

- A well thought-out business model with clearly defined goals and financially sustainable model
- Effective governance in which all parties (physicians and hospitals) feel their voice can be heard
- Strong, experienced management that understands the business of the joint venture and are allowed to manage

The New Landscape: Transition to Value-Based Organizations

Value is rapidly becoming the new measure for success in healthcare reform and is driving the strategies that are emerging to integrate providers. Professor Michael E. Porter, Ph.D. of Harvard Business School defines value as "the health outcomes achieved divided by the total costs for the full cycle of care." In essence, value is created from the efficient achievement of good health outcomes and is not derived from the individual services provided.[58] This new landscape of hospital–physician integration is markedly different from previous attempts because the major emphasis and rewards focus on the health outcomes achieved for individuals and populations as a whole. Previous attempts at integration have resulted in project-by-project and point-in-care improvements but may not be sufficient to meet the evolving demands of patients, employers, communities, and regulators into the future. To meet these demands, physicians and hospitals need to fundamentally change the way they work together in order to motivate both groups to achieve the desired results.[59] Co-management, CI, and ACOs are integration models that, if structured correctly, can shift the purpose from volume to value.

Co-Management

Co-management arrangements are frequently utilized as a means to build integrated relationships with critical service line specialists without formal employment arrangements. The participating specialists may already be structured in large medical groups and may not be interested in employment. In those markets where medical practices are still fragmented in smaller groups, developing a co-management arrangement can be an effective means of creating a collaborative structure without requiring the physicians to merge their practices. The co-management structure provides physicians with desired input into decision making in the clinical environment so they can achieve operational efficiencies and savings while still maintaining their independence. Core co-management responsibilities include financial and operational oversight, planning and business development, and quality of care. Due to the import of cardiovascular services and orthopedics to many hospitals, these service lines have been the first to develop co-management structures in many organizations.

Physicians and hospitals need to fundamentally change the way they work together in order to motivate both groups to achieve the desired results.

Co-management arrangements can range from simple to complex. In a simple arrangement, the hospital contracts with a physician organization, under which the physicians are granted input and managerial authority to design and enforce clinical and operational standards. Generally, the physicians provide only their time and have limited risk in the arrangement. Under this arrangement, the physician entity assigns a physician as the executive physician director, and the hospital assigns a service line/department director to serve on a co-management committee. The co-management committee is typically composed of an equal representation of the participating physicians and hospital management. Sub-committees or councils may be developed under the co-management committee to coordinate sub-specialty areas as needed. In terms of governance, the physician executive retains a major role in establishing and maintaining key items such as policies and procedures, and quality and efficiency standards. The hospital retains all reserve powers and day-to-day management is provided by the service line/department director. All budgetary and strategic decisions that would normally come to the hospital board of directors still come to the board for consideration, but the board will have the added assurance that the recommended actions or resource expenditures have been developed and fully endorsed by an engaged group of physician participants.

58 Diane Shannon, "Managing the Critical Transition from Volume to Value," *Physician Executive Journal*, May/June 2011.

59 Alice Gosfield and James Reinertsen, *Achieving Clinical Integration with Highly Engaged Physicians*, 2010.

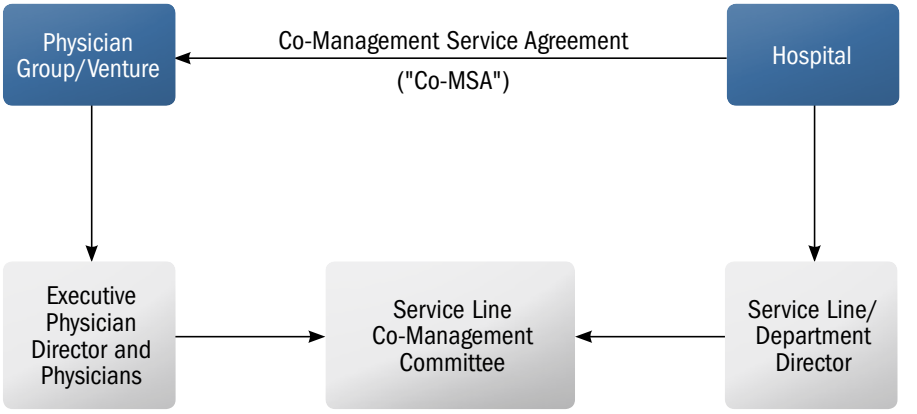
A more complex structure involves dual ownership of a management company by both a hospital and physicians. A hospital contracts with the management company to manage a service, and it may provide personnel, equipment, and supplies, as well as be responsible for establishing and enforcing clinical and operational standards. In a complex structure the governance of the management company is generally shared between the hospital, which may include representatives from the hospital board as well as management and physicians. The equity split is typically 50/50, but this is not required. The goal is to create an attractive arrangement for both the physicians and the hospital.

In both simple and complex structures, the physician organization or management company enters into a management services agreement with the hospital to manage the designated service line(s). The management services agreement typically includes a multi-faceted compensation structure including a base compensation for medical direction and administrative duties and a P4P incentive component based on the attainment of specified quality goals. (See **Exhibits 23** and **24**.)

Base Management Fee

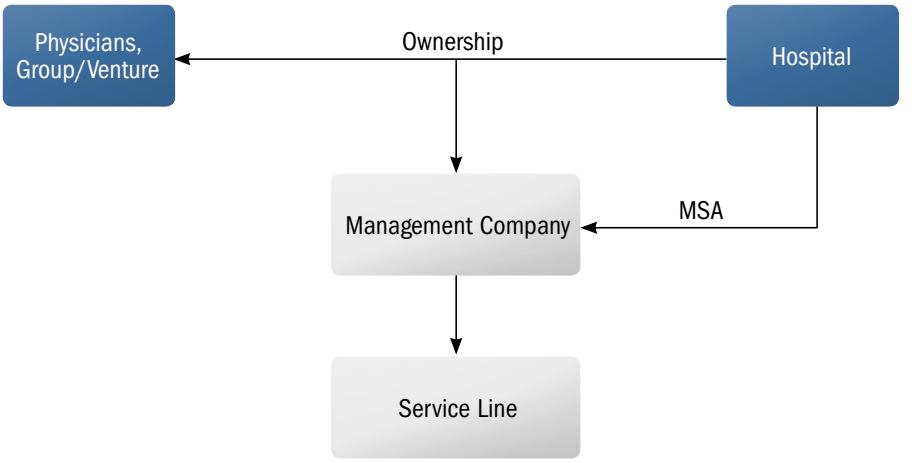
The base management fee is typically comprised of a monthly fixed amount calculated on estimated hours of physician services at fair-market-value hourly rates, projected expenses for other services offered, and an estimate of physician group overhead expenses.

Exhibit 23: Co-Management Arrangement (Simple Structure)



Source: The Camden Group.

Exhibit 24: Co-Management Arrangement (Complex Structure)



Source: The Camden Group.

Incentive Compensation

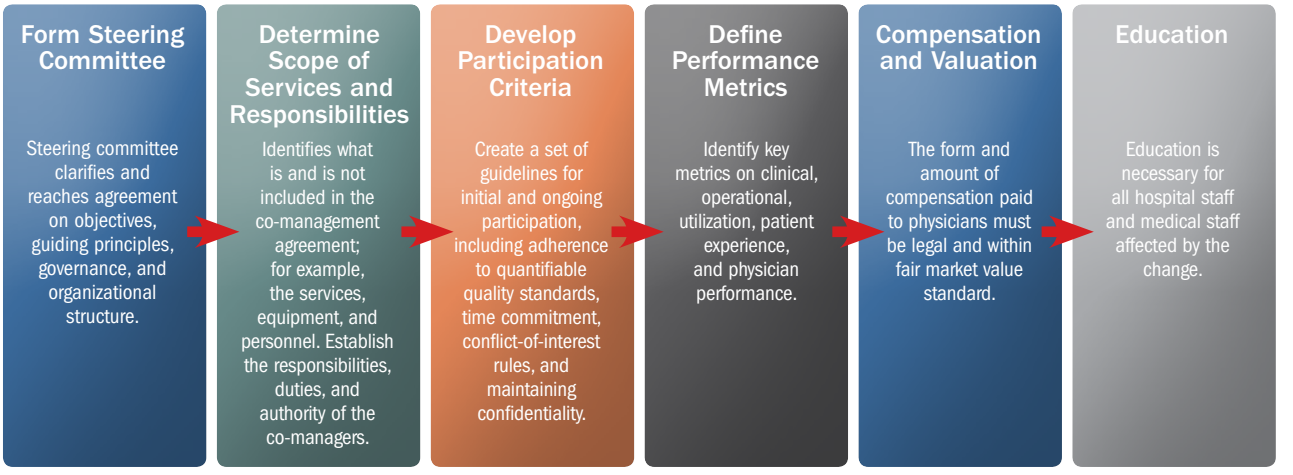
Incentives are based on achieving meaningful goals on quality and operational efficiency that are not the result of a reduction of care to patients. Incentive measures can be structured as partial payments, with increasing payments as performance improves. Total potential incentive pools typically range from 10 to 20 percent of other fees paid and the total compensation, including the total base and incentives, can range from 3 to 5 percent of service line revenue. (See **Exhibit 25**.)

There are a number of steps to be mindful of when creating a co-management arrangement, as outlined in **Exhibit 26**. Most notable is to ensure that the hospital and physicians clearly align as partners and have a demonstrated commitment to the hospital, community, and service line. In addition, careful attention should be paid to establishing quantifiable quality standards, identifying key performance metrics, and ensuring that the compensation structure is legal and within fair market value.

Exhibit 25: Management Company Compensation Example

Source: The Camden Group.

Exhibit 26: Steps in Forming Co-Management Arrangements



Source: The Camden Group.

A co-management arrangement is the first formal step in preparing for bundled payment or other new forms of reimbursement. Co-management integrates the management of service lines and allows hospitals and physicians to begin crucial conversations on the topic of evidence-based care and operational efficiencies. Opening the dialogue between a hospital and physicians creates the platform to move to CMS-sanctioned gainsharing models that reward physicians for increased quality and reduced costs. Co-management agreements can be attractive to both hospitals and physicians for the reasons listed in **Exhibit 27**.

Clinical Integration

Hospital–physician integration models such as physician employment, joint ventures, and co-management align defined groups of physicians and hospitals around common goals and incentives and provide opportunities to manage patient outcomes and costs. CI takes integration one step further through the integration of community physicians, employed physicians, and hospitals across the care continuum.

The patient experience currently can be summed up as distinct episodes of care resulting in multiple care managers at each stage in the process, from the physician office, through the hospital admission, discharge, to post-acute care. Each stage in the process leads to further fragmentation along the continuum of care, resulting in poor patient quality outcomes, inefficiencies in transition of care, higher costs, and poor patient satisfaction. CI aims to integrate the healthcare landscape by bringing together providers across the continuum under a single structure. Clinically integrated organizations for physicians mean accountability for clinical results, adherence to care plans and protocols, and shared clinical information. CI for patients means access to individualized care plans, engagement in their care process, and a collaborative treatment team led by their primary care physician (medical home). In CI, hospitals are now members of a team of care providers and now share responsibility for care with physicians and other members of the continuum.

Exhibit 27: Reasons for Physicians and Hospitals to Consider Co-Management

Market	Clinical and Quality	Operational	Finance
► Can attract physicians interested in involvement in the management and strategic direction of service lines ► Meet the needs of the community ► Rapidly attract new services and technology to the market for the benefit of the community ► Mitigate areas of hospital and physician conflict and competition	► Improve patient care and clinical outcomes ► Improve access to a clinical service line through improved efficiency ► Increase patient satisfaction ► Proactively define long-term relationship between the hospital and key physicians	► Improve coordination and efficiency of the service ► Secure and improve the relationship between the hospital and physicians, allowing them to learn to partner effectively ► Enhance physician commitment to support operational changes	► Align incentives between the hospital and physicians ► Drive costs out of the system ► Protect capital and other significant financial investments or commitments ► Means to cope with reduced physician income related to professional fees and in-office ancillaries

Source: The Camden Group.

Creating CI requires an organized process of developing new skills, creating new tools, and potentially new organizations to more effectively deliver care to a patient population as illustrated in **Exhibit 28**.

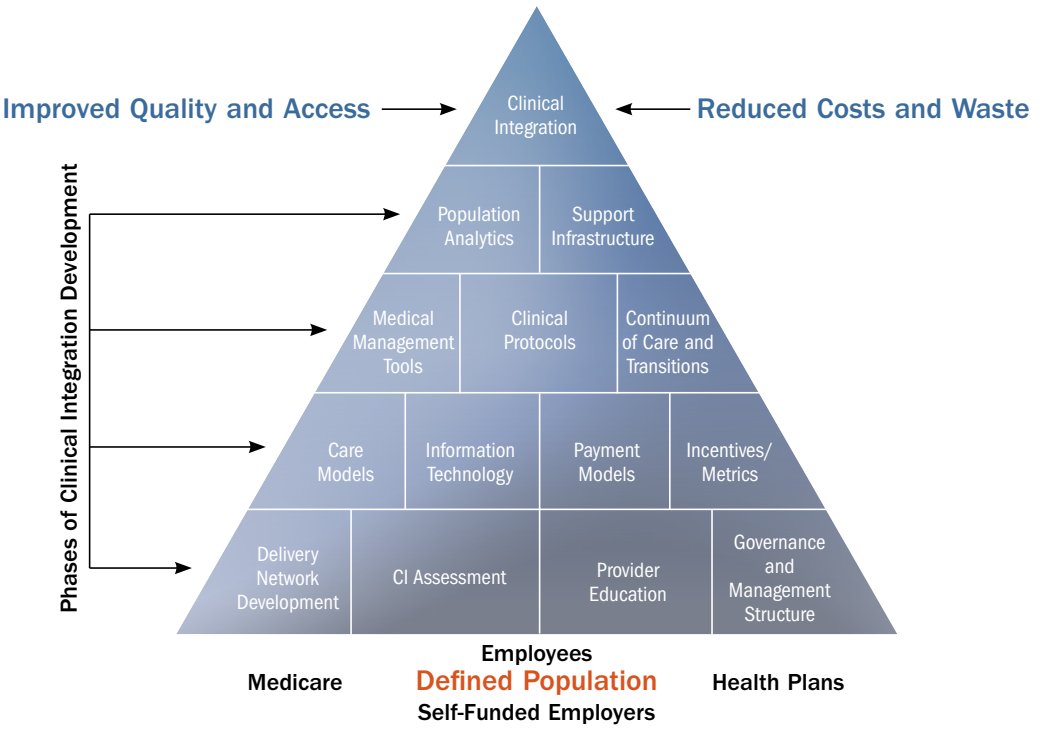
All clinically integrated organizations must comply with regulations of the Federal Trade Commission (FTC). The term CI was first conceived in the 1996 Statements of Antitrust Enforcement Policy in Health Care produced jointly by the FTC and U.S. Department of Justice. CI was defined as "an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[60] Furthermore, the FTC defines the primary aim of CI as the ability to realize efficiencies by monitoring utilization and controlling costs, selectively choosing physician participants and investing in the necessary human and monetary capital to meet the defined objectives.[61]

Complying with the FTC to minimize antitrust risk for providers engaging in a CI requires a number of components: 1) the presence of mechanisms that achieve efficiencies, including monitoring and controlling costs; 2) selectively choosing physician participants; and 3) significantly investing in monetary or human capital and infrastructure. Questions to consider to determine if the physician network passes the FTC "test" include:

- Is the CI "real"?
- Are authentic initiatives actually undertaken?
- Are the initiatives of the program designed to achieve improvements in healthcare quality and efficiency?
- Is joint contracting with FFS plans "reasonably necessary" to achieve the efficiencies of the CI program?

There are several CI models that have evolved over the last few years. Three models are discussed below: CI through information technology, a wholly-owned subsidiary model, and a joint venture model. Each provides a vehicle for physicians and hospitals to share information and create the infrastructure required to begin to address quality and efficiency through population management.

Exhibit 28: Building Blocks for Clinical Integration



Source: The Camden Group.

60 Federal Trade Commission and the U.S. Department of Justice, *Statements of Antitrust Enforcement Policy in Health Care*, Statement 8 (www.ftc.gov/reports/hlth3s.htm#8, accessed November 28, 2011).

