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Physician/Hospital Integration in Pediatrics: An Update for Pediatric Cardiologists

By Michael A. Rebolledo, MD, MBA and Darin E. Libby, MHA

Certainty in a Time of Uncertainty

The healthcare industry is undergoing a time of unprecedented change that will require hospitals and physicians to work more collaboratively to reduce the cost of care while improving quality (Porter and Teisberg 2006). Regardless of the exact changes to be implemented as a result of the Patient Protection and Affordable Care Act (PPACA)¹, lowering cost, improving quality, and increasing access will be paramount to success. And the degree of success will be linked to the ability to realize improvements across a continuum of healthcare services. This will require that hospitals and physicians rethink their business strategies and implement more integrated care models. While the future of healthcare industry changes are less than certain, it will be essential that hospitals and physicians integrate care delivery and information exchange to drive more value.

Déjà Vu

For those who practiced in the 1990s, the call for integration may sound all too familiar and likely has evoked memories that are less than favorable. Back then providers and hospitals began to form alliances in order to strengthen their positions against managed care organizations (Fraschetti and Sugarman 2009). Hospitals acquired physician practices in an attempt to better control expected decreases in inpatient occupancy rates and increases in outpatient care (Feldstein 2007). Many of these ventures failed. These failures were often due to significant cultural clashes and distrust between hospital leadership and physicians (Fraschetti and Sugarman 2009). Other problems included the failed economics of high practice-acquisition valuations and decreased productivity after physicians were awarded multi-year salary guarantees. These challenges were compounded by poor practice management, in which hospitals assigned management responsibilities to hospital-trained executives with limited physician practice management expertise (Feldstein 2007). Institutional memories remain, and today hospitals and physicians are using the lessons learned from past failures to enable successful alignment.

This article shares key insights that pediatric cardiologists should consider when evaluating alignment with hospitals and reviews the Professional Services Agreement (PSA)² structure as an alternative to employment.

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Impetus for Change

Why are physicians now considering alignment with hospitals? While the answer to that question will vary depending on the circumstances of the physician's practice (e.g., specialty, location, group structure), there are several common industry forces that are moving hospitals and physicians into more collaborative arrangements. Figure 1 illustrates several of these key drivers of alignment.

Impact to Cardiologists

Over the past year, many private practice cardiologists have been driven to consider closer alignment with hospitals, even employment, due to significant cuts to cardiology payments in the 2010 Medicare Physician Fee Schedule (Anderson 2010). A recent American College of Cardiology (ACC) member survey (ACC 2010) found that 30% of those in private practices have plans to be employed by a hospital system, while 25% are considering employment but do not have a plan in place. In addition, cardiologists are facing the same industry forces mentioned above, such as increasing overhead and regulatory concerns. Furthermore, demonstrating meaningful use criteria for electronic health records is also creating additional financial and administrative pressures. Many small group practices simply do not have the resources to adequately respond to these demands. In order to cut costs, cardiology private practices have been decreasing staffing, reducing services, and/or limiting new Medicare patients (ACC 2010). With these pressures, cardiologists may not have any choice but to seek hospital integration.

Pediatric Market Challenges

Beyond the alignment drivers enumerated in Figure 1, there are additional factors driving physician/hospital alignment in pediatrics.

Footnote 1. PPACA is a federal statute that was signed into United States law by President Barack Obama on March 23, 2010. This act and the Health Care and Education Reconciliation Act of 2010 compose the healthcare reforms of 2010.

Foremost, the financial pressures on physician practices are more severe, as pediatric specialists rely more heavily on government-based payors, such as Medicaid. Unemployment has softened insurance membership, and a slowed recovery, combined with the expansion of Medicaid eligibility requirements and the use of exchanges, is expected to continue to lead to growth in Medicaid and governmental payor membership. These macroeconomic forces are anticipated to add financial pressure on pediatric medical groups. The economic impact is less income, as noted in a recent study that illustrated pediatric specialists earn 65% of the income of adult specialists (ECG 2010). Not surprisingly, our nation has physician shortages across pediatric specialists. The increased competition for pediatric specialists has resulted in many children's hospitals pursuing alignment strategies to ensure that their clinical programs and services are maintained. Pediatric care delivery is also gaining more interest from delivery systems, as it offers unique services to the market and may result in a more favorable negotiating position with payors. All of these forces are driving greater financial and operational alignment between children's hospitals and physicians.

