THE HEALTHCARE EXECUTIVE’S GUIDE TO PHYSICIAN-HOSPITAL ALIGNMENT

COKER GROUP
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**About Coker Group**

Coker Group, a national healthcare consulting firm, helps providers achieve improved financial and operational results through sound business principles. Coker’s team members are proficient, trustworthy professionals with expertise and strengths in various areas, including healthcare, technology, finance, and business knowledge. Coker works with hospitals and physicians to develop sound strategies for forming and maintaining successful alliances and relationships.

Service areas include, but are not limited to: hospital-physician alignment, ACO readiness, capital advisory, strategic financial advisory and analysis, practice management, mergers/acquisitions and due diligence, compensation, pre- and post-merger integration, strategic IT planning and review, vendor vetting,
managed IT services, hospital operations, medical staff development, and executive search.

Coker Group’s nationwide client base includes major health systems, hospitals, physician and specialty groups, and solo practitioners in a full spectrum of engagements. Coker has gained a reputation since 1987 for thorough, efficient, and cost-conscious work to benefit its clients both financially and operationally. The members of the firm pride themselves on their client profile of recognized and respected healthcare professionals throughout the industry. Coker Group is dedicated to helping healthcare providers face today’s challenges for tomorrow’s successes.
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Kay Stanley, who has contributed to Coker’s 60-plus books since Coker’s publishing initiative began in the early 1990s, has served as editor along with Trish Hutcherson as project manager.

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Alignment is a word that most of us connect to our automobiles. I learned early in life that the front end of my car must be aligned or steering would be difficult and my tires would wear out unevenly and prematurely. Without the equipment in its proper position, the car was unlikely to perform well.

In healthcare, alignment has taken on a different meaning. As its forerunner, the oft-used term in the 1980s and 1990s was integration. Integration is the process of blending several parties’ operations and overall strategies. Indeed, during the 80s and 90s, hospitals and physicians were integrating. However, integration was a limiting term, typically meaning parties merged operations into a single “NewCo,” whereas alignment does not always encompass such dramatic changes.

Alignment is the process of healthcare providers working together to combine and synchronize their operations, strategies, relations, and overall delivery of care. They strive to coordinate all their services in order to respond to the market and other changes occurring within the overall delivery system. Alignment includes many forms of integration. Although the two terms can be somewhat synonymous, alignment takes the working relationships to higher and more varied levels of affiliation.
Introduction

This book will focus on the dynamics between the two major and most prominent providers of healthcare—physicians and hospitals—and their alignment. Physicians still have a significant role as they provide leadership in the delivery of clinical care. Hospitals, often as major health systems, also provide an important part of the overall healthcare services that are so highly regarded in the United States. Thus, physicians and hospitals/health systems have continued to work together in an unprecedented approach. Alignment models have allowed the two entities to almost become one, integrating in almost every way. Yet, with alternatives to full integration, alignment models vary, depending upon the individual needs, preferences, and overall relationships of the entities. Further, the market is driving many of the models that are coming into play. Although some alignment models presented in this book may not be the primary preference of either physicians or hospitals, the providers are compelled to adopt them due to market and competitive conditions.

In delving deeply into the subject of physician-hospital alignment in this book, we will consider key areas of the various components of the physician-hospital alignment continuum. We will explore the challenges and the benefits of physician-hospital alignment in the context of current healthcare reform legislation, looking at both current law and anticipated changes. We will examine the models and break down the strategies for health systems/hospitals’ application of these models.

We will also consider alternative models from the medical practice/physician’s perspective as well as the hospital/health system. These models are reviewed relative to the following:
Introduction

- Compensation and other financial ramifications
- Legal and regulatory components
- Information technology/systems
- Case studies using real examples of alignment strategies

Alignment in the healthcare vernacular has tremendous ramifications and complexities, which present challenges as well as opportunities. Being a part of the U.S. healthcare delivery system at this time is one of those rare opportunities to “hold on tight” as changes and new developments occur rapidly. In this book, we will examine the dynamics of the industry in the physician-hospital alignment arena.