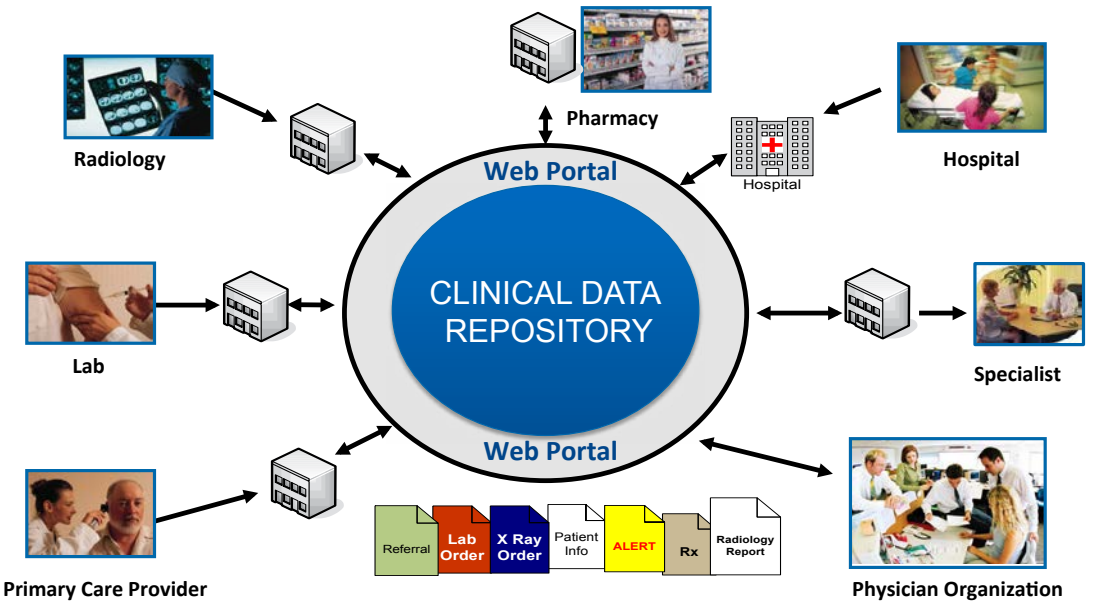
61 *Ibid.*

Clinical Integration through Information Technology

Hospitals have been able to move toward CI by investing in electronic medical records, offering physicians a powerful platform that facilitates access to data for improving disease management, reducing health benefit costs, and developing pay-for-performance incentives. This platform allows networks of physicians and hospitals to enter into collective arrangements with health plans in a manner that does not violate antitrust laws. Clinically integrated organizations can produce data that supports enhanced quality at reduced costs, which translates into increased P4P incentives or other favorable contracts with payers.[62]

Greater Rochester Independent Practice Association's GRIPA Connect™ Clinical Integration program is an example of a clinically integrated program created to electronically connect GRIPA's provider network of community physicians, hospitals, labs, and imaging facilities under a shared patient portal. GRIPA physicians have access to a health information exchange (HIE) that allows them to collaborate in the treatment of patients, share a commitment to evidence-based clinical care, and access care management services for patients with complex health issues. All of these factors enabled GRIPA to obtain a positive FTC advisory opinion, which ensures they are complying with federal antitrust laws and allows them to obtain favorable contracts with payers on behalf of their members. GRIPA has been able to create a model of CI that differentiates its members in the marketplace from competitors while controlling cost and ensuring quality.[63] The FTC advisory opinion regarding GRIPA provides insight into how the FTC views joint pricing of physician services and can be helpful for IPAs as they look toward value-based pricing strategies with payers.[64] **Exhibit 29** illustrates GRIPA's use of health information technology to facilitate CI and meet the integration test created by the FTC.

Exhibit 29: Clinical Integration IT Infrastructure Model



Source: The Camden Group.

62 John H. Duffy and Trent Green, *Hospital–Physician Clinical Integration* (monograph), Center for Healthcare Governance, 2007.

63 Greater Rochester Independent Practice Association Web site (www.gripa.org/why-clinical-integration.asp), accessed November 28, 2011.

64 Bill Darling, "FTC Issues Approval of Clinical Integration Model," *Health Industry Online*, Strasburger & Price LLC, October 10, 2007. Available at www.strasburger.com/p4p/publications/FTC_clinical_integration_model.htm.

Wholly-Owned Subsidiary Model

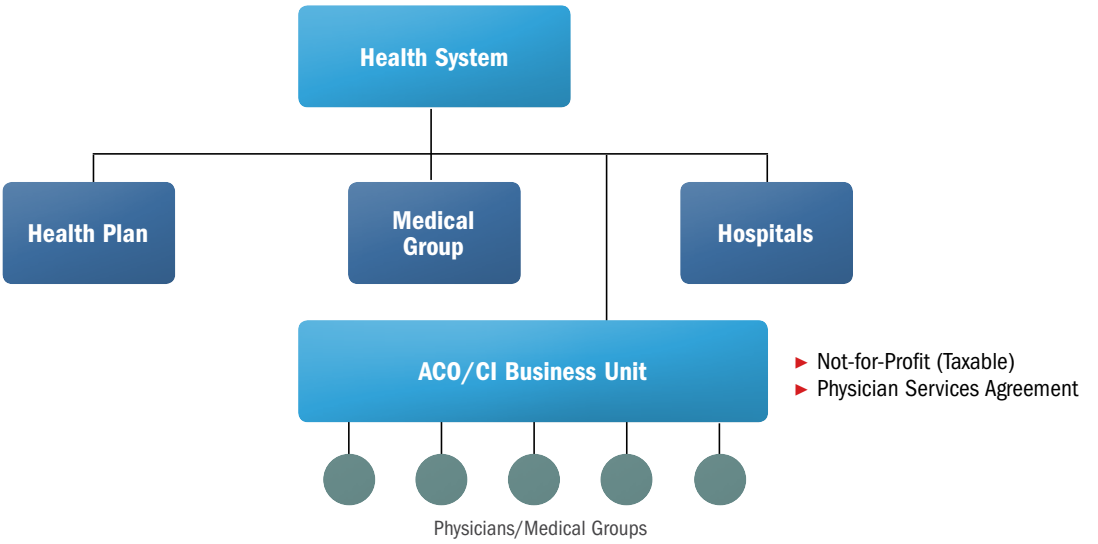
A second model for CI, illustrated in Exhibit 30, is the creation of a is a wholly-owned subsidiary in which physicians are not required to invest in the entity but receive access to IT and other health system resources.

Under this model, both employed and independent physicians can participate. Non-employed physician participation is established through a professional services agreement with a newly created, not-for-profit CI business entity. Governance of the entity can be established with a majority physician interest with the health system retaining reserve powers and super majority rights. This model supports CI strategies and ACOs, so organizations can transition from CI to ACO as they build competencies and expertise.

Joint Venture Model

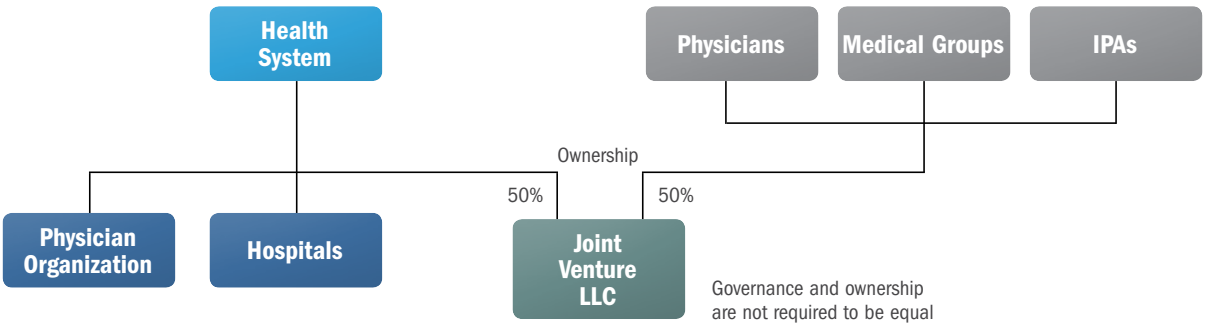
The third CI model is to create a joint venture relationship between physicians and the health system. This model, as illustrated in Exhibit 31, allows physicians to have a majority interest on the board with equity interest generally split evenly. Under this arrangement, the health system is permitted to provide management services to the LLC, including information technology. Like the wholly-owned subsidiary model, the joint venture LLC can also function as an ACO entity.

Exhibit 30: Clinical Integration Wholly-Owned Subsidiary Model



Source: The Camden Group.

Exhibit 31: Clinical Integration Joint Venture Model



Source: The Camden Group.

Consideration should be given to each model to determine which best supports the needs of the hospital and the physicians. Exhibit 32 provides a comparison of each model with the key attributes of each.

Regardless of the model, there is immense value in establishing clinically integrated organizations as a means to align physicians and as a precursor to ACO development. CI and ACOs are inherently related—CI is the process or the "way" integration is achieved, and ACO is the structure. As demonstrated in Exhibit 33, there are benefits for patients, hospitals, physicians, and payers when hospitals and physicians come together to become clinically integrated.

Exhibit 32: Comparison of CI Integration Models

	CI through Information Technology	Wholly-Owned Subsidiary Model	Joint Venture Model
Integrates employed and independent physicians	X	X	X
Requires capital investment and acceptance of risk for physicians			X
Allows for physician ownership			X
Governance can be established with an equal or majority physician interest		X	X
Provides access to HIE across the provider network	X	X	X
Enables single-point payer contracting		X	X
Other	Can be used as a starting point for hospitals looking to align with a largely independent physician community with limited exposure to risk-based contracting and formal alignment structures.	Successful model for hospitals that have some experience with physician integration and are looking to further their CI across the continuum. May have some experience with risk contracting.	Appropriate model for hospitals with experience in more formal physician integration structures and risk contracting.

Source: The Camden Group.

Exhibit 33: Value of Clinical Integration

For Patients	For Physicians	For Hospitals	For Payers
▶ Improved clinical outcomes and patient safety ▶ Better care coordination and disease management ▶ Improved efficiency of care with reduction of duplication of services ▶ Creates a coordinated provider network across the continuum ▶ Broad geographic coverage and access ▶ Better "service"	▶ Physician-led quality initiatives ▶ Remain in current practice model (solo, group, Independent Practice Association [IPA], Foundation) ▶ Practice growth through: » Demonstrating superior clinical outcomes and service » Joint marketing of a "branded" product ▶ Financial gains ▶ Compensation for time spent participating in improvement efforts ▶ Joint contracting ▶ Better managed practice costs through shared infrastructure	▶ Aligns physicians and hospitals to achieve common goals: » Improved clinical outcomes and patient safety » Improved coordination of care » Improved efficiency of care ▶ Creates a value-driven and integrated healthcare network ▶ Prepares hospitals and physicians for new payment models	▶ Higher-quality, lower-cost care: » Improved clinical outcomes and patient safety » Better care coordination and disease management » Improved operational and financial efficiencies ▶ Broad geographic coverage and access ▶ Enables single-point contracting

Source: The Camden Group.

ACO Development

While many hospitals and physician groups across the country are evaluating the feasibility of participating in Medicare's ACO Shared Savings Program, there has been a greater movement with commercial ACOs and the Pioneer ACO program. In December 2011, CMS announced the 32 organizations that were selected to participate in the Pioneer ACO; they represent organizations of various sizes and geographical services areas, from urban to rural. Among those selected are Eastern Maine Healthcare Systems; the University of Michigan Medical Center in Ann Arbor; Dartmouth-Hitchcock Medical Center in New Hampshire; six systems in California; and five in Massachusetts. Organizations are also partnering with some of the largest health plans in the country including Aetna, Cigna, and WellPoint to form commercial ACOs in their communities, as well as exploring shared savings opportunities through the Medicare Physician Group Practice Demonstration.

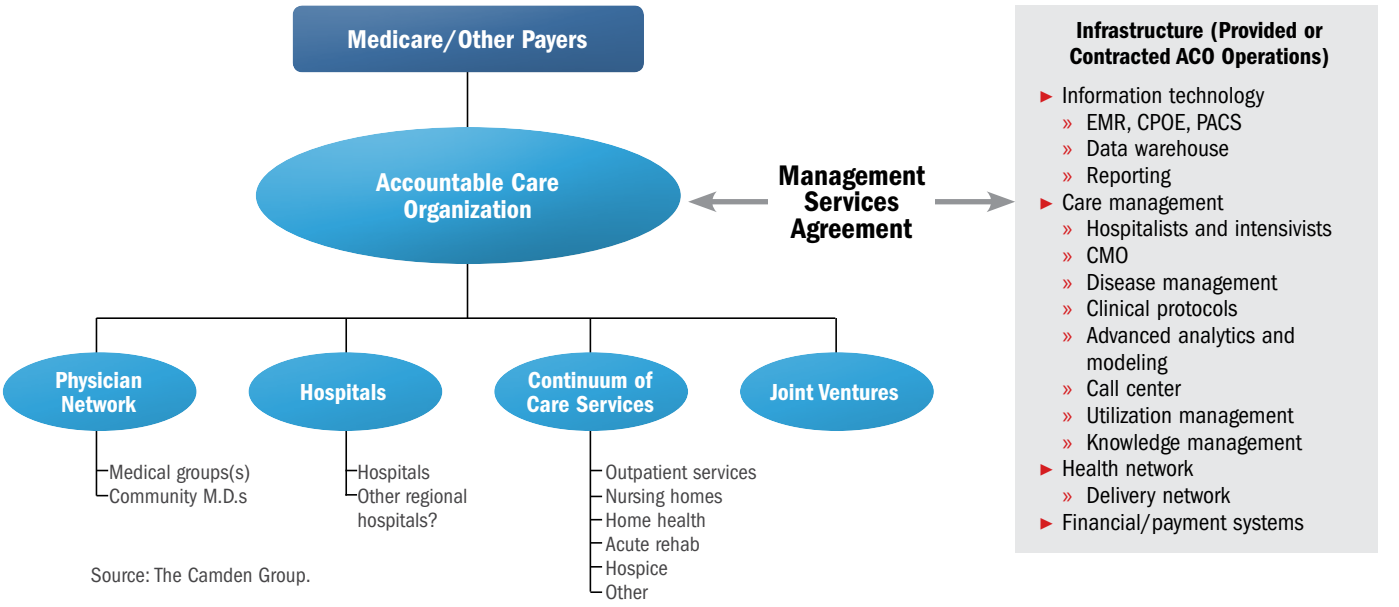
Organizations that pursue becoming ACOs will need the capability to provide primary care and basic medical/surgical inpatient care for a patient population as well as address care throughout the continuum, be willing to take responsibility for overall costs and quality of care for a defined population, and have the size and scope to fulfill this responsibility. Organizations with these capabilities generally include integrated delivery systems, physician–hospital organizations (PHOs), independent practice associations (IPAs), partnerships of PHOs and or IPAs, and large medical group practices. In order to qualify as an ACO, the organization must have an infrastructure in place that supports ACO operations, including integrated IT systems, care management, a coordinated delivery network, and a financial payment system. The organization must have the capacity to manage at least 5,000 Medicare beneficiaries and be willing to commit to the project for a minimum of three years. As physicians and hospitals move toward the development of ACOs, they will need to adopt the role of an at-risk payer, gaining comfort in integrating hospital–physician accountability, accepting financial responsibility, and using data metrics to drive care decisions.

ACO as a Physician Integration Strategy

ACOs provide the structure and the incentives for physicians and hospitals to build a shared culture around outcomes-based medicine and cost-effectiveness. A well-structured, physician-led ACO creates interdependence and cooperation between a hospital or health system, private practices, employed physicians, and a health plan that creates value for patients.

While ACOs do not need to be newly created entities, they are required to have formal legal structures for receiving and distributing shared savings payments or accepting risk. Regardless of the payer relationships, ACOs should be developed with governance and organizational structures that best fit the organization, including strong physician leadership and infrastructure support, the latter of which may be acquired through an MSO agreement. ACOs must also have patient-centered processes that involve patients in their care and methods to coordinate care across the delivery network. A sample ACO configuration is illustrated in Exhibit 34.

Exhibit 34: ACO Configuration Example



Source: The Camden Group.