Pursuit of Greater Alignment With Children's Hospitals

Children's hospitals understand the need for critical pediatric subspecialty and surgical programs to support missions and recognize that without financial support to physicians, it is difficult to retain and recruit pediatric subspecialists. Consequently, hospitals are increasingly seeking greater financial and operational alignment in order to recruit physicians, meet regulatory concerns related to hospital payments to physicians, respond to a growing number of physicians who are not interested in the challenges and risks of managing a private practice, and ensure that value is received for increasing physician support.

While children's hospitals may be categorized under various organizational models, such as freestanding hospitals, hospitals within hospitals, or components of academic medical centers, there are basically two types of integration vehicles: employment or affiliation (Roorda 2008). The integration vehicle may be restricted based on the organizational model or state corporate practice of medicine laws.

There are many options for physician/hospital integration (Figure 2) (Bhatt and Welter 2009), which range from lower cost and integration (e.g., medical director) to higher cost and integration (e.g., an employed multispecialty medical group).

While many of these relationships are traditional employment arrangements, there are alternative alignment vehicles that can better meet the respective goals of the parties. One such model is the PSA structure, also referred to as a medical foundation model, which is used in many states that have restrictions on the corporate practice of medicine.

Medical Foundation Model (PSA)

The medical foundation model is a unique nonprofit corporation (usually a subsidiary of the hospital) that does not employ physicians, but instead contracts with them to provide professional services to foundation patients (California Health and Safety Code, Section 1206 n.d.). The model is commonly used in California and Texas due to statutes that prohibit hospital employment of physicians.

The PSA model exists as a relationship between the foundation board and the medical group, as illustrated in Figure 3. The foundation is linked to the medical group via a PSA. This agreement defines the details of the relationship between the parties and states

Footnote 2. The PSA structure is synonymous with the medical foundation model used in several states, including California and Texas, due to restrictions on the corporate practice of medicine.

Alignment Driver	Description
Physician Shortages	Physician supply is not keeping pace with demand, creating physician shortages in many specialties.
Recruitment Risks	Medical groups and independent physicians are unable and/or unwilling to recruit to the levels that hospitals and/or communities need.
Practice Economics	Physicians are facing income pressures, as costs have significantly outpaced reimbursement over the last several years.
Administrative Burden	The burden of operating a practice in an environment with heightened administrative requirements is forcing physicians to spend more time on non-patient care activities.
Patient Access	Increasingly, physicians are closing their practices to new patients, refusing specific insurance plans, or pursuing concierge medicine, which further restricts patient access to select physicians.
Increased Scrutiny on Quality	Payors and employers are demanding transparency and added scrutiny on quality and utilization management.
Payment Reform	New payment models, such as bundled payments, require defined funds flow arrangements among hospitals and select physicians.

Figure 1. Alignment Drivers.

the specific terms of how they will operate in alignment. It also defines terms related to joint governance, funds flow, organizational structure, and operations. Essentially, the foundation board oversees the business side, while the medical group governs physicians and care coordination. Payor contracts are held by the medical foundation; therefore, this entity assumes reimbursement risk and may compensate physicians under various performance systems. The medical group retains control over physician affairs, including peer review, hiring and firing, and compensation. In summary, the structure enables the parties to manage the operational activities that are within their respective expertise and forms joint oversight for setting the strategic direction.

Several California children's hospitals already utilize the foundation model in order to align with physicians, and the benefits of this structure compared to direct employment have increased its adoption in other states. Key benefits of the PSA model are outlined below.

- The medical foundation model transfers the risk of financial loss, with regard to collections and costs of overhead, from the physicians to the medical foundation or hospital owner.
- The entity also bears the responsibility of managing infrastructure, such as support staff and cost of IT implementation.
- This model is a vehicle by which physicians can be recruited and paid predictable market rate salaries.
- The foundation is required to perform medical research and provide educational services for its patients.
- Full integration is part of a sustainable long-term strategy that results in a stronger market presence.
- Compared to joint ventures, which can be short-lived, fully integrated models create a permanent partnership strategy.

