California HealthCare Foundation

# Physician-Hospital Integration in the Era of Health Reform

*Prepared for*
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*by*
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## About the Authors

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**The Camden Group,** with offices in California, Illinois, and New York, is a national health care business advisory firm. Its advisory services include strategic and business planning, regulatory compliance, physician-hospital relationships, feasibility studies, and provider performance improvement/turnarounds.

## About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

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# I. Executive Summary

Market and economic forces over the past 20 years have led physicians and hospitals to engage in a variety of approaches to achieve greater integration, with varying degrees of success. Physician-hospital integration has increased during periods when patterns of reimbursement align physician and hospital incentives, competition intensifies, or other economic or demographic changes require collaboration. Over this time, four distinct periods can be identified in physician-hospital integration, each with particular economic and market characteristics (see Figure 1).

By early 2010, integration was again on the upswing in response to market forces. The Patient Protection and Affordable Care Act (ACA), with its introduction of accountable care organizations (ACOs) and expansion of other value-based payment methodologies, is now accelerating this trend.

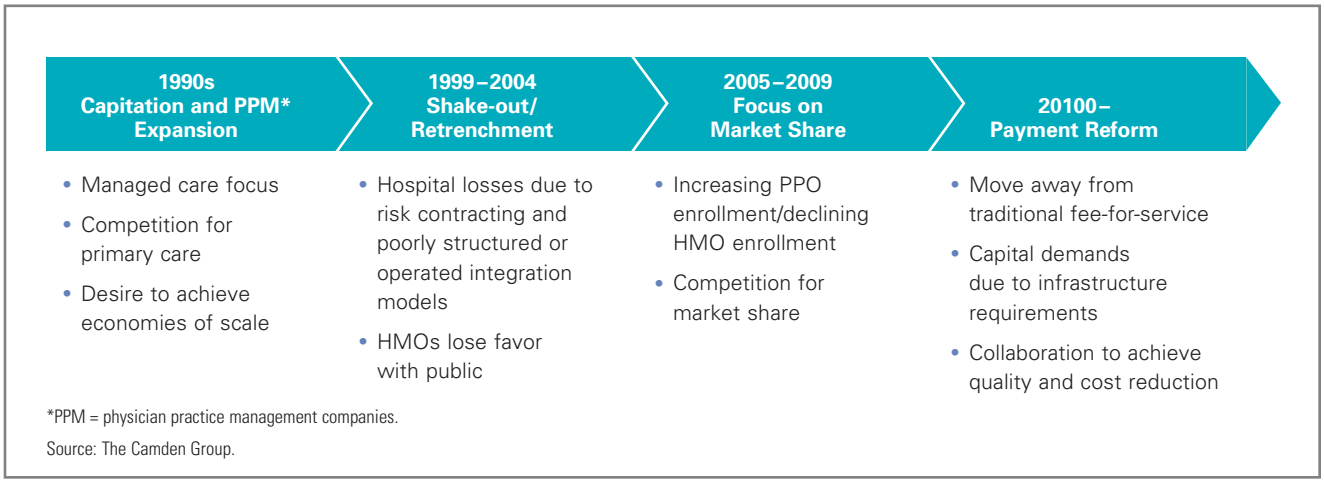
## Payment Reform Drives New Relationships

Because of the growing consensus that fee-for-service payment methodology is a major contributor to uncoordinated care, unnecessary duplication of services, and ever-rising costs, new payment methodologies are emerging that emphasize managing cost and quality of care for an identified population of patients or diagnoses. This has led to an increase in physician-hospital integration to better coordinate care and align their financial incentives.

ACA includes several payment reform initiatives that encourage