In this model, the ACO is structured as a separate legal entity, consisting of a hospital or health system, community physicians, post-acute care services, and a joint venture. The ACO has chosen to contract to meet its infrastructure needs rather than develop the capabilities internally. This approach minimizes the capital requirement necessary at the ACO level in order to ensure participation by providers throughout the continuum. An HIE infrastructure is established under the MSO to extend technology use into independent practices and other ancillary services to ensure clinical information is shared across the network. Technology is used to track performance metrics, aggregate data, and report progress on adherence to standardized protocols and quality measures created by the network physicians. Furthermore, the physicians are able to remain in independent practice with their existing business models while leveraging the infrastructure of the ACO network to improve care coordination.

> Most critically, the ACO structure must be physician-led and -driven.

There are several critical success factors organizations need to consider when putting together an ACO. Hospitals/health systems should ensure that they are working with a willing payer and that incentives are built in for shared savings and shared risk. The care delivery network needs to include a full spectrum of physician specialties, hospital and sub-acute care providers, diagnostic/treatment services, and case management providers. Considerable attention needs to be paid to the infrastructure of the organization, ensuring that the structure has data warehousing and population management capabilities, an ability to capture financial and clinical data, and a contracting mechanism with a method for distributing payments. Most critically, the structure must be physician-led and -driven.

Each of the hospital–physician alignment strategies discussed in this publication can be valuable models to bring physicians and hospitals closer together; however, it is important to understand the pro and cons of each model and the factors that are critical for success (see **Exhibit 35** on the next page).

Legal Implications

There are numerous legal implications to consider in forming hospital–physician integration structures; although a benefit to healthcare reform has been an easing of some of these restrictions.

Stark Physician Self-Referral Laws

The Stark Physician Self-Referral Laws ("Stark") prohibits physicians from making referrals for Medicare "designated health services," including hospital services, to entities with which they or their immediate family members have a financial relationship, unless an exception applies. There are several permissible arrangements including joint ventures. For example, a physician practice may provide imaging services in the office or may engage in a joint venture arrangement with a hospital to provide imaging or other services without violating Stark laws, as long as a Stark exception is met.

Anti-Kickback Statute

The anti-kickback statute (AKS) provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive compensation for the referral of business reimbursable by a federal healthcare program. The AKS employs safe-harbor provisions (exceptions) that cover such activities as investments in publicly traded companies, joint ventures, rental of space or equipment, personal services agreements, discounts, etc. While these safe harbors share many elements with the Stark exceptions, compliance with one does not necessarily ensure compliance with the other.

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMP) prohibits a hospital from making a payment, directly or indirectly, to induce a physician to reduce or limit services to Medicare and Medicaid beneficiaries under the physician's direct care. Physicians can be fined for accepting a payment, and hospitals can be fined for knowingly making such payments.[65]

65 U.S. Code, Pub. L. 104-134, 110 Stat. 1321-373 (codified at 28 U.S.C. 246, note).

Exhibit 35: Limitations and Considerations for Hospital–Physician Relationships

	Pros	Cons	Critical Success Factors
Traditional Medical Staff	▶ Clearly understood model ▶ Incorporates all physicians regardless of affiliation ▶ Effectively meets the historical requirements for physician involvement in hospital care	▶ Losing primary care members with advent of hospitalist programs ▶ Can be more difficult to attract and retain highly qualified physicians in high-demand specialties because of traditional medical staff obligations (i.e., ED on-call) ▶ Need more integrated structures for participation in value-based care	▶ Effective physician leaders ▶ Collaborative medical staff leadership/hospital relationship ▶ Redesign to more effectively meets the needs of the new healthcare environment, including aligned incentives and a shared mission of purpose
Employment	▶ Enhances competitive position and protects market share ▶ Model can attract and retain high-quality physicians ▶ Creates a solid platform on which to build strong physician leadership and collaboration ▶ Provides for enhanced contracting and positions the hospital for value-based payment models	▶ Can be costly to manage ▶ Reduces physician autonomy and influence over the medical group culture	▶ Common vision and clearly defined expectations for the hospital–physician relationship ▶ Physician compensation structured to align incentives with organizational goals ▶ Investment in knowledgeable physician practice administrators ▶ Lean management structure with on-site management–physician leadership dyads ▶ Realistic performance metrics and ongoing board monitoring
Joint Venture	▶ Allows for access to new products, services, or markets ▶ Opportunity to gain or learn new skills or expertise ▶ Provides for diversification of risk	▶ Decision making can be slow or impeded ▶ Aligns two parties with different cultures	▶ Clearly defined objectives and goals and aligned incentives ▶ Clear leadership structure and process for decision making
Co-Management	▶ Aligns incentives for physicians and hospitals in specific service lines for managing the care of a patient to improve patient outcomes ▶ Does not require a more formal structure of employment, practice acquisition, or other affiliation ▶ Participants can learn to work through common operational and clinical issues on a small scale before moving to a more formalized structure ▶ Physicians are empowered to make decisions that affect their service line, which often creates a stronger sense of ownership	▶ Regulatory environment creates additional complexity; consideration must be given to the financial arrangement between the hospital and physicians in light of anti-kickback, fraud, and abuse prevention laws and regulations.	▶ Ability to build and lead effective teams including clinicians and management collaboratively ▶ Hospital willingness to create a culture of transparency and openly share financial and operational data ▶ Requires robust data mining capabilities and ability to produce data that is timely and accurate ▶ Hospital management and physicians must establish common goals and set realistic timelines for achieving targets
Clinical Integration	▶ Integration of the patient care delivery process to improve outcomes and decrease resource consumption ▶ Aligns community providers with the hospital without requiring exclusivity or total integration ▶ Allows for joint contracting with payers ▶ Stepping stone to becoming an ACO	▶ Expensive, requires a substantial investment and ongoing commitment to IT and infrastructure	▶ Clearly defined vision, goals, and aligned incentives ▶ Providers need access to real-time information ▶ Physician leadership, including significant (at least 50%) representation on CI entity governing body. ▶ Receptive payer (commercial or government) to implement modified payment method: pay-for-performance, shared savings, capitation
ACO	▶ Potential for shared savings with acceptance of shared risk ▶ Formally aligns providers, hospitals, and payers to manage outcomes across the continuum ▶ Provides a process to promote evidence-based medicine and patient engagement	▶ Few providers have experience in managing risk ▶ Many providers and community organizations do not have an integrated IT infrastructure ▶ Potential for increased liability with acceptance of shared-risk	▶ Must be physician-led with a clear governance and leadership structure with defined roles and expectations ▶ Ability and experience to aggregate clinical and financial data ▶ Culture to measure and enforce clinical and service standards ▶ Established care management process to address patient care needs across the continuum ▶ Proactive, consistent engagement with the community at-large ▶ Informed board, medical staff, and management team

Source: The Camden Group.

Gainsharing

Gainsharing has been in use in other industries outside of healthcare and has recently begun to obtain more attention as hospitals try to find ways to incentivize physicians to operate more efficiently thereby reducing costs. Gainsharing models are legally permissible under most circumstances, but they do invoke the CMP statute as well as anti-kickback laws because of the potential abuse of providers who stand to benefit from the financial relationship.

From the hospitals'/health systems' perspective, gainsharing allows them to operate more efficiently, reduce costs, improve patient care, and standardize procedures and clinical protocols. From the physicians' perspective, gainsharing allows them to participate in a risk pool in which excess funds are distributed at the end of a defined period. The shared risk pool funds increase or decrease based on the ability of the hospital and physicians to manage patient care at a lower cost or combination of cost and performance measures.

All of the various models of hospital–physician alignment discussed above have gainsharing components; however, both the FTC and the Department of Health and Human Services Office of Inspector General have indicated that they will work with providers to facilitate appropriate integration to achieve quality and cost goals. For example, the government has revised regulatory sanctions on ACOs, waiving certain provisions of Stark, AKS, and CMP. The OIG and CMS recognize that some of the fraud and abuse provisions may impede the development of integrated structures and models envisioned as part of the SSP.[66]

A key component of safe harbor protections under the AKS is available when a transaction is set at fair market value (FMV), and the transaction price does not induce referrals. FMV is determined on a case-by-case basis on the facts and circumstances of each particular agreement. Hospitals need to take precautions when establishing contractual relationships with physicians including physician compensation arrangements, physician management fees in co-management agreements, and shared risk pools. Hospitals should be careful to ensure that compensation for services meets FMV standards. To assess FMV, organizations need to consider both the value of the individual compensation components, such as performance metrics and individual tasks, as well as all of the components in aggregate. Regardless of the approach, it is important to note that all arrangements are unique, and a successful valuation will be based on the merit of each individual component.[67]

IRS Tax-Exempt Status

The majority of hospitals in the U.S. are not-for-profit, accounting for over 5,000 hospitals, of which the majority are also tax exempt. Tax-exempt status allows hospitals to be exempt from federal income taxes and require that they establish charity care policies, and programs that provide services and benefits to the community. Non-profit hospitals cannot have shareholders, but can issue tax-exempt bonds and solicit donations. Any surplus revenue at the end of the year must be invested in the hospital.

The IRS recently released a report on its findings of 500 tax-exempt hospitals; the purpose of which was to understand the community benefit provided by hospitals and executive compensation practices. While no significant variance was reported, the IRS stated that it will continue its enforcement in this area and ensure compliance through further examinations and initiatives.[68] Recent scrutiny by the IRS and changes in health reform law is causing concern for not-for-profit healthcare organizations in ensuring they can retain non-profit/tax-exempt status. The new provisions in reform law require tax-exempt hospitals to conduct a community health needs assessment at least once every three years that is to include input from the community served. Failure to conduct the survey will result in a $50,000 fine beginning in 2012. Hospitals are also required to submit a report to the IRS documenting their strategies to address the community need identified both in terms of activities they are pursuing and activities not being addressed. Hospitals must also implement a financial

66 Matthew Albers, J. Liam Gruzs, and Jolie N. Havens, "CMS Releases Interim Final Rule for ACO Fraud & Abuse Waiver Provisions," Vorys, Sater, Seymour and Pease LLP, November 3, 2011.

67 Greg Anderson and Scott Safriet, "Chapter 21: Valuing Clinical Co-Management Arrangements," *The BVR/AHLA Guide to Healthcare Valuation,* 2009 Edition (Mark Dietrich and Cindy Eddins Collier, editors), Business Valuation Resources, LLC, 2009.

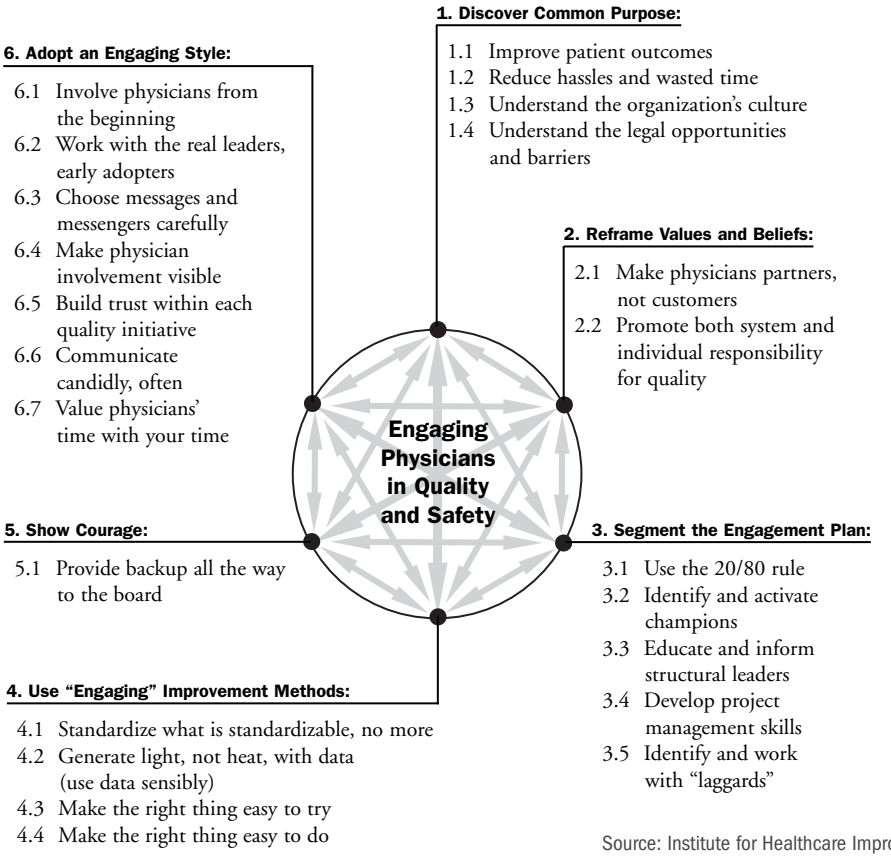
68 IRS Nonprofit Hospital Project, Final Report (February 2009; last reviewed and updated March 02, 2011; see www.irs.gov).

assistance policy that ensures that patients without insurance are not charged more than the lowest charged amount for patients with insurance.

Physician Leadership

Movement towards any of the new integration strategies or payment models, whether in an ACO, co-management, CI, or P4P arrangement requires strong physician leadership. Organizations that have built collaborative, healthy physician relationships and have existing contractual alignment can leverage these arrangements to develop the structural and governance models that support an ACO or other alignment vehicle. While an ACO might be an end goal, organizations can start down the care continuum by taking small steps that lead to the end result. The Institute for Healthcare Improvement designed a framework consisting of six elements for leaders to consider in engaging physicians in quality improvement (see **Exhibit 36**).

Exhibit 36: Framework for Physician Engagement



Source: Institute for Healthcare Improvement, © 2007.

Organizations across the country are evaluating their hospital–physician integration strategies and are looking for new ways to partner together. Respondents to The Governance Institute's survey for this publication reported utilizing multiple, simultaneous integration strategies, with physician employment clearly standing out as the leading strategy with 97 percent of respondents. CI was the second most pursued strategy with 72 percent of respondents. Hospitals indicated that these strategies are being pursued in large part to meet cost containment goals, improve quality, and to implement population health initiatives. Despite the strong direction toward physician employment and CI strategies, only a handful of respondents have made changes to their governance structure, with just 37 percent reporting changes.

Organizations that have built collaborative, healthy physician relationships can leverage these arrangements to develop the structural and governance models that support an ACO or other alignment vehicle.

As organizations pursue CI initiatives with their physicians, they must also be prepared to provide ample opportunity for physicians to lead these new or reorganized entities. While this may not require major restructuring of hospital/system boards, it often requires a governance model for a PHO or other CI entity that may be owned or joint ventured by the hospital/health system that is composed of a majority, or at least equal component, of physicians. This is crucial to assuring that the entity is focused on clinical improvement and efficiency built on sound, evidence-based guidelines, and that it facilitates physician engagement and commitment to achieving these aims. We see this as a turning point for governance of many organizations as they evolve from a hospital-centric to a population-centric approach. To effectively make this transition, the hospital or system governing board must delegate leadership of the clinical transformation of the enterprise to a physician-led body, while still maintaining fiduciary responsibility, commitment to serving the interests of the community, and assuring overall quality for the system as a whole: hospital, physician enterprise, and other care delivery business units.

Key Considerations for Board Members

- Aligning incentives with physicians financially and clinically is more important than ever; physicians must be the champions to reduce costs and improve quality and patient outcomes. What is your organization doing to foster physician leadership?
- Continue to monitor market activity closely, evaluate all options and determine if new relationships may hold benefits not feasible in the past. Is your organization posed to explore new relationships or reevaluate past attempts at partnerships?
- Have you explored co-management agreements and other risk-sharing activities as a method to increase volume, improve quality, and reduce expenses? Are you actively involving physicians in these discussions?
- Are governance structures being considered that provide physicians with ample opportunity to lead and be accountable for clinical transformation and health status improvement to your service area population?

IV. PUTTING IT ALL TOGETHER

Case Study Spotlight: Provider Organizations

In this section, the following case studies describe how five different provider organizations across the country are adapting to healthcare reform through various hospital–physician integration strategies. These organizations represent evolved and evolving integrated systems, urban and rural systems, and systems that cross state lines. All of these organizations are unique in their care delivery model and are at distinctive places along the care continuum. These provider stories highlight the process of creating change, strategies for hospital–physician integration, and the steps taken in response to healthcare reform (see **Exhibit 37**).