REFERENCES

1. NewCo is a generic name for proposed corporate spin-off, startup, or subsidiary companies before they are assigned a final name, or for proposed merged companies to distinguish the to-be-formed combined entity with an existing company involved in the merger which may have the same (or a similar) name.

2. In this book, we use the terms hospital and health system synonymously—depending upon the structure and makeup of that entity.
Overview of Alignment

In the 1990s, in anticipation of a dramatic change in the structure of reimbursement, hospitals focused on purchasing practices. The thinking was that reimbursement would become a risk-based model where large groups of populations would be managed and reimbursement would be structured on a per-member/per-month capitated rate. Primary care physicians were the intended gatekeepers in the risk-based model and the federal government was to have a greater role in the management and delivery of healthcare, with overt attempts made to move toward a semi-socialistic system. Regardless of whether the political landscape changed, the perspective even in the private sector was that there would be more risk-based contracts, requiring physicians and hospitals to be integrated in the delivery of services. The response for some providers, in extreme cases, was to establish integrated delivery systems and for others, integration was a forecasted strategy for the future.

Based on their expectations of the primary gatekeeper model, hospitals began to develop their integrated delivery system through the acquisition of physician practices. Employment of those physicians soon followed on the premise that the risk-based contracts would soon unfold.
The alignment structures in the 90s were similar to, yet different from, those of today. The differences related to the way physician-alignment agreements were structured. Mostly, alignment meant employment, with little variation. Physicians were often compensated through generous guaranteed salaries with some minor incentives tied to productivity. Non-productivity-based incentives were uncommon. And, where capitation or fixed-based revenue existed, even minor incentives for productivity were diminished. Often, practices were acquired based on the determination of fair market value (FMV), which was much more liberal during that period. Hospitals paid significant dollars up front for those practices, in amounts often tied to more than tangible assets—usually goodwill.

With this structure, common reasoning would be that hospitals and physicians were truly developing a partnering attitude. This was not true; something different resulted. Hospitals failed to partner with physicians in many ways, both financially and in decision-making. There was little incentive for cost management, which was a fundamental requirement under a capitated model. In fact, physicians resented hospitals’ focus on cost-cutting programs.

The structures of the deals with physicians made it difficult for hospitals to obtain any return on investment as their models were dramatically flawed. The anticipated reimbursement structure, moving to risk-based contracts and capitated income, never significantly unfolded in the private sector. Although capitation did take hold in some parts of the country and still exists to some extent, for the most part, this system of reimbursement and overall structure never prevailed. By the end of the 90s, many health systems concluded that strategically, operationally, and economically, they did not need to continue to employ physicians.
Their losses were massive, and for the most part, the physicians were not happy with their structure. Administrative management and oversight were largely inefficient and ineffective. Thus, the attempt at integration and alignment in the 90s essentially failed.

Entering the 21st century, some forms of physician-hospital integration began to resurface. Concurrently, many hospitals continued to divest their employed physicians, while others lost interest in expanding that structure. Mutually, physicians preferred to continue in private practices.

Further, physicians—particularly specialists—sought ways to augment their incomes by moving into new service areas previously considered as hospitals’ “turf.” Private practice physicians began to own and operate surgery centers, diagnostic clinics, sleep centers, and various ancillary services to supplement their income from professional fees and in an effort to deliver services to patients more efficiently, conveniently, and economically than by the hospital.

Essentially, the physician-hospital integration paradigm largely disappeared in many areas. Physicians fundamentally preferred being in private practice.

Meanwhile, fee-for-service was the primary reimbursement structure across private, state, and federal payer programs. The stresses on the healthcare delivery system continued to increase from virtually all perspectives, as the first decade of the 21st century ended. The cost of delivery continued to escalate well above inflation rates, for example. Today, achieving reimbursement from third-party payers and the government at existing fee-for-service rates is increasingly challenged. Also, some physicians have an unrelenting desire to order extensive tests
and services (not discouraged in a fee-for-service environment), which continue to drive up utilization, costs, and the overall amounts spent on healthcare.