As with any alignment structure, drawbacks do exist. One is that the PSA model may present limitations on the percentage of physician members that can be on the foundation's board of directors. This causes some loss of autonomy for the contracted physicians. There is also the possibility of a backlash from physicians who are not in the foundation medical group. The foundation may also be seen as a competitive threat to other physicians, health systems, and payors. Other potential barriers to success include significant cultural differences and lack of trust between physician groups and hospital organizations. Fundamentally, physician groups and hospitals have entirely distinct business models. Hospitals are used to amassing and preserving capital through low-volume, high-dollar

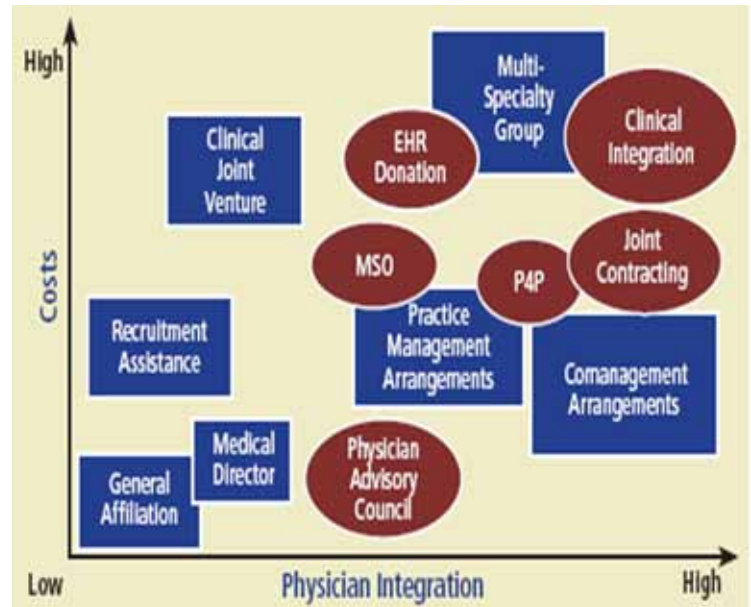


Figure 2. Physician/Hospital Integration Options.

transactions, and, in addition, they have a service mission to the community. Therefore, hospitals are used to operational and strategic control. Because of the tax code, physicians are discouraged from amassing capital. Most physicians perform high-volume, low-dollar transactions, which allows them to exercise significant control over revenue management. Likewise, physicians feel they should have strategic control over the enterprise.

There are critical components necessary for successful physician/hospital integration, as discussed by Robert Frascchetti, former President and CEO of St. Jude Medical Center, Fullerton, California (Frascchetti and Sugarman 2009). All parties must understand that success depends on cooperation and interdependence. Trust takes time to develop between the hospital and physicians. There must be recognition and respect of institutional cultural differences. Accountability and transparency are essential to maintain performance. Shared governance and management structure are