Lancaster General Health

Lancaster General Health (LG Health) is a Pennsylvania regional not-for-profit healthcare system that has served its community for over 100 years. Anchored by Lancaster General Hospital, the system also includes Women & Babies Hospital, the Lancaster General Medical Group (LGMG), several outpatient facilities including an urgent care center and retail clinics, and a number of post-acute care service organizations.

While LG Health is a significant provider in the area, the system does face some competition from for-profit competitors and physician-owned entities that employ physicians and may offer ownership stakes in select ventures. Because of their market position, LG Health has been approached by many payers and providers in their service area seeking to partner with the system. Their challenge is to sort out the opportunities and ensure they are consistent with, and can serve as a catalyst for, the system's strategic direction.

In order to thoughtfully select its partners, strategies, and investments, the system is embarking on business transformation with three primary goals in mind:

- Improve and enhance the value of health services
- Build a new primary care experience and a next generation ambulatory network
- Build creative healthcare solutions

Physician alignment and business innovation are integral components of the transformation. LGMG, a growing multispecialty group of over 125 employed physicians and midlevel providers, provides a vehicle to disseminate initiatives

Exhibit 37: Case Study Provider Organizations

Attribute	Lancaster General	Augusta Health	PeaceHealth	Presence Health Network *(formerly Provena-Resurrection)*	Sutter Health
State	Pennsylvania	Virginia	Multi-state (Alaska, Oregon, Washington)	Illinois/Northeast Indiana	California
Organization Type	Regional not-for-profit health system	Not-for-profit community hospital	Not-for-profit health system	Catholic not-for-profit health system	Not-for-profit integrated delivery system

Source: The Camden Group.

across the system, such as the patient-centered medical home. Meanwhile, a roadmap for CI has been established, which includes independent physicians. LG Health is also exploring other value-based models, including bundled payment and shared savings.

While significant changes have not been made to the parent board structure, there is an evolution in physician governance that also reflects the trend toward greater physician engagement. The physician services board has been reconstituted to promote ownership of medical group performance and advance the role of physician leadership in setting medical strategy for the community. Through this board, physicians, system administrators, and two lay members work together to govern the physician employment strategy and fiduciary responsibilities of the employed medical group. To ensure a link between the physician services board and the parent board, a lay member, who is also a member of the parent board, chairs the physician services board. Actions of the physician services board are reported at the professional affairs committee of the parent board, which governs major physician-related issues such as medical development and manpower plans, compensation strategies, and the physician alignment strategy.

There is an evolution in physician governance at LG Health that also reflects the trend toward greater physician engagement.

At the medical group level, physician-led operating and finance committees were recently established. Physician leaders were actively involved in developing the compensation model, setting performance expectations, and communicating the plan among their peers. On the independent medical staff side, there is a shared governance model where appointed chairs are paired with administrators. Together, they are accountable for the performance of their respective service lines. To promote clinical and business innovation, the system is forming LG Health Innovative Solutions, an entity whose purpose is to grow innovation competencies and navigate the disruptive strategies that accompany transformative ideas. Currently, the company is focused on 10 key innovations and building an investment portfolio that will advance the system's business transformation goals and, ultimately, increase net revenue.

While the system is seeking ways to build the necessary infrastructure faster, foundational pieces are already in place. For example, a single EMR has been implemented across the medical practices and hospitals. That record has been extended to independent physicians, and over 5,000 patients are actively using a patient portal for health information and access to primary care services. Next steps include the addition of provider point of care tools, predictive modeling and risk stratification, and enhanced decision support and reporting.

However, moving a large complex and dynamic organization in a rapidly changing environment is very challenging and raises a number of fundamental questions:

- How much change/disruption is the right amount?
- How do you pace the change to ensure the timing is right?
- How do you align physicians in a mixed payment model?
- Should the health system be related to a payer, be a payer, or something in between?

As LG Health attempts to answer these questions, the system has some early insights about its strategy for converting to a value-driven company. While LG Health will explore regional affiliations, it appreciates its current role in the local (primary) market. The system believes it is possible to assume a greater responsibility for the promotion of value that includes responsibility for measured risks in accountable care endeavors. By executing a prime-mover, small-market strategy, LG Health will maintain its independence and principal commitment to the communities it serves. As a result, their current focus is to reduce the cost profile, obtain experience in accountable care strategies, and partner with others for an enhanced infrastructure in its local (primary) market.

Augusta Health

Augusta Health is a regional referral center for Augusta County, Virginia, which serves a primary market of 120,000 in the Shenandoah Valley. This 255-bed hospital received several awards in 2011 including the HealthGrades Patient Safety Excellence Award as well as the Distinguished Hospital Award for Clinical Excellence. It is also the only hospital in Virginia to receive the Top 100 Hospital designation from Thomson Reuters and is one of six hospitals of the Top 100 to receive the Everest Award, a special designation honoring hospitals that achieve the highest levels of performance and the fastest long-term improvement over five years.

Although Augusta is the market leader in its primary service area with a market share of over 70 percent, competition is heating up in both the primary and secondary service areas. A university teaching hospital has declared Augusta County its primary market, and providers in the secondary market of 200,000 are preparing for healthcare reform. In the secondary market, a large, multispecialty group is participating in an accountable care pilot, and two community hospitals have joined a large national system, mirroring the trend of provider consolidation in Virginia.

To ensure that Augusta retains its position as market leader, the organization has been expanding the breadth and depth of its service lines. Simultaneously, it is very focused on clinical quality and cost (Augusta is the seventh-lowest cost provider in Virginia, of over 70 hospitals statewide) and has launched several initiatives designed to more efficiently treat high-risk patients and build competencies associated with shared risk models. These initiatives include:

- A congestive heart failure readmissions pilot
- A medically complex clinic based on the medical home model
- Development of a predictive model to identify patients at high risk of readmission
- A co-management model for orthopedics

> Augusta is in transition, but preserving its deep ties to the community is one of its highest priorities.

Augusta is rapidly implementing the IT tools that are critical for obtaining and demonstrating their desired quality and cost outcomes. In 2012, the ambulatory electronic medical record, a health information exchange, and patient and provider portals will become operational. In addition, a more comprehensive data repository will enhance clinical and financial decision support and reporting capabilities. These enhanced tools will aid medical staff engagement, which is vital to the success of these initiatives.

There is a strong tradition of independent physicians in the Augusta community. Many primary care physicians are in solo practice, and most of the subspecialists belong to independent groups. However, through the Augusta Medical Group and competing organizations, employment is becoming a fast growing option. Fifty-two of the 125 physicians on the medical staff are primary care physicians, hospitalists, or specialists employed by Augusta Medical Group.

Augusta's current board structure ensures physician participation at the board level for both employed and independent physicians. Augusta recently reconstituted its board after working with The Governance Institute to institute best practices. The 15-member board has three appointed physician voting members and two elected medical staff members who have a voice but not a vote. The remaining 11 members are all community residents, and the CEO is also a voting board member. The board frequently reaches out to the medical executive committee for input and advice, and the two bodies are highly collaborative.

Physician leadership on the executive team, including the chief medical officer, chief medical information officer, and executive director of the Augusta Medical Group, work closely with the medical directors of the service lines and hospitalist service on improvement initiatives. Because 70 percent of admissions come through the hospitalist service, it is an essential partner in the transition to a clinically integrated organization that can demonstrate value.

Augusta is in transition, but preserving its deep ties to the community is one of its highest priorities. Despite the challenges of decreasing federal reimbursement, increasing charity care and bad debt, and increasing competition, Augusta's vision is to be a vibrant, independent community healthcare system. Independent, however, does not mean insular.

The organization is open to partnering with other leading organizations that could bring valuable resources to the community. For instance, the organization recently partnered with Duke University Medical Center to bring cutting edge oncology services to the area. Through these innovative partnerships and continuation of the efforts that led to their national recognition, Augusta is optimistic it can weather its challenges.

Multi-State Provider: PeaceHealth

PeaceHealth is a Catholic integrated delivery system based in the northwest, with hospitals and medical groups in Alaska, Oregon, and Washington. Consistent with its mission-based roots, PeaceHealth's traditional market position has been to be the leader in mid-sized, rural, and underserved areas. However, as the integrated system continues to be called to serve additional communities, it has also become the market leader in a growing number of urban markets.

The northwest market has some unique attributes and challenges:

- Historically, medical groups and hospitals in the region have remained fragmented and independent and have been slower to embrace integration and consolidation strategies.
- Oregon and Washington's Medicare reimbursement rates are among the lowest in the country.
- Hospital utilization as measured by days per 1000 is significantly lower than the national average.
- Geographic barriers such as mountains and islands pose logistical complexities in the provision of healthcare, particularly during the winter.

PeaceHealth's strategic plan prioritizes the acceleration of changes in care delivery so it will be able to sustain its mission for another 150 years.

Although the area has been slow to adopt integration strategies, PeaceHealth has established strong relationships with physicians since its inception. Collaboration is one of the system's four core values and has been the foundation for a variety of physician alignment strategies. These strategies include the formation of a medical group, establishment of multiple joint ventures, and development of a physician leadership training program for community-based and employed physicians. The system is also exploring the creation of physician–hospital organizations, and has applied for a demonstration grant for orthopedic co-management and multiple CMS innovation grants centered on physician and community collaboration.

PeaceHealth Medical Group (PHMG) has evolved rapidly. Established less than 10 years ago, this multispecialty group currently has over 800 members and anticipates growing to approximately 1200 providers by 2012. PHMG is in the process of becoming a single, multi-state provider organization, which will enable and facilitate the dissemination of best practices across all of its care settings. The infrastructure to support that goal, including care management, information technology, and systems to manage prospective payment mechanisms, is currently being built.

PeaceHealth was an early adopter of information technology. A single electronic medical record was installed in all of its practice sites in the 1980's, and telehealth systems were developed to serve more rural and remote areas. Other resources currently in place include:

- Patient portals (including simultaneous release of lab results to patients and ordering providers)
- A community health record which, unlike the typical EMR, allows patients to input personal health information from multiple providers and multiple sources
- A system similar to an HIE that allows independent providers across a community to view a patient's medical history
- A robust internal data warehouse

Although PeaceHealth operates in what are largely traditional PPO and FFS markets, it is nevertheless preparing for new payment models. The new emphasis on population health aligns well with PeaceHealth's mission to preserve and improve the health of individuals and whole communities. The challenge is to develop new care models in an environment where incentives and reimbursement are still based on volume instead of value. Participation in medical home pilots, as well as the utilization of real-time tools to proactively guide and manage care, are initial priorities in the system's intentional migration toward value-based and outcomes-based care.

Another critical component of organizational transformation is the evolution of physician leadership. Physicians have always been part of the leadership structure in the hospitals. However, their role has largely been a representative one as compared to a full leadership role with the associated authority and accountability. PeaceHealth recognizes that clinical leaders are essential to redesigning care processes and has been actively cultivating physician leaders for over two decades who will lead and drive clinical and quality initiatives. PeaceHealth's physician leadership program (Advanced Training Program), built upon and modeled after Intermountain Health's program, has been providing the foundation needed for the system to evolve, meet the challenges of a changing environment, develop physician leadership talent, and preserve its core mission.

PeaceHealth takes great pride in its commitment and service to the underserved. It has always been the disproportionate share provider in its markets providing care to all who seek services, but the impact of recession on each state economy is leading to unprecedented cuts in Medicaid and other safety net services. These cuts, in combination with already low Medicare rates, are creating larger holes in the safety net and placing a growing burden on PeaceHealth, which in turn, creates even greater incentive to redesign care models and reimbursement systems. PeaceHealth's strategic plan prioritizes the acceleration of the changes necessary in care delivery so it will be able to sustain its mission for another 150 years and "provide every patient with safe, evidence-based, compassionate care; every time, every touch."

Presence Health views the changing landscape as an opportunity to strengthen physician partnerships and collaborate on quality, access, and cost drivers.

Presence Health

Resurrection Health Care and Provena Health recently merged to form Presence Health, the largest Catholic healthcare system in Illinois. The new non-profit entity encompasses 12 hospitals, 28 long-term care and senior residential facilities, numerous outpatient services, clinics, home health services, hospice, private duty, and comprehensive behavioral health services. Presence Health's service area of 4.5 million people covers the Chicago metropolitan area, east central and northwest Illinois, and northeast Indiana.

Presence Health operates in a very competitive market with over 100 acute care hospitals. Competition includes well-developed systems such as Advocate Health Care, as well as several academic medical centers. Presence Health's challenge is to strengthen its market position and prepare for healthcare reform by engaging the historically independent physician community. The combined medical staff numbers nearly 5,000 physicians.

Presence Health views the changing landscape as an opportunity to more tightly align with employed and affiliated independent physicians through strengthened physician partnerships and collaboration on quality, access, and cost drivers. Presence Health also recognizes the need for a high-quality, low-cost provider network as a competitive alternative in the marketplace.

Presence Health is currently engaged with its physicians in a collaborative initiative that would transform it into a clinically integrated and accountable healthcare provider. This initiative, the Provena-Resurrection Health Network CI/Accountable Care Organization Joint Venture (CI/ACO), will result in a new organization between Presence Health and physicians that is supported by an infrastructure capable of demonstrating higher value and lower costs to payers, providers, and communities Presence Health serves.

Efforts are underway to implement the CI/ACO joint venture along with the associated network and infrastructure. A dependable infrastructure, as well as accessible, active management, will allow the network to monitor, report, and act on data, facilitating the use of evidence-based guidelines and driving positive quality, service, and cost-saving results. When the network is fully operational, approximately 3,100 physicians in 11 markets will participate in its CI program.

No CI effort would succeed without physician leadership in clinical care redesign. Teams of physicians in each specialty across the Presence Health facilities have met to develop inpatient order sets for the conditions within each specialty, been involved in workflow design, and designed clinical content to be included in the electronic health record. Prior to the merger, both systems had begun the journey toward CI.

At Provena Health, significant discussions around CI began to occur through its physician–hospital organization, Alliance PPO, as early as 2003. However, the membership chose to remain a messenger model (a type of IPA that negotiates contract terms with managed care organizations on behalf of member physicians) until 2011. Recently a consensus was obtained to align with Provena Physicians' Alliance (PPA), an organization that also includes employed physicians, and focus on CI implementation. PPA has made significant progress in implementing the Crimson performance management system, establishing clinical protocols and physician participation requirements, and building data reporting and sharing capabilities.

Meanwhile, Resurrection Health Care engaged in a structured, collaborative, and multidisciplinary approach to develop a plan for CI, engaging key stakeholders and gaining input into the appropriate model and operational development. The process was driven by the input of nearly 400 healthcare administrators, physician leaders, and affiliated providers.

As a result of its joint efforts, Presence Health's affiliated physician groups, both employed and independent, will gain access to a collaborative network of providers supported by electronic tools capable of providing real-time information sharing across the care continuum. In order to support this network, the system added key physician leadership positions including an executive vice president of clinical integration and innovation, who is responsible for CI and clinical innovation throughout the system, and a number of system medical

directors who will be responsible for both traditional medical staff duties at the hospitals and will be in charge of population management in their markets. As a result, Presence Health will be empowered to realize its vision of being the high-quality, low-cost alternative in the marketplace.

During this time of transition and transformation, the governance structure is also evolving. Currently, the system board only has one physician member. However, the board is seeking to fill several seats with physicians who have expertise in integrated network development, insurance and risk contracting, and quality management. There are also plans to create a board for the employed physician group.

While it may take some time to achieve these changes in governance, other mechanisms are being developed to ensure broad physician participation at the top level of the organization. leadership. A strategic planning effort to create the vision and strategy for the new entity is underway and has significant physician involvement. Additionally, creation of a systemwide physician leadership council is a priority for the first year of the merger.

Evolved Integrated System: Sutter Health

Sutter Health is a not-for-profit, integrated delivery system that delivers care to patients in over 100 Northern California cities and towns. With approximately 5,000 affiliated physicians, 47,000 employees, 24 hospitals, as well as a number of ambulatory and specialty centers, Sutter is one of the largest systems in the country.