Private and government payers finally have realized that fee-for-service is an unsustainable model, as evidenced by the passage of the Patient Protection and Affordable Care Act healthcare reform in March 2010. Without debating the pros and cons of that particular law, this legislation represents an attempt by the federal government to place constraints on healthcare providers. Private insurers are also moving in this direction at a rapid pace. This is largely fueled by the stresses on the system of increased costs, higher utilization, and the socioeconomic strain in our country, which includes an aging population, an increasing number of foreign-born individuals entering the United States, and a growing number of uninsured patients.

The outcome is this: physician-hospital alignment is once again rising in importance in order to meet the challenges of the times. Hospitals, by necessity, are purchasing practices, but at FMV tangible asset value, which entails little up-front payments and virtually no goodwill. Reimbursement remains primarily as fee-for-service, though incentives for cost controls, quality outcomes, and patient satisfaction (i.e., something other than direct physician productivity) is under discussion. Nevertheless, physician productivity is still the key matrix in the provider compensation structures under the employment model (or models similar to employment) through a professional services agreement (PSA).

As hospitals and physicians are integrating again, they are now truly looking at alignment, which may not always connote employment. Moreover, they are looking for ways to form true partnerships that focus on quality of patient care,
delivery of services, and cost-effective management. As noted, non-employment models that range from simply working together on a limited contractual basis to full forms of alignment (but actually not including employment) are now considered in the continuum of this process.

Hospitals/health systems have come a long way toward realizing a value proposition in alignment. Many of them acquire the ancillaries developed by the private practice physician groups, paying at FMV rates, and capturing the revenue stream going forward. For now, the federal government, through the Medicare and Medicaid system, often pays more to hospitals that bill for those same ancillary services under a hospital outpatient department structure.

Most hospitals today are adopting a broader approach to physician-hospital alignment. They understand that they need to work closely with their physicians, but the relationship is not limited to an employment model, particularly like those structured in the past. More emphasis is now placed on information technology (IT) and clinical integration where continuity of care is a primary goal. Communication and the exchange of information data that is essential to managing cost and realizing greater quality outcomes is dependent upon clinical integration.

**Physicians’ Interest in Aligning With Hospitals**

There are a number of reasons physicians are interested in aligning with hospitals, but the primary reasons include:

- Financial stability through improved compensation
- Shared risk
Chapter 1

- Improved quality of life
- Infrastructure support to off-load administrative duties
- Practice style (shift variances to hospital)
- Recruitment and retention (private practices cannot compete with hospitals)
- Succession strategy (no cash-out value in private practices)

Financial stability is a challenge for physicians; therefore, they are looking to hospitals to partner with and to achieve improved compensation. Beyond employment, alignment arrangements may be through a PSA or some other limited services contract that allows the physicians to be compensated for the work that they do and for the hospitals to improve their return on investment. All such compensation must be at FMV and commercially reasonable rates, as defined in Chapter 9. Arrangements must be made within specific guidelines, with each particular plan measured within its individual and specific tenets.

Another reason for physicians to align with hospitals is the ever-increasing risk of malpractice liability and the cost of the insurance protection from lawsuits. Although malpractice insurance costs have somewhat stabilized in comparison to earlier years, it remains a major factor for physicians to partner with hospitals to share the risk in liability. Often, larger health systems have a self-insurance plan that effectively lowers the cost of the malpractice insurance by spreading the expenditure over a larger pool of physicians.
Lifestyle is another reason that many physicians want to align with hospitals. Although not new, quality of life issues seem to be more central, especially among younger physicians just coming out of training. Although they are as dedicated to their careers and the clinical quality of their practice as older physicians, newer physicians are less concerned about practice ownership and being devoted to that business. Rather, many want someone else (e.g., a hospital or corporate entity) to provide the administrative and management services, so that they can commit professional time to clinical services. Certainly, some physicians want control and active involvement in their businesses; however, fewer physicians are interested in working additional hours in order to manage the business.