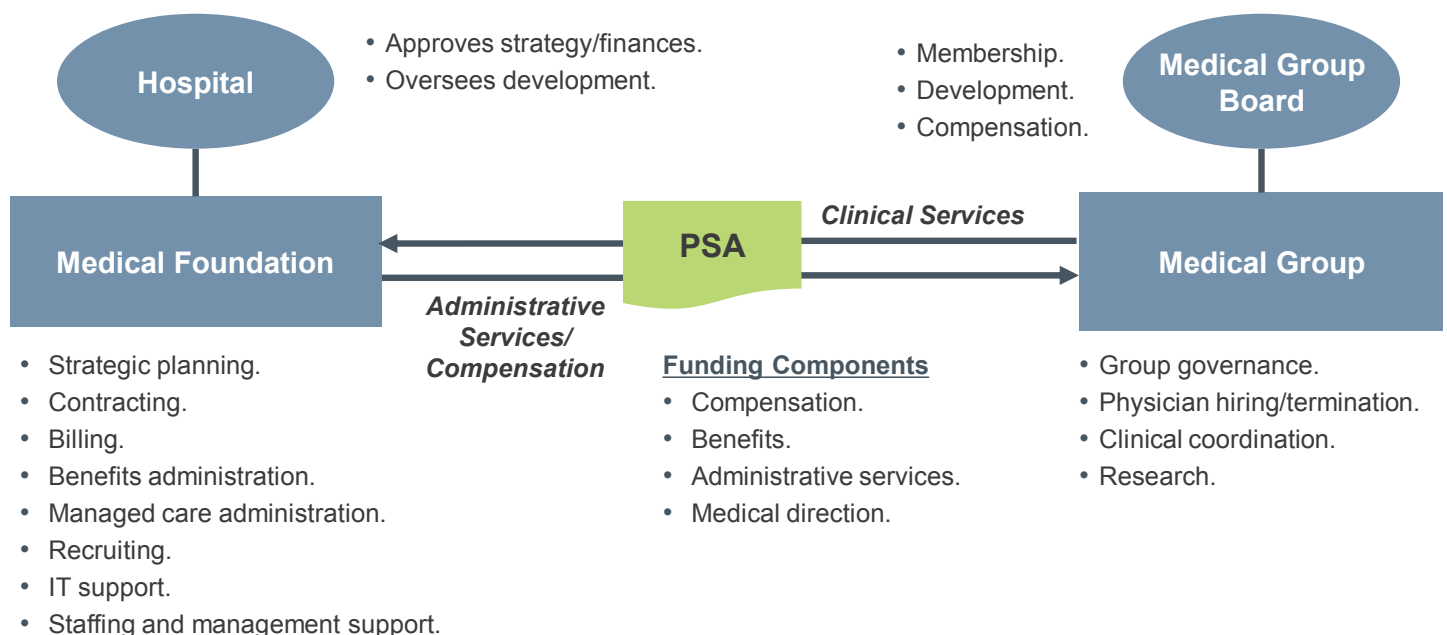


Figure 3. Medical Foundation (PSA) Structure.

also essential. To summarize, the physician group focuses on recruiting and clinical and compensation issues, while the foundation board controls finance, contracting, and operations. The foundation pays an aggregate amount to the group for serving its patients, and the medical group determines how to divide compensation among its members.

Conclusion – Critical Components of Pediatric Physician/Hospital Alignment

In the pediatric environment, physician/hospital alignment will be essential to long-term success. While children's hospitals that have integrated physician organizations are better able to meet the challenges of the current pediatric environment, the ability to maximize the benefits of the relationship will depend upon accord in leadership, strategic alignment, organization of research and education programs, and financial integration (Roorda 2008).

Regardless of the specific organization models in place, effective physician/hospital alignment must address four key areas (Roorda 2008):

- Leadership – A critical component of a successful relationship is the overlap and alignment of leadership. In particular, leadership roles that are aligned within the hospital, physician group practice, and medical school lead to positive and productive interactions and day-to-day functioning in support of common goals. Often, the structure is composed of a single individual who has leadership positions in each organization.
- Strategic Alignment – The strategic integration between children's hospitals and physicians can be measured by the degree to which these entities have joint and/or integrated planning processes surrounding the medical staff and key programs. Organizations that are tightly and strategically integrated have structured processes in place to determine the size and mix of specialties needed on the medical staff, as well as strategic program growth.
- Organization of Research and Teaching Programs – Research and medical education programs are areas of overlap that are increasingly important alignment vehicles for hospitals and physicians. As children's hospitals seek "top tier" status among peers, the strength of these programs is reliant on the ability to attract the best faculty and provide the optimal

environment for research and teaching, in conjunction with clinical care.

- Financial Integration – Integration of finances means more than just providing resources. Rather, optimal integration will

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align incentives with organizational goals, including quality, access, program growth, and financial success. The financial integration between the children's hospital, medical school, and group practice can be measured by the degree to which these entities are linked in relation to their funds flow.

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Corresponding Author



Michael A. Rebolledo, MD, MBA
 Assistant Clinical Professor
 Department of Pediatrics
 School of Medicine, UC Irvine
 Medical Director, Echocardiography,
 Children's Hospital of Orange County
 455 S. Main St.
 Orange, CA 92868 USA
 Phone: 714-221-5500; Fax: 714-221-5515

mrebolledo@choc.org



Darin E. Libby, MHA
 Senior Manager
 Healthcare Practice
 ECG Management Consultants, Inc.
 11512 El Camino Real, Suite 215
 San Diego, CA 92130 USA
 Phone: 858-436-3220; Fax: 858-436-3221

dlibby@ecgmc.com

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Contact: Darin E. Libby, Senior Manager Healthcare Practice
 11512 El Camino Real, Suite 215 San Diego, CA 92130
 Ph: 858-436-3220, Email: dlibby@ecgmc.com