Through its regional structure and engagement of both independent and medical foundation (employed) physicians, Sutter has developed partnerships with like-minded physician organizations to advance a common vision. In the Sacramento area, Sutter Physician Alliance has been in existence for over a decade and has achieved full CI. A broader effort is underway through the Sutter Medical Network (SMN), a virtual medical group of 5,000 physicians that was formed approximately four years ago. The SMN is focused on coordination of medical care throughout the Sutter system.

Physician engagement and self-determination have been critical success factors in the system's evolution to date. The medical foundations work in partnership, through contractual arrangements with multispecialty groups, which are self-governed: physicians determine compensation models and are engaged in operations. In addition, physicians who are members of SMN agree to abide by common participation requirements.

Sutter has developed partnerships with like-minded physician organizations to advance a common vision.

Physicians are also well-represented at the top of the organization: three system-level board members are physicians, and four members of the senior management team are physicians. Sutter sees an increasing need for physicians to step forward and lead. The system is proactively preparing physicians who have demonstrated leadership potential through their leadership development academy, managing clinical excellence program, and leadership lab.

While Sutter has not found it necessary to make any structural changes in its organization because of the PPACA, payer dynamics have changed significantly. In Northern California, many of the most active payers are self-insured employers who are concerned about the cost of care. These employers are being increasingly selective in choosing partners and want rate increase guarantees. Meanwhile, Sutter is the largest Medi-Cal provider in Northern California and impending reimbursement reductions will have a tremendous effect on the organization. Three changes are expected to have the largest impact:

- Federal cuts in Medicare and Medicaid through healthcare reform and sequestration
- Reduced payment rates from the plans offered on the California health insurance exchange
- The elimination of the California provider tax, which has been used to maximize Medicaid reimbursement through federal matching dollars, will occur in 2013

The organization is adopting some new strategies to ensure it remains a leader and preserves its strong financial position. Sutter has been working to take $850 million of cost out of the system, assume more risk through capitation and bundled payment, and establish a provider network that can provide a predictable cost for employers. The development of care models to support these strategies is underway. Because Sutter Health spends approximately half a billion dollars on health benefits for its employees, a natural starting point for piloting these new models is within its own system. Three medical homes are being piloted, and an ACO-like shared savings model will be established in 2013.

Many of the foundational technology tools that are necessary to drive improvements in cost and quality of care are already in place or in the process of being rolled out. All of the 2,600 physicians in the medical foundations and approximately one-fourth of Sutter's hospitals utilize the Epic electronic health record (EHR) system with Sutter's remaining hospitals scheduled to implement the standard Epic EHR over the next couple of years. Provider portals for independent physicians are also operational for the most common EMR systems. Many of these capabilities are scheduled to be enhanced with the addition of predictive modeling, risk stratification, and more robust disease registries to augment care management.

Community access is encouraged through a patient portal and "Care Everywhere," a new technology that enables medical teams from separate organizations to share relevant patient information at the time he or she receives care. Through this technology, Sutter Health is now linked with UC Davis Health System, Stanford Hospitals and Clinics, Santa Cruz County Health Services, and other provider organizations to share vital patient information.

While Sutter has achieved a great deal in providing essential services to its communities and leading the market in the quality of care provided, it faces two increasingly common challenges:

1. How does the system find the right partners to align with as it moves the entire organization to managing population health?
2. How does it obtain incentive structures that support that transition?

Key Considerations for Board Members

- Despite a slow economy, leaders must find ways to selectively grow market share. Is your organization evaluating opportunities to grow market share through a strategic alliance or acquisition of a group or organization with a specific expertise, skill, or brand niche?
- In evaluating payment reform and hospital–physician integration strategies, evaluate the best strategy to meet your mission and maximize organizational effectiveness. Are there physician specialties that should be augmented or added to increase capacity, build market awareness, and draw or increase visibility among specific population segments?
- The board needs to maintain the long view of the organization's role in the market. Are there alliances that should be formed that will achieve an overall greater good for the population you serve or propose to serve as market share expands?

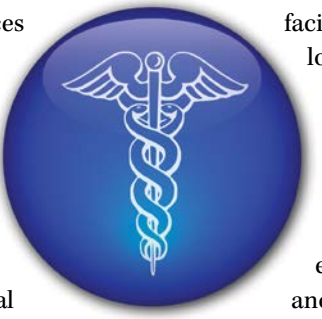
V. HOW IS THIS DIFFERENT FROM PAST ATTEMPTS AT INTEGRATION?

As payers and providers explore and implement these various integration strategies, many of these strategies may seem familiar to previous attempts at integration, particularly the HMO movement and the frenzied acquisition of medical practices by hospitals in the 1990s, as well as the joint ventures between hospitals and physician partners. But there are a few significant factors, particularly advances in information technology and payment reform, that make these attempts at integration and the results they expect to achieve, different from the past.

The Role of Payment Reform and the Payer Response

Prior to healthcare reform, payers and providers focused on measures that allowed them to sustain their margins and protect market share. Payers were seeking to manage a patient population with a minimum medical loss ratio while trying to control utilization, while providers were trying to understand how to stay in business while managing an unprofitable payer mix.

With the passage of the PPACA, payers are seeking new ways to effectively manage claims expenses and are battling to gain market position as they prepare for 2013 and 2014 reform provisions. The PPACA included a provision requiring insurers to spend 80 to 85 percent of premium dollars on medical care and healthcare quality improvement. Hence, payers are increasingly exploring ACOs or other shared risk models with provider organizations, and in some cases are acquiring physician practices or investing in physician management companies in order to have more control over the provision of healthcare. In 2011, UnitedHealth Group Inc., through its subsidiary, Optum, announced the purchase of Monarch HealthCare, an IPA with over 2,300 physicians in Orange County. Similarly, Highmark received federal approval in April 2012 for its plans to purchase West Penn Allegheny Health System, transitioning the company from a traditional insurer to a competing integrated healthcare provider and financing system with five hospitals and over 1,600 physicians.



Other payers have implemented different approaches in response to healthcare reform. Aetna Inc. has developed strategies to enable CI and business model transitions for hospitals and physician groups nationwide. The company has formed the Accountable Care Solutions unit, which will support the alignment of physicians and hospitals through the provision of payment models, private label health plans, consulting services, and tools to support disease management, wellness programs, health plan underwriting, and administrative services.

ACOs encourage engagement with providers and improve healthcare delivery and outcomes, with the potential for financial benefits at lower costs.

Another provision under the PPACA that will change the payer landscape is the creation of state-based insurance exchanges, which are scheduled to be operational in 2014. These exchanges, created to ensure all eligible citizens have access to affordable healthcare insurance, are anticipated to facilitate insurance coverage to millions of patients, including low- and middle-income families.

Individual states have the latitude on whether to develop an insurance exchange and, if so, the best means of implementation. States that fail to implement exchanges will be required to give residents access to the federal health insurance exchange. Across the nation, 17 states have established plans to build a health insurance exchange; another 11 states do not plan to implement exchanges or have

failed to advance laws to do so.[69] Exchanges already in development are expected to offer different levels of coverage with defined provider networks at each level as a means of controlling costs. The coverage levels will range from "platinum" plans with high premium costs that cover 90 percent of medical expenses, to "bronze" plans with low premium costs that cover 60 percent of medical expenses. Lower coverage levels will likely restrict benefits, and access to certain providers altering physician and hospital referral patterns and patient volumes, as patients are redirected to in-network providers.

HMO versus ACO

Many in the healthcare industry have compared the ACO movement to the HMO movement of the 1990s, questioning whether there really is much difference between the two. However, technological advances, financial incentives for providers, and support from both governmental and commercial payers in alternative payment models are the "game changers" this time around. These factors make the current ACO model very different from the HMO model of the past.

A key attribute of the HMO model was "locking" patients into a PCP, whose function was one of a "gatekeeper," rather than a general care provider and advisor. Primary care providers received a set amount of reimbursement generally on a per member, per month basis and were incentivized to manage utilization and referrals to specialists. The payment model was designed to focus on prevention but with limited infrastructure in terms of information technology, evidence-based care, and data warehousing. The end result was an ineffective healthcare system that often resulted in more silos, inefficiencies, and dropped hand-offs of patient care. Despite these limitations, the HMO movement did slow the accelerating healthcare cost curve, but the model suffered from the backlash of limited provider choice and lack of focus on quality and improving the patient experience. Quality metrics existed at only the insuring organization level, with few true care measures relating to providers and patient outcomes. The ACO model, however, is designed to bend the cost curve, improve the quality of care delivered, and improve the care for the end user, the patient. It also requires a transparency in reporting quality and cost data that was not possible in the 1990s. The difference in the goals these two models were designed to achieve dictates the difference in results.

The ACO model also requires providers to assume responsibility for the care model and claims management infrastructure, rather than the insurers. This model has actually been in effect in California where many physician organizations accept full delegation for population and financial outcomes. The delegated/ACO model allows those healthcare providers willing to step up and transform their delivery model to take control and accountability for delivering care and managing the health of a population. This model does not limit patient choice of providers; rather, it encourages providers, through financial arrangements, to develop a continuum of care that will attract patients. It further rewards better-coordinated care and improved quality for all providers involved in the care of a patient; in past models such as capitation, PCPs were rewarded for limiting referrals to specialists, and in FFS models physicians are rewarded individually based on the volume of patients seen. The providers in these integrated care delivery models can share the savings their model of care produces and receive greater financial incentives for improving the health of their patients. As for patients, the ACO encourages engagement with providers and improves healthcare delivery and outcomes, as well as possible financial benefits at lower costs.

Data exchange and real-time data reporting and capture are critical to the success of the ACO model, and unlike in the 1990s, the technology exists to support the ACO model. The U.S. healthcare system has been highly invested in the growth of technology over the last decade. Despite rising costs, technology has become a necessity in modernizing the evolution of care. The ability of providers to deliver safer, accountable care to a defined patient population is closely tied with how information is communicated between providers. The ARRA recognized this need and included an abundance of subsidy incentives for hospitals to invest in EHR technology. Government initiatives, like the Meaningful Use program, assure that organizations are utilizing their EHR on a value-driven platform. The use of medical devices, diagnostic tools, and treatments paired with evidence-based protocols and programs ensure the best patient outcomes at a reasonable cost. This is a game changer in truly integrating care across a continuum and supporting improved outcomes at a lower cost.

As with any new model, there are risks. Many worry that the ACO model will increase market power of providers and actually drive up healthcare costs through demand for higher fees. The Federal Trade Commission is monitoring this risk closely.

69 The Henry J. Kaiser Family Foundation, "State Action Towards Creating Health Insurance Exchanges" (Web page: www.statehealthfacts.org, accessed November 9, 2011).

Physician Employment

As hospital and healthcare systems rush to employ physicians, many healthcare leaders are also reminded of the practice acquisition frenzy and subsequent divestiture of the 1990s. Is this history repeating itself, or will lessons learned from the past result in a fundamentally different outcome than 20 years ago?

There are some indications that hospitals and health systems have learned from past mistakes and are taking steps to avoid the previous financial losses and culture clashes. To minimize the financial impact, they are being more selective about physicians they hire, have tightened their definition of practice value, and derive compensation from actual clinical productivity as well as other qualitative measures.

While the primary motivation for employing physicians in the 1990s was to secure a primary care referral base, the current critical goals include building a network of primary care and high-value specialists who can collaborate with hospitals to be successful under the new, value-based models. In order to drive quality outcomes and cost efficiencies, a true partnership must be forged, where physicians serve in key leadership roles to advance clinical initiatives. In addition to providing operational leadership, such as site directors or medical directors, it also may require the appointment of an actual or virtual "board" for the employed physicians. The most successful employment model includes an engaged physician group leadership council or other similar governance structure that establishes performance goals for the physician enterprise, monitors achievement of those goals, and recommends incentives to drive physician performance consistent with organizational financial, clinical, and operational goals. Typically these physician group governing bodies are paired with a "joint operating committee" that includes physician leaders, hospital management, and clinic management to discuss operational performance including budgeting, staffing, growth, and other strategic initiatives. This structure of shared leadership and governance will help to alleviate the concerns of physicians who fear the loss of autonomy in an employed model. It also encourages physician engagement in achievement of the financial, clinical, and strategic goals of the system.

Previously, physicians who sold their practices were seeking to maximize the payout for their practice, but lifestyle concerns and access to capital have replaced economic reward as the primary motivation. The majority of graduating residents prefer hospital employment to private practice[70] and are more willing to accept established organizational policies and procedures in return for a predictable schedule and financial safety net. According to the Medical Group Management Association (MGMA), 49 percent of doctors hired out of residency in 2009 were placed in hospital-owned practices.[71]

Exhibit 38 summarizes the changes that have taken place between the first wave of acquisitions and the current environment.

Exhibit 38: Physician Practice Acquisition 1990 vs. Today

	1990s	Present
Hospital Motivation	Secure referral base in response to managed care and HMOs	Gain market share and prepare for value-based payment reform
Physician Motivation	Obtain top dollar for their practice	Lifestyle, assistance with capital, and payer and regulatory complexity
Target Practice	PCPs	PCPs and high-value specialists
Practice Buy-Outs	Purchased assets and ancillaries; included substantial payments for goodwill	Assets purchased at fair market value; no goodwill
Compensation Model	Guarantee of previous year's income	Productivity models based on performance benchmarks, movement towards measuring quality and outcomes
Role in Decision Making	Minimal	Growing role in management and governance
Cultural Fit	Physicians want to maintain autonomy	Some acceptance of joint stewardship
Physician Motivation	Lack of practice management experience, focus on losses	Better understanding of system value and the need for practice management

Source: The Camden Group.

70 Merritt Hawkins and Associates, *2008 Survey of Final Year Medical Residents*, 2008.

71 Medical Group Management Association (MGMA), *2009 Physician Placement Starting Salary Survey: 2010 Report Based on 2009 Data.*

While it is conceivable that the current environment will achieve more favorable outcomes for hospitals and health systems that pursue physician employment, persistent efforts will be needed to realize the full potential. Practices are transitioning to value-based payment, but they still comprise a relatively small percent of the total book of business. Furthermore, there is the potential for higher costs for both payers and patients in hospital-owned practices. The practice of provider-based clinics charging facility fees and the market leverage of integrated delivery systems to negotiate higher payer rates are two examples of hospital-owned practices driving up costs.[72] In order for hospitals to be successful with hospital-owned practices, they need to obtain physician practice management expertise and ensure efficient operational performance, adherence to regulations, and maximum collection of professional fees by knowledgeable staff or contracted vendors.

Environmental factors, payment reform, technological innovation, and a desire to do it better are driving physicians and hospitals to align in more meaningful ways.

Joint Ventures versus Shared Risk

Although there have been substantial benefits to joint ventures in the 1990s, the healthcare financial landscape has changed considerably, initiating a cautious approach to joint ventures. Reduced volumes within hospitals decreased the need to expand services to off-site venues such as ASCs to accommodate demand. Additionally, changes in Medicare regulations decreased the reimbursement to hospitals and ambulatory centers, which limited the capital available for further investment.[73] To make things even more complex, the Stark laws restricted the types of arrangements allowed.[74] Despite the above mentioned impediments, joint ventures between hospitals and physician partners continue to be an important component of modern CI models. Joint ventures in today's environment are less concerned with joint investment in equipment and facilities and are largely focused on partnerships that improve care and efficiencies across the care continuum, quantify outcomes, and manage costs. They have also started to include third-party payers in order to engage all of the components necessary to create a financially sustainable model.

The alignment of these three entities (hospitals, physicians, and payers) is imperative in today's financial market where capital is difficult to raise by physicians or hospitals alone. The addition of payers as a venture partner increases the ability to raise capital because they decrease the risk of financial underperformance.[75]

Commercial payers are not the only ones interested in these integrated models. Government payers have also aggressively joined the movement by easing some of the restrictive regulations that historically hampered alliances between hospitals and physicians. Commercial and government payers are counting on better financial performance through the improvement of care outcomes to improve the entire healthcare system. These partnerships will drive operational improvements through streamlined processes, transform provider culture to become more patient-focused, and require that evidence and data drive medical decisions.[76] These positive products of the modern joint venture, over and above financial considerations, greatly enhance the likelihood that these new forms will succeed where those in the past have not. Hospitals and physicians have also learned from the experiences of the 1990s and are better able to manage joint ventures through solid governance structures, relationship building, and clearer formal agreements.[77]

Greenwich Hospital and Orthopaedic & Neurosurgery Specialists, PC (ONS), in Greenwich, Connecticut, is one example of a recent joint venture based on this new paradigm. The entities announced the formation of a joint venture ambulatory survey center agreement in April 2011.[78] ONS President Dr. John Crowe remarks of the agreement, "ONS and Greenwich Hospital are at the forefront of the evolution of healthcare. Across the country, physician groups and hospitals are combining their resources to provide more convenient and better care for patients. The partnership with Greenwich

72 Ann S. O'Malley, Amelia M. Bond, and Robert A. Berenson, *Rising Hospital Employment of Physicians: Better Quality, Higher Costs?,* Center for Health System Change, Issue Brief No. 136, August 2011.