Although hospitals did a rather poor job of managing practices in the 90s, the infrastructure support that they can provide today is much better. This includes one of the top reasons for many physicians to align with hospitals in the context of infrastructure support—the hospital’s ability to provide advanced IT support. This is a key point that must be considered going forward. There is no alternative to a medical practice having an electronic health record and related IT support. Chapter 11 explores the IT arena in the context of physician-hospital alignment.

Shifting practice style variances to the hospital is another reason for many physicians to become aligned. The means letting the hospital partner with the practice in developing the full continuum of services and balancing the differing practice styles under an alignment structure. As often seen in larger single- and multi-specialty groups, physicians differ in practice styles; these variances are best dealt with within a hospital infrastructure.
Physician recruitment and retention is another challenge best handled by health systems. Private practices are under continual stress for adding new providers to increase revenue. Many private practices within particular specialties simply cannot compete with the local and regional market requirements, such as compensation and benefits including income guarantees, tuition payments, etc. (The recruitment/incubation alignment strategy is discussed in Chapter 4.) As hospitals are better equipped to meet market demands in these areas, it makes good sense for practices to shift physician recruitment and retention to hospitals.

Finally, many private practices are struggling with their existing buy-in/buy-out terms and conditions. Often, these terms were set so that departing physicians were required to be “cashed out”; now, liquid funds are not available in private practices. Younger physicians coming into the partnership or practices are not interested in a large buy-in amount, which again challenges the very existence of the private practice. Developing a mechanism where succession planning works within the hospital alignment structure is becoming of interest to physicians.

**Hospitals’ Interest in Aligning With Physicians**

The main reasons hospitals are looking to align with physicians include:

- Market share
  - Recruitment and retention
- Accountable care
Overview of Alignment

- Response to physicians’ needs
  - Administrative
  - Financial
- Long-term sustainability

Hospitals and health systems are understandably concerned about maintaining a share of the market so that they can remain viable. Being able to capture a base of physicians—from primary care to specialists—through alignment is the foundation for maintaining market share.

Aligning with physicians also helps ensure success in both recruitment and retention efforts. Recruitment is a major challenge; however, this challenge can be reduced when physicians know they have an option as to various alignment models. Likewise, retention is a major part of any hospital’s strategy relative to its medical staff. Being able to retain physicians because of the varied alignment strategy is a major benefit. Again, the broader approach to alignment helps because it gives physicians more independence.

Moving into the era of accountable care, hospitals and health systems must have a full pool of physicians that will be a part of their accountable care organization (ACO). Although ACOs do not require physicians to be employed (they can be contracted by the ACO), the ability to recruit and retain physicians will be largely dependent upon the level of alignment that exists. This is particularly the case with primary care, as the Medicare ACO requires that primary care physicians only become a part of one ACO instead of several at one time.
Chapter 1

Responding to physicians’ needs has long been a reason for hospitals to align with their medical staffs. As mentioned at the beginning of this chapter, this was a major thrust of the employment model of the 90s—and still is. But it also can be effectuated through other forms of alignment, which we will discuss in more detail throughout the book. Hospitals are responding to both administrative and financial needs of physicians. Administratively, physicians often are frustrated and weary of the day-to-day hassles and responsibilities of managing and operating the non-clinical portion of their practice (i.e., the business side). And financially, many physicians’ incomes have been cut by reduced reimbursement and escalating costs. The ability for hospitals to respond to physicians’ financial and administrative needs, while still maintaining FMV and commercially reasonable compensation rates, is a major reason hospitals are aligning with their medical staff.

As also discussed earlier in this chapter, hospitals and physicians have struggled over the years with trust and good relationships with each other. Now, hospitals are seeking ways to align to improve relations with individual physicians. Working through various alignment models is a viable goal and objective relative to hospitals’ alignment strategies.