73 John M. Harris and Karin Chernoff Kaplan, "Physician Business Deals: Surveying the New Landscape," *hfm,* Vol. 63, Issue 5 (2009); p. 32.

74 John R. Washlick, "Examining the Impact of the New Stark Rules on Joint Ventures," *hfm,* Vol. 62, Issue 11 (2008); p. 48.

75 James J. Pizzo and Lewis Redd, "Hospital–Physician Joint Ventures: Maximizing the Potential," *hfm,* Vol. 60, Issue 11 (2006); p. 80.

76 Brian Sanderson, Blix Rice, and Melanie Fox, "Physician Integration is Back—And More Important than Ever," *hfm,* Vol. 62, Issue 12 (2008); p. 64.

77 Allen Fine and Brandon Frazier, "Can a Hospital Benefit from Partnering with Physicians?" *hfm,* Vol. 64, Issue 5 (2011); p. 70.

78 Orthopaedic and Neurosurgical Center of Greenwich Now Operational, April 28, 2011 (www.prweb.com).

Hospital in the ASC will provide patients with the benefits of the latest surgical technology and the convenience of a same-day center."[79]

Another example is the joint venture formed between Regent Surgical Health, Chicago's Swedish Covenant Hospital and 23 physician partners on a new ASC. "Hospitals and surgeons are both facing the same difficult challenges related to competition, the economy, and healthcare reform. It is much easier to solve these problems together. At Regent, we have developed ownership models that bring these two sides back together. Hospitals, surgeons and the patient community all benefit from these collaborations," explains Regent Chief Development Officer Jeffrey Simmons.[80]

Clearly, joint ventures will continue to evolve in response to healthcare environmental forces. Through the past 20 years, joint ventures have proven to increase service volume, enhance revenue, and support new relationships, and we'll likely see joint ventures play a role in the new hospital–physician integration initiatives to improve quality, outcomes, service, and access to care.

While past attempts at integration have not yielded expected results, environmental factors, payment reform, technological innovation, and a desire to do it better are driving physicians and hospitals to align in more meaningful ways. We should expect to see greater alignment in the coming years with some successful organizations taking past lessons to heart, and some not so successful repeating past mistakes.

Key Considerations for Board Members

- Whether or not you pursue an ACO or bundled payment contract this next year, preparing to accept and manage financial risk for a defined population will be a critical core competency to develop in the next three years. What steps has your organization taken to prepare for managing risk? Do you have robust data analytic software? Do you have internal capabilities to design and interpret medical informatics to assist in managing a population of patients?
- The future of healthcare is focused on data and CI. Useful, actionable data that provides direction on clinical and financial decisions is a key component in increasing revenues and decreasing expenses. Is your organization involving physicians in the early stages of IT planning and implementation to ensure relevance, usefulness, and buy-in?
- Integrating services across the care continuum including primary care, acute care, and post-acute care coordination is a success factor for achieving CI and care-delivery redesign. How is your organization partnering with post-acute and primary care providers? Does your strategy integrate these providers in a meaningful way?

79 Rob Kutz, "Orthopaedic & Neurosurgery Specialists in Connecticut Joint Ventures with Greenwich Hospital," *Becker's Orthopedic, Spine & Pain Management,* April 28, 2011.

80 Becker's ASC Review, "Regent Surgical Health Partners With Chicago's Swedish Covenant Hospital, 23 Physicians on New Surgery Center," (Press Release), Regent Surgical Health, March 22, 2011.

VI. CRITICAL SUCCESS FACTORS: MOVING FROM PROVIDER TO INTEGRATED DELIVERY SYSTEM

As the trends described in earlier chapters impact hospitals, physicians, and other providers, the pressures on all are driving a greater need and demand for integration. As discussed, integration can take various forms—employment, joint ventures, CI—but to achieve success in the changing healthcare climate, the "parts" that come together must truly work in an integrated fashion. This chapter describes the key differentiators in creating a successful integrated delivery system to respond to the increasing demand for "value" by payers and patients alike.

What's the Difference?

Many healthcare organizations today include all of the components of an integrated delivery system: multiple hospitals, employed physicians, joint-ventured diagnostic centers, ambulatory surgery centers, home health services, post-acute, community health, etc. The distinction to make between these organizations and those that are truly functioning as integrated delivery systems (or, some might say, ACOs), is the degree to which each business unit is integrated and supports the performance of others. **Exhibit 39** on the next page highlights some of the differentiating characteristics between these two descriptors.

These differences are not intended to describe "right" or "wrong"; the manner in which the healthcare delivery system is organized, led, and governed must reflect the environment in which it operates. In many communities, payers have yet to introduce significant new ways of reimbursement beyond FFS structures for each type of provider. This necessitates a "focused factory" approach for each venue of care: maximize the performance of each business unit based on the manner in which reimbursement is paid (e.g., per-diem, per case or DRG, cost-based, per visit or procedure, etc.). As payers begin to expect and pay based on value as defined by quality, efficiencies, and cost savings across the continuum of care (inpatient, outpatient, post-acute), the need for business units to integrate and collaborate grows in importance. It also increases the need for clinical and administrative leadership to co-lead many aspects of the management of the organization. This necessitates a new culture of physician–hospital leadership that can be described as a true partnership, versus the "cohabitation" that often describes the traditional medical staff–administration relationship. For example, many organizations have instituted a "dyad" leadership structure that creates joint physician and administrative accountability for a service line (e.g., cardiovascular services), business unit (e.g., physician practice), or organization-wide initiative (e.g., ACO). Further, as organizations evaluate strategies to pursue ACOs or other CI models, those that are most effective have boards that are typically composed of at least 50 percent physicians and often chaired by a physician. Therefore, community health system boards are increasingly finding that the most significant transformation is occurring within these physician-led organizations that have a reporting or potentially overlapping board membership with the "parent" board.

The following is a list of key elements that create a culture and capability for success as an integrated delivery system:

- Establish the vision
- Articulate and build the culture
- Create the structure
- Develop the resources and tools
- Access and allocation of capital
- Align performance measures and incentives
- Develop the leadership structure and talent

Establish the Vision

No different than any other enterprise, the need for a clear vision for the organization is the cornerstone of success. With the pace of change and the dramatic shifts in the competitive landscape occurring in many communities, the commitment to a long-term vision for the organization is never more important. The board's role is paramount: consideration must be given to what the desired "successful state" needs to look like in 10 to 15 years. This requires a realistic assessment of the needs and demands of the community, the competitive forces

Exhibit 39: Differentiating Factors between Hospital and Integrated Delivery Systems

Characteristic	(Today) Hospital System	(Tomorrow) Integrated Delivery System
Financial Performance	► Largely driven by hospital profitability and performance ► Entry into new services largely driven by how they complement hospital performance (drive referrals, enhance efficiency, meet unmet need)	► Reliant on how the entire system works well together ► Reimbursement rewards right care in the right venue
Payer Relationships	► Each provider-type paid differently and with distinct payer relationships	► Single-payer relationship that rewards population management
Physician Relationships	► Reliant on medical staff structure to drive quality improvement ► Employed physicians function in a silo; often individual employment arrangements; compensation largely productivity-driven ► Variety of ventures may exist with independent staff (e.g., joint ventures, medical directorships)	► Physicians organized in cohesive structures that are self-governed and incentivized to drive system-wide performance ► Co-management arrangements replace individual medical directorships
Service Line Orientation	► Each hospital in the system has service line goals and physician relationships ► Service line capabilities often overlap or include duplicative services between hospitals	► Service lines led on a system-wide basis, with clinical services rationalized over provider settings (e.g., hospitals, outpatient settings) to avoid unnecessary duplication
Core Competencies	► Provider-specific (e.g., hospital executives run hospitals, physician practice managers run physician practices, home health runs home health, etc.)	► Provider-specific, with additional overlay of centralized care management, population management, and integrated service line leadership (e.g., "dyad" of physician and manager) of service lines across the system
Capital Allocation	► Often hospital needs outweigh other business units due to greater ROI ► Facility needs can outstrip other demands for capital due to clearer or greater short-term payback	► ROI depends on impact on managing population health: "softer" capital needs of information management, investment in human resource development may take greater priority
Physician Role in Management	► CMO, VPMA, medical directors: where well-defined clinical leadership needs have been identified ► Physicians as "clinical" leads	► In multiple roles in senior leadership: CEO, CSO, CMO, CIO ► As partner in "dyads" throughout the organization: administrative and clinical leads for service lines and specific business units
Physician Role in Governance	► Physician seats on the board; often including chief of staff	► Physician seats on board ► Physicians leading clinically integrated enterprise board (e.g., clinically integrated PHO or ACO)

Source: The Camden Group.

exhibited by payers, other providers, and other stakeholders, the capabilities, resources, and capacity for change existing in the organization, and the hopes and dreams of the leadership in what "could be." It requires a careful evaluation of the following questions:

- What is the organization's role in improving community health? Does the organization want to be the best hospital in the region or take the responsibility for improving health regardless of the venue of care or intervention required to achieve it?
- What are the current capabilities to manage population health?
- What roles do "partners" (physicians, physician groups, and other providers) want to play in improving community health outcomes?
- What is the current state of fiscal and organizational health?
- Does the organization have the resources to invest in the new tools required to operate an integrated system, or will success likely require a partner or affiliation with others?
- Is there a history of successful change management? What is the tolerance for risk and implementing new ventures? How quickly is the organization willing to change? How quickly will change be needed to achieve this vision?

The answers to these questions, among others, will create the framework and "blueprint" for how and to what degree "integration" will occur in the organization.

Articulate and Build the Culture

Too often, a vision is crafted that is compelling, yet the attributes that define the culture of the organization are left unsaid. This goes beyond the values of dignity, integrity, and stewardship that may be imbedded in the organization's mission. One of the differentiators in successful integrated delivery systems is the humility with which the organization is led. This is due to the fact that there are at least these four key drivers of culture:

- Patient centered
- Relentless pursuit of improvement
- Transparency
- Partnership and collaboration

Patient Centered

While most healthcare organizations have the intent of being patient centered, consider the following:

- How many times does a patient need to register between physician office, hospital, and diagnostic center?
- How quickly can a patient get an appointment with the desired clinician? Can they access the provider via email or other social media like most of the other services they utilize?
- Do care transitions provide complete assurance that the patient's treatment plan is clear to caregivers in the next venue of care (i.e., medications, therapies, diet)?

> Succeeding in a pay-for-value environment necessitates a new culture of physician–hospital leadership that can be described as a true partnership.

Integrated systems are integrated at every point of patient contact. It is invisible to the patient what legal entity or organization is responsible for their care at any point in time, because the hand-offs are so smooth. It is the responsibility of the system, not of the patient, to connect the dots of their treatment plan. In this sense, the patient is never "discharged" from one venue to another; rather there is a smooth transition.

Relentless Pursuit of Improvement

This attribute requires a willing recognition that every party can contribute to improving outcomes; there is a willingness to change at all levels. Systems must be imbedded in the organization that facilitate rapid-cycle process improvement and involves clinicians, managers, financial analysts, and others in every aspect of care delivery and administrative processes. This also requires a commitment to the next attribute, *transparency*.

Transparency

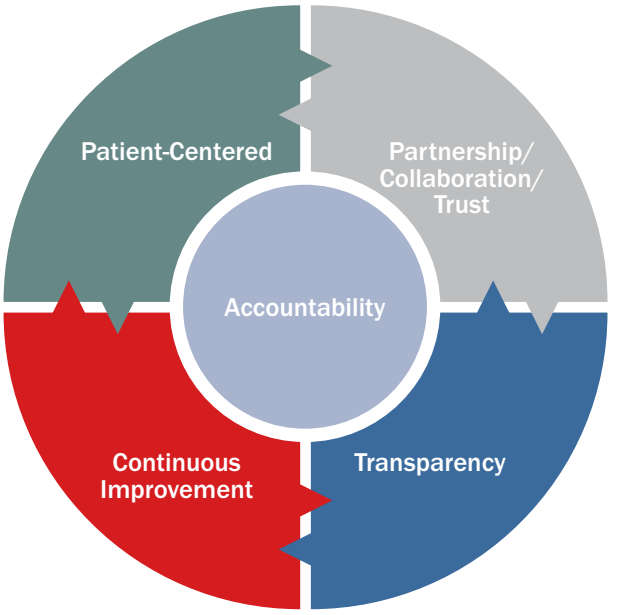
While there is increased external pressure to share quality and other outcomes with consumers, to shift organizational performance in a meaningful, consistent way requires internal transparency as well. This often creates discomfort at the administrative level, when it requires sharing of financial (cost and revenue) data with physician partners; just as it creates unease within the medical staff in sharing physician performance data related to quality and patient satisfaction. But organizations committed to creating a truly integrated culture are prepared to put all the data on the table that is necessary to determine the most critical areas of improvement required.

Partnership, Collaboration, and Trust

This final attribute is the result of the successful application of the prior attributes, but it is also required to achieve them, as shown in **Exhibit 40**.

Integrated delivery requires partnership in many forms: between clinicians and managers; physicians and other physicians; acute providers and long-term providers; etc. What stops the successful deployment of integration is not the willingness to collaborate, but control. Concern that the other party will or has previously exerted too much control on the other party is often what stops joint ventures from happening or being successful. Partners are typically not willing to give up control when there is a lack of trust. And both physicians and hospital managers have stories about the other that create a concern about trust: will they just be looking out for their own personal or departmental gain? How can their inherent "greed" (for money or power) be tamed? While perhaps not stated in those terms directly, many legal structures, decision-making processes, and even governance models are designed to protect one party from being unfair or exerting too much control on the other. Often, only with time and experience in working together does the trust required of true partnerships fully mature.

Exhibit 40: Creating an Integrated Culture



Source: The Camden Group.

Create the Structure

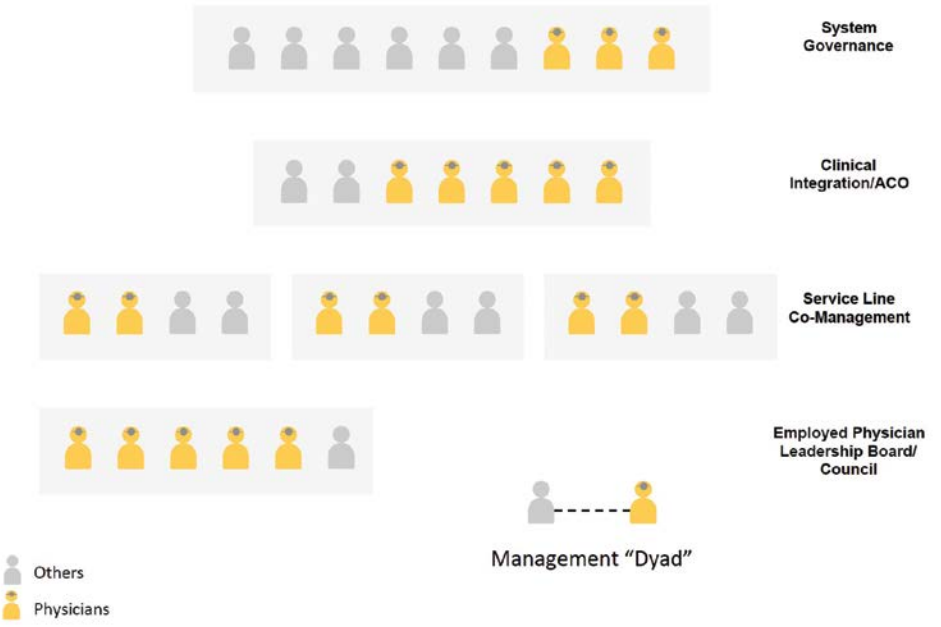
The adage, "form follows function" could never be truer today in designing or redesigning an integrated delivery system. While most hospital systems today include many outlets and opportunities for physician involvement, the focus is typically on providing input into the hospital's strategies, operations, and clinical improvement initiatives. The difference with truly integrated delivery systems is that there is a much more robust presence of physicians and other clinicians (nurses and pharmacists are critical) at every level of the organization, including management. Boards, advisory councils, co-management committees, and other forums are organized to focus on CI, identify system-wide initiatives, and manage financial risk. These structures "institutionalize" shared accountability, which is crucial to achieving true integration. (See **Exhibit 41**.)

Many integrated systems include a combination of structures and vehicles to achieve the strategies described in the prior chapter: co-management, CI, physician practice management. Each requires engaged participation of physicians in order to be successful.

Co-management is typically focused on establishing a structure and shared accountability for meeting the goals of clinical service lines. This often is applied to significant services that may span multiple hospitals; cardiovascular services, oncology, orthopedics are the most common today. The governing bodies for these types of arrangements are typically steering committees that include equal representation between physicians and management to set, measure, and drive strategic, clinical, operational, and financial goals. The physician enterprise, which may include employed and independent physicians, are equally as incentivized as the hospital or system management to achieve the identified metrics and performance standards.

Clinical integration, which weds employed and independent physicians into an accountable network along with the hospital, requires a governing body that is predominately physicians. With the aim of a clinically integrated enterprise to improve population health and the efficiency and quality of care provided, clinicians must drive the "bus." Some organizations, which are viewing this strategy as a prelude to acting

Exhibit 41: Structures for Engaging Physicians



Source: The Camden Group.

as an ACO, might also include consumer representation to meet CMS guidelines.

The missing link between a "hospital that employs physicians" and an integrated delivery system can often be detected in the governance structure that provides oversight of physician practice operations. In many organizations, physician employment relationships have evolved over the years with various specialists, individuals, and locations added under the employed "enterprise" as a result of either competitive response, opportunity, and/or response to recruitment need. The result is often a myriad of compensation arrangements, management structures, and even information systems. In order to provide the fuel for optimizing performance and capitalizing on the potential of the clinical enterprise represented by the employed physicians, there must be a centralized leadership structure led by physicians that functions much like a board of directors might for an independent medical group.

This thought strikes fear into many hospital executives, because it does create a locus of power for engaging the employed physicians into a common leadership structure. As noted in the section, "Articulate and Build the Culture" above, one of the first requirements of building a culture that supports integration is no longer worrying about who has the most "control." The employed physician models within health systems that typically perform best are led by a strong group of physicians with management support ("physician led, professionally managed") that feel, act, and are accountable for the performance of the physician practices. This does not necessarily require creating a separate legal entity (e.g., foundation or separate medical group), but it does require establishing a charter for governance that the physicians themselves have a hand in creating. For structures where there is a medical group that contracts with a foundation or hospital, this means a board composed of physicians that is responsible for the professional performance of its members. For hospitals that directly employ physicians, these entities are often structured as leadership councils that, while not formal boards, function in a similar manner. The hospital management still retains oversight on payment models and ultimate fiduciary responsibility is still housed in the hospital board, but the employed physicians are engaged in oversight of the achievement of clinical and professional standards that have been approved by the hospital board.

On a more granular level, the engagement of physicians must also occur at the management level. The "co-management" concept that relates to the manner in which a service line may be governed must also be housed in a physician–administrative "dyad" management structure. That is, at virtually every level of the organization, business units are led by a team of physician and non-physician leaders who are jointly accountable for clinical, financial, strategic, and operational performance. This includes physician practices, service lines, hospitals, and even system-wide operations. It is different from the traditional model where "administrators worry about finances and operations, and physicians worry about other physicians and clinical care." In the dyad model, both physicians and non-physicians are jointly accountable for *all* aspects of the business unit's performance.

Develop the Resources and Tools

As with any transformation, bringing new capabilities and resources into the organization is often required to achieve success. For organizations moving from provider-focused, "silo" operations to those that seek to manage population health in an integrated, seamless fashion, this often means introducing brand new concepts and capabilities into the organization such as disease management, predictive modeling, and health information exchange. Key questions for the organization are:

- Are the basic operations functioning to optimal capacity? For example, if revenue cycle functions are underperforming for any aspect of the healthcare enterprise (physicians, hospital, post-acute, ambulatory), this must receive top priority before more complex payment models are put into place.
- Can the organization facilitate smooth transitions across care venues? This typically requires centralized care management resources that are devoted to assuring that handoffs between primary care/hospital/home/primary care happen smoothly and support the care protocols established by the system. Organized hospitalist teams that work in concert with the care management staff as well as other hospital-based physicians are critical.
- What is the state of the clinical information technology? Having electronic medical records and computerized order-entry systems are now "table stakes" for participation in today's healthcare environment. Creating an integrated organization requires a centralized data repository and a health information exchange to assure provider, management, and patient access to needed information to facilitate effective and efficient clinical care delivery.
- Does the organization have expertise in medical informatics and predictive modeling? Having the information is only the start. It is necessary to interpret the meaning and utilize data to craft outreach strategies that will prevent illness from occurring as well as reduce the risk of unnecessary treatments and proactively treat the chronically ill. Using this information to design effective disease management programs is also a requirement for those pursuing population health management.
- Can new capabilities be built or do they need to be purchased? The answer to this fundamental question will depend on existing capabilities, available resources, availability of outsourcing options, timing, and organizational

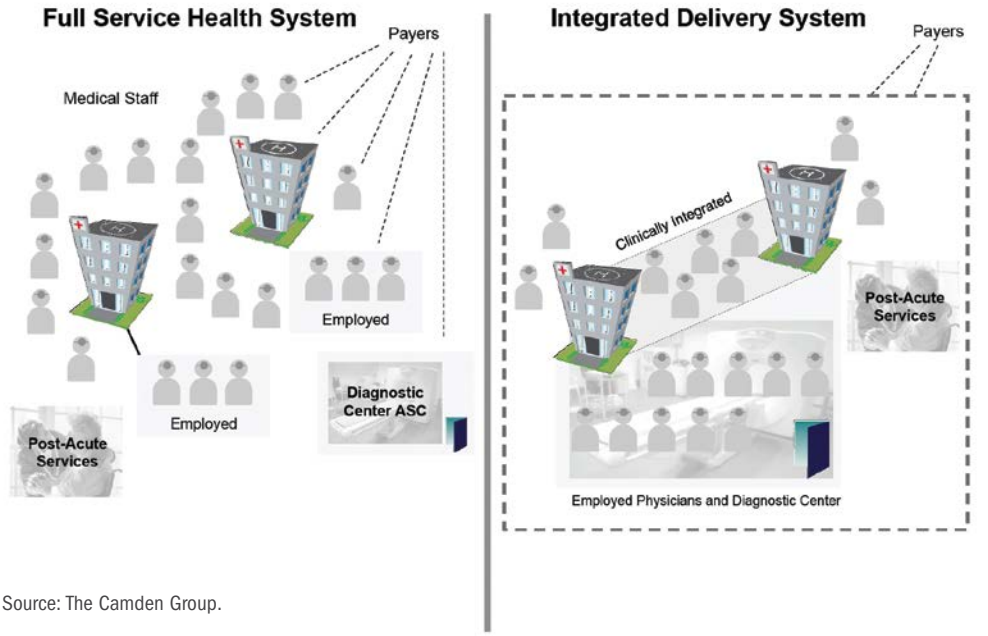
culture. Some organizations feel the need to build everything themselves. Depending on the pace of change in the community, some capabilities may simply be too far out of the core competencies and take too long to perfect, requiring outsourcing. Collaborating with other community organizations (physician organizations, health plans, other hospitals) may also facilitate acquisition of these needed skills.

Access and Allocate Capital

As most hospital organizations that have built an employed physician enterprise know, the funds required to establish the infrastructure required to manage physician practices is only the beginning of the investment required. With today's expectations for not only strong practice management systems and revenue cycle performance, but also electronic medical records that meet "meaningful use" requirements, capital for information systems alone is significant. The MGMA has determined the estimated capital cost of implementing an EMR at approximately $33,000 per physician FTE, with $1,500 in ongoing maintenance costs per year.[81] In addition, most hospital-owned physician practices require subsidization to cover operating losses, due to the reallocation of revenue from ancillary services. That is, the ancillary services that normally might be provided in a physician's office practice are provided in hospital-based departments (lab, radiology, imaging, physical therapy), thereby moving the revenue stream out of the practice into the hospital. While this typically improves reimbursement, since hospital-based services are paid at higher rates than office-based services, it leaves the practice showing a loss; while the increased profitability to the hospital is often imbedded in overall hospital financial performance.

With MedPAC proposing that all outpatient services be reimbursed at the same rate,[82] thereby eliminating the revenue differential paid to hospital-based services, this reallocation of revenue from one health system "silo" to another is likely to be a pointless exercise in the future. **Exhibit 42** illustrates a possible scenario of the current impact of a hospital-acquired practice and the possible financial impact under an integrated scenario where hospital and physician-practice ancillary revenue is reimbursed equally. The only difference in the revenue between the independent and integrated practice is the potential for improved payer contracts in an integrated setting.

Exhibit 42: Illustration of Ancillary Revenue Reimbursement under Integrated Structures



Source: The Camden Group.

81 Shirley Grace, "Technology: Calculating an EMR's ROI: The Case for EMRs in Dollars and Cents," *Physicians Practice*, Vol. 17, No 1, January 1, 2007.

82 Douglas B. Swill and Eric M. Berman, "United States: MedPAC Recommends a Reduction in Hospital Outpatient Department Medicare Payments," Drinker Biddle, January 25, 2012.

The major point here is that investing in a physician enterprise must be evaluated just as any other investment in a critical business unit. At the same time, as payers change the "rules" and look for ways to minimize the difference in reimbursement for the same service delivered in different venues, decision makers should be cautioned about evaluating physician strategies simply for the benefit of "pull through" revenue or referrals. The strategy, as well as the investment, should be analyzed based on its contribution to the success of integration and the organization overall.

Capital allocation decisions become more complex in an environment where reimbursement rules are apt to make 180-degree changes over the next few years. For example, the profitability of imaging services is based on a FFS reimbursement system. How will this service fare in a population-based, shared savings, or even capitated environment? These issues must be considered as capital is being allocated between projects with traditionally high ROI (surgery, imaging) and those critical for success in a value-based reimbursement environment (primary care, health information exchange, post-acute care).

Critical questions to be addressed by the board include:

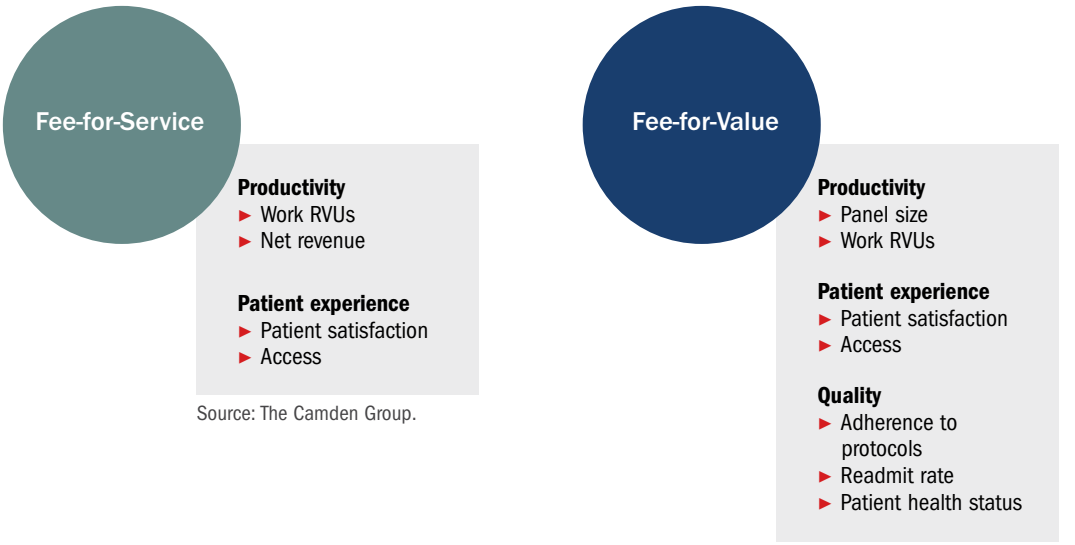
- What is the expected timeline in the market for major shifts in reimbursement? What is the organization's dependency on Medicare and Medicaid and how do anticipated changes in reimbursement for these payers impact proposed capital projects?
- What new capital requirements are necessary as the physician enterprise is expanded? This could include major upgrades in practice management and revenue cycle capabilities, ambulatory medical records, resources for CI with independent physicians, or ambulatory services/medical office buildings.
- Are the necessary financial resources available to fund the capital requirements, or should outsourcing or partnering with other organizations be considered to achieve goals?

Align Performance Measures and Incentives

The incentive structures for management and physicians should be reflective of the goals and desired behaviors of the organization. Physician compensation methodologies have evolved over the last decade from "guaranteed" income to productivity based incentives, to include many more measures indicating the quality and experience of patient care.

As shown in **Exhibit 43**, while some of the performance measures under FFS and fee-for-value payment structures are similar, there is much greater emphasis on quality and patient status in a fee-for-value payment structure. Productivity measures shift to measuring "panel size" as an indicator of the size of the patient population for whom the provider is

Exhibit 43: Aligning Performance Measures and Incentives



Source: The Camden Group.

responsible. In most cases, just as the payer environment is evolving from pure FFS to reimbursement more dependent on quality and efficiency outcomes, compensation structures can evolve over time as well. However, this does require consideration as physician employment agreements are structured to assure that there is enough flexibility in the model to allow the introduction of new measures and re-weighting of incentives (more quality, less productivity) over time.

Achieving successful integration also requires synergy between management incentives and those of the physicians and other clinicians. It also requires consideration of whether or not there is incentive to achieve system requirements over those of each business unit. For example, to assure that the physician–management "dyad" is truly incentivized to work as a team, both should be equally motivated to achieve quality, financial, and operational objectives. Likewise, the hospital "dyad" should be rewarded for the growth of the physician enterprise, and the physician enterprise should be rewarded for helping to achieve goals that benefit the hospital (e.g., reduced readmission rates).

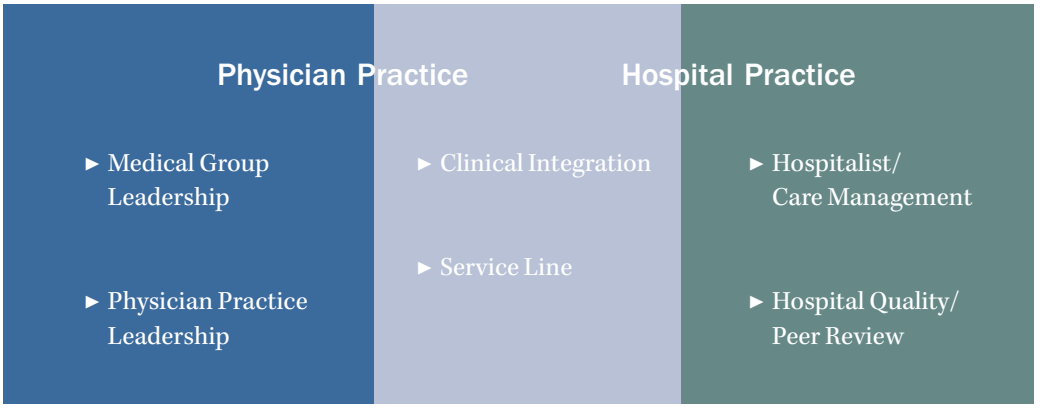
Questions the board should consider are:

- Is there an annual review of incentives across the organization to assure that they are synonymous with the organization's objectives relative to integration?
- Are physician and administrative leaders motivated to achieve goals that are supportive of integration? Are their incentives similar enough to make sure that they will support the efforts of one another? Can the same be said for the incentives for leaders of each business unit (i.e., hospitals, physician enterprise, post-acute care, etc.)?