Finally, long-term sustainability is a major goal for hospitals in their alignment strategy. Hospitals provide services within the healthcare continuum that cannot be fulfilled by other entities, but they must have physicians in order to offer these services. Thus, to realize such long-term sustainability, it is essential to have loyal and aligned physicians in the healthcare system.
Current Trends

We must understand that current trends are similar to the experiences in the early 1990s. For example, a recent survey\(^2\) stated that 81% of hospital leaders indicated a moderate to high interest in acquiring practices/engaging physicians in employment. They also acknowledged that types of alignment other than employment are under way and of interest. Thus, a key trend today is stronger collaboration between hospitals and health systems and physicians and practices.

Figure 1.1 illustrates that specifically, relative to government forms of reimbursements, health systems and practices are responding through greater forms of

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**FIGURE 1.1**

**SURVEY OF HEALTHCARE LEADERS**

How will you respond to low Medicare/Medicaid reimbursements?

- Seek a partnership or other alignment structure with a health system or large medical group practice: 26%
- Seek employed position with hospital or health system: 24%
- Stop taking new Medicaid patients: 22%
- Stop taking new Medicare patients: 17%
- Stop practicing medicine or retire: 15%

alignment. Statistics from Merritt Hawkins’ 2012 report of its recruiting assignments indicate that 63% of physician recruitment in 2011 was for hospitals—up from 56% the previous year and only 11% as recent as eight years ago. Moreover, family physicians and general internists top the list of the most common physician recruitment assignments. This illustrates that hospitals are becoming the choice of full alignment, often through employment of physicians. The Merritt Hawkins report concludes that three of four physicians hired in the year 2014 will work for a hospital.

Figure 1.2 illustrates a survey from a HealthLeaders Media Intelligence Report wherein the question was asked: Which of the following physician specialties are most relevant to your organization’s M&A strategy? Primary care was at the forefront; but interestingly, some of the “higher-end” specialties such as orthopedics, cardiology, and others are also ranked very high at or above 50% of their strategy.
Alignment strategies are in place and are being considered by virtually every physician and hospital in the United States. Physicians and hospitals both face unprecedented challenges in their ability to maintain viability. Partnering alternatives are, without question, the best solution for responding to these challenging issues, such as new federal and state structures, ACOs, and the like. Hospitals and physicians should assume a broad approach to alignment, not necessarily a “one-size-fits-all” approach. Employment or employment “lite” models are not
always the models of choice. Therefore, it is necessary to consider options and alternatives and be responsive to each individual situation.

It is also important to keep in mind the key alignment challenges. These include:

- Culture
- Operations
- Autonomy and control
- Trust
- Competition
- Sharing revenue

Discussed in more detail throughout this book, these key points must be addressed within every relationship between hospital and physician leaders. Each point must be a part of the overall deal because they are all important parts of the entire physician-hospital alignment structure.

REFERENCES

1. The IRS defines fair market value as the price at which property or the right to use property would change hands between a willing buyer and a willing seller, neither being under an compulsion to buy, sell, or transfer property or the right to use property, and both having reasonable knowledge of the facts.

A comprehensive guide to physician-hospital alignment strategies post PPACA.

Many hospitals now have millions of dollars each year at stake on quality and patient satisfaction measures, and in many cases, a hospital's net operating margin could be impacted by successful performance on these measures. In order to succeed, it is imperative for hospitals and physicians to work together.

*The Healthcare Executive’s Guide to Physician-Hospital Alignment* offers a comprehensive look at the drivers of physician-hospital alignment and the impact of health reform on alignment. It outlines the pros and cons of various physician-hospital alignment models, and discusses how alignment strategies differ based on service line.

This road map to physician-hospital alignment will help you and your organization:
- Understand key drivers of alignment from the physician and hospital perspective
- Identify common roadblocks and challenges of various physician-hospital alignment strategies
- Examine alignment models
- Create alignment strategies based on service line

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