Develop the Leadership Structure and Talent

While incentives may drive performance, the talent must be present and nurtured to assure that the organization is led effectively and in a manner that fosters the organization's desired cultural attributes. As organizations seek to enhance the effectiveness of their hospital–physician integration strategies, one of the greatest investments that can be made is investing in leadership development for clinicians. (See **Exhibit 44**.)

Exhibit 44: Physician Leadership Requirements



Source: The Camden Group.

Physician leadership development is crucial as an integration strategy in and of itself, since an integrated delivery system requires physician leadership in multiple venues:

- **Physician practice leaders to co-lead the management of office practice.** As noted earlier, the most successful physician practices, even those in hospital-owned systems, are those where there is active physician engagement and leadership in driving the financial, operational, and clinical performance of physician practices. This includes leaders for each practice site as well as those to lead the physician enterprise overall.
- **Physicians to lead CI efforts.** Since there is usually a blend of employed and independent physicians, it is critical that initiatives to achieve system-wide CI goals are led by physicians. The primary leader may be an employed or independent physician, and it is often a different person than the hospital chief medical officer. As noted earlier, a governance model that includes physicians representing a variety of practice settings (employed, independent, hospital-based) will be important to assure success for a population-based CI effort.
- **Physicians as service-line leaders.** Most organizations today have a plethora of medical directors for key clinical service lines or departments. But how many of these individuals have clear performance goals, are measured against these goals, and are selected based on their ability to lead?
- **The critical role hospitalists and other hospital-based physicians play in facilitating effective patient care in the hospital, as well as coordination of care post-discharge requires leadership that teams with nursing and care management staff.** Skill in leading the hospitalists as a group requires personnel management skill. To be optimally effective in achieving goals for coordination of care, this individual also must be in sync with the nursing teams, other hospital-based physicians (e.g., intensivists, emergency department, radiology), as well as hospital management.
- **Physicians to lead hospital quality and peer review initiatives.** Many hospitals today have chief medical officers as well as the traditional hospital chief of staff. With the critical impact of quality performance on reimbursement as Medicare's value-based purchasing program rolls out, these positions have never been more important. However, a key warning is not to over-burden these individuals with every initiative that is physician-related (i.e., the other roles listed here). The vice president of medical affairs or chief medical officer is critical for advancing quality within the hospital as well as other venues, but he or she cannot be the sole physician leader on whom the organization relies. Further, the traditional medical staff leadership structure of elected leaders (chief of staff and medical executive committee) will only be effective if supported by a designated (employed) chief medical officer to provide the focus required to advance quality improvement efforts.

Physician leadership development is crucial as an integration strategy in and of itself.

Identifying physicians who can best serve in these roles must involve consideration of clinical and communication skills, as well as cultural fit. Clinical skill and reputation are important, but the ability to communicate and work with management and clinicians alike both within and outside the hospital is just one of the attributes that should be considered when selecting leaders for these positions. Providing training and mentors to advance leadership skills is then necessary to optimize physician satisfaction in their role as well as their effectiveness. One benefit of developing the types of governance councils and committees identified earlier in this chapter is the opportunity they create for involving physicians at every stage of their career in leadership roles. Those that demonstrate interest in taking on greater responsibility can be provided additional training and coaching to advance their skills and support their interest. No longer can organizations rely on the political process of medical staff elections to bring physician leaders to the table. The issues are too complex, the roles too broad to rely on popularity or obligation to achieve the results that integrated systems need for success.

Issues for board consideration include:

- What are the venues across the organization from which physician leaders may be identified? Clinical improvement councils, medical staff organization, physician practice leads, and service line co-management committees are a few of the areas to look.
- Are performance expectations clear for physician leaders in the organization? Do they get feedback on their performance, and are there incentives in place that reward achievement of the goals?
- What does the organization spend today on physician leadership development? What process is in place to assure that emerging leaders receive the training and coaching they need to be successful?

VII. LEADERSHIP AND GOVERNANCE IMPLICATIONS: QUESTIONS, ISSUES, AND OPTIONS

The primary question to answer is whether the board and senior leadership team are effectively and proactively responding to the evolving healthcare reform environment. Boards and senior leadership teams of healthcare providers that are keeping pace with change recognize the need to constantly examine new and different methods to address the strategic/competitive positioning, policy, financial, clinical, and operational aspects of their organizations. Consider the following:

- What policy, strategic, and operations-related changes have you already embraced, and what will be required in the future to address longer-term economic, clinical, operational and regulatory shifts?
- Does it feel like the board and leadership team is ahead of the curve, just keeping up, or falling behind?
- Are board members and senior leaders energized by, or overwhelmed at the magnitude of potential change?
- Does the board effectively understand and embrace the increasing complexity of the roles they are being asked to fill?
- Does the board feel adequately informed, educated, and kept abreast of the important issues they must understand, interpret, plan for, and act upon?

Leadership and Board-Specific Issues

Areas many boards are proactively assessing and considering now include:

- Board structure and size (e.g., too large/small; number and type of committees; centralized/de-centralized control for systems)
- Composition relative to the "talent resource profile" of directors specific to areas of expertise, such as merger/acquisitions/affiliations, public health policy, population health management, risk-oriented managed care, physician/clinical experience in areas of quality, utilization management and evidence-based medicine, entrepreneurship, technology, legal/compliance, and others.
- Focused and intensive "advanced placement" education for all directors to raise their awareness and competency levels to understand strategic and business implications of trends, change, and policy shifts.
- Board and committee meeting agendas that focus on policy and strategy implications of healthcare reform as much as on operational topics of finance, quality, and credentialing issues.
- Committees and issue-specific task force groups that aggressively drive to the forefront issues of redesigning models of care delivery, population health management, alternative forms of reimbursement including bundled payment, risk-sharing arrangements, shared savings models, patient centered medical home, value-based purchasing, and clinical integration.
- Capital priorities that balance IT infrastructure development, physician recruitment/retention, facilities expenditures, and others.

Is There a Merger/Affiliation/Consolidation Strategy in Your Future?

Many smaller organizations will not have the critical mass to dedicate time, money, and staff to addressing these strategic, policy, operational, and infrastructure issues. To survive, many are now exploring strategies that include mergers, affiliations, networks, partnerships, and other alliances with organizations with the resources and capabilities to access capital and provide infrastructure advancements required

for survival. In fact, some organizations are seeking merger or affiliation for the sole purpose of advancing their physician alignment strategy.

Many organizations will find it essential for their boards and senior leadership teams to determine whether the organization can or should remain independent in a changing healthcare environment. Answers to these questions will require careful analysis of issues including:

- Capital needs (five, 10, and 15-year horizons)
- Debt capacity and the ability to fund future capital needs independently
- Capital accessibility and cost
- Operating margin trends and future projections (taking into account estimated shifts in Medicare, Medicaid, and commercial reimbursement levels)
- Strength and breadth of the physician enterprise (employed, clinically integrated, or both) necessary to maintain market strength and respond to the demands of health payment reform
- Ability to effectively and significantly redesign clinical care delivery processes, with physicians as champions and leaders of the process
- Ability to streamline throughput and ensure efficient transitions of care through the emergency department and other inpatient, outpatient, and post-acute care settings and services
- Ability to incorporate post-acute, palliative, and hospice services more seamlessly into the care continuum to better manage costs and provide care in appropriate settings at the right time and point of need
- Ability to be profitable on Medicare rates
- Ability to grow market share and eventually accept responsibility for delivering care to a defined population of patients and people (on an at-risk payment basis)
- Current IT infrastructure/capabilities and future needs (EMR, CPOE, clinical data repository, HIE, etc.) and the ability to achieve meaningful use thresholds
- Competitor initiatives such as physician employment, ACO development, and other models developed for healthcare reform and capturing population

Addressing the questions and issues above will provide a guide for policy decisions and strategic plans that will be essential to develop for the next five, 10, and 15-year horizons.

Physicians in Governance and Senior Leadership Roles

The advent of healthcare reform has made it clear that boards and senior leadership teams must involve physicians and other clinicians in discussions of policy and strategy regarding clinical care delivery and process redesign. This involvement also extends to governance and senior leadership team levels. More organizations are expanding the involvement of physicians in governance and leadership roles through membership on boards, key governance-related committees, on senior leadership teams, and in other high-level advisory capacities.

The physician perspective is essential to define and execute effective board and senior leadership team activities of all types. Nevertheless, as many organizations have learned through experience, status as an academically or clinically credentialed physician alone is an insufficient qualification to effectively perform duties of governance or organizational leadership roles and responsibilities.

We often ask the question of whether it is possible to develop a leader or if leadership comes only out of innate talent that cannot be learned. Organizational development guru Warren G. Bennis once made the still-provocative statement, "Leaders are made rather than born." The quest of most modern healthcare organizations is to develop effective (if not extraordinary) physician leaders and integrate them appropriately into increasingly formal and responsible leadership and governance roles. Timing, place, and circumstance are all critical elements in the process of discovery and application of talent, interest, willingness, capability, and fit in the leadership development equation.

Physician leadership development education and training is more accessible now and is being taken advantage of by clinicians of every specialty and type. This is preparing more physicians to participate as effective contributors in governance and leadership roles.

Identifying New Physician Leadership: Qualities and Skillsets

New healthcare models require not only changes to the autonomous, physician-driven care model but also for a transformed physician leader/role. It requires an individual who can lead other physicians, clinicians, and others toward new clinical and financial benchmarks while driving and engaging all members of the healthcare team toward future success; this necessitates specific skills and characteristics.

The successful new physician leader is one who fosters collaboration and cooperation, with the vision to look to the future and navigate the system, physicians, and teams through the challenges of healthcare transformation to the next level and beyond. It requires an ability to build new teams across the care continuum using an open mind and a willingness to accept different ideas and to embrace change. The culture of these new teams will only materialize when their members believe their voices are heard, their contributions matter, and their ideas are considered. These leaders must be able to find compromises, welcome new ideas, and often meet in the middle to forge a culture of collaboration and mutual respect. Additionally, they must possess strong verbal and written communication skills.

Top 10 Essential Physician Leadership Qualities and Skillsets

1. Collaboration and cooperation. These are both mandatory traits. Finding compromises, welcoming new ideas, and often meeting in the middle are necessary attributes in leadership roles. Building new teams across the care continuum requires an open mind and a willingness to accept different ideas and change.

2. Strong listening skills. The collaboration and teamwork requires good listening skills. Good listeners hear the true message conveyed—not just the words. The ability to listen to conflict and disagreement while working towards cooperation must be developed.

3. Communication skills. Both verbal and written communication skills are critical. Clarity, precision of message, and the ability to be consistent and be heard are necessary to deliver a message of change. The ability to present and tell a story with listeners engaged and understanding the message is critical.

4. Self-confidence and mental resilience. Both are necessary for a change agent. Not all may welcome the changes in healthcare, and the agent of change at times needs to have a tough skin. Remember, in transformation periods one can often tell the leaders by the arrows in their backs!

5. Humility. Humility and the ability to accept the missteps and mistakes that will occur at times are essential. While this seems in conflict with the characteristic of self-confidence above, it is the balance of self-confidence and humbleness that will serve physician leaders very well in being effective at every level of governance and leadership.

6. Lack of arrogance. A lack of arrogance in giving direction and guidance is necessary. Transforming healthcare requires teambuilding as well as giving direction. However, the direction needs to invoke a collaborative and participatory environment—not one of "I say; you do."

7. Appreciation for others. An appreciation for others' thoughts, ideas, and input is vital. A team culture will only materialize when its members believe their voices are heard, their contributions matter, and their ideas are considered. People will defend and take ownership of decisions they have helped to make.

8. Mentoring. Mentoring team members must be in the skill set, and if it is not, then it must be developed. The skills to allow professional development of other physicians, clinical staff, and administrators may take time and effort but promotes successful, self-sustaining teams.

9. Life balance. A life balance needs to exist that includes work, family, colleagues, work environment, and physical and mental fitness. Whether this includes some clinical practice is dependent on the situation. More physician leaders now prefer to retain some clinical duties rather than previously, and many hospitals and health systems support this as well.

10. Vision. The vision to see beyond the short-term and stay the course toward the future is needed. True physician leaders have the vision to look to the future and navigate the system, physicians, and teams through the challenges of healthcare transformation to the next level and beyond.

Applications, Questions, and Recommended Discussion in the Boardroom

In the boardroom and C-suite, regularly discuss the status of healthcare reform elements and their potential impact on your organization, aligned physicians, patients, and the community. Ensure that the management team conducts thorough research and evaluation of the best practices of organizations that have significant experience with managing risk, pay-for-performance, service line co-management, and other clinical integration activities. Learn from their successes and challenges. Be mindful that "one size does not fit all" when it comes to clinical integration and alignment strategies. Each strategy must be designed to fit your circumstances; something that works well in another organization cannot be transplanted wholesale into your situation. Always customize initiatives to your unique environment and enterprise.

The physician perspective is essential in the boardroom and in senior leadership positions. Begin now to identify physicians with leadership potential and support their education, training, and coaching efforts consistently.

Some organizations may find they will need to appoint to the board an "imported" physician(s) from outside the community to add a specific capability of high-level expertise and objectivity in areas such as clinical quality or population management.

Outside expertise can add a broader base of experience, objectivity, and freedom from peer influence and risks associated with the potential for damaging referral relationships among colleagues when hard decisions or corrective feedback are required.

Assess the composition of your board and incorporate into your recruitment/succession plan an appropriate level of clinical expertise to be represented among the directors. Consider the following questions:

- Is your organization already physician led?
- Does your board include physician members? How many is the right number?
- Has your organization's experience with physicians as directors been positive, negative, or neutral? Why has this been the case? How can this be applied for involving physicians on the board in the future?
- What lessons learned would you share with others who are making decisions about expanding the number and type of physicians on their boards?
- What types of physicians make the best board members? What characteristics make a positive difference?
- What is the profile of an effective physician director? (How is this different than that of any other director?)
- What are the benefits as well as potential risks associated with physicians on the board (that are uniquely different than for non-physician directors)?

CONCLUSION

Emerging payment models will attempt to bend the healthcare cost curve and focus payments on outcomes that enhance patient health status. Hospitals and health systems are charged with developing a new kind of provider relationship in order to prepare for and succeed in a new payment environment. This necessitates a restructuring of the way care is delivered in the nation's hospitals; healthcare leaders must go beyond basic alignment of financial incentives with physicians and seek a true integration strategy that enables physicians and hospitals to seamlessly orchestrate high-quality, cost-effective care.

Achieving success in hospital–physician integration requires much more than acquiring and employing physicians throughout the community. In fact, a successful integration strategy may emphasize "virtual" integration through CI and co-management over direct employment. Building an ACO may be the right option for many organizations, but it is not the only integration option. Organizations must consider the various integration models presented, evaluate their position in the market and current relationships with physicians, determine community health needs, consider the current strategic plan and future vision, and identify the model or structure that will be the best fit for the organization. It is possible that more than one model or structure could be applied. The key, as with any strategy, is being clear about the vision and goals for the organization, articulating and building a culture of accountability for value-based care, establishing the structures and incentives that support those goals, allocating resources in a manner consistent with the objectives, and developing leaders that will drive the enterprise toward that vision.

An effective leadership structure involving the board, administration, and physicians is the essential foundation for a successful integration structure. The leadership structure may be similar to what is currently in place, or it may end up being very different. Physician leadership especially will be one of the most sought-after attributes for organizations seeking to thrive under evolving new payment models—is the organization dedicating the time, money, and effort to support clinical leadership success? Has it articulated its path toward delivering "value" over "volume"? The answers to these questions will be critical indicators of an organization's readiness to take on the demands of a marketplace that expects accountability for quality, cost, and community health.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AS HOSPITALS AND HEALTH SYSTEMS NAVIGATE THE VARIOUS MODELS AND OPTIONS FOR INTEGRATING WITH PHYSICIANS, IT CAN BE DAUNTING TO DETERMINE WHICH CHOICES TO MAKE FOR SUCCESS IN A NEW ENVIRONMENT OF VALUE-BASED HEALTHCARE. MOST HEALTHCARE ORGANIZATIONS TODAY ARE AT SOME POINT ALONG THE INTEGRATION SPECTRUM AND CONSIDERING OPTIONS TO BEGIN INTEGRATING, ENHANCE EXISTING INTEGRATION EFFORTS, OR COMPLETELY TRANSFORM THEMSELVES INTO A FULLY INTEGRATED DELIVERY SYSTEM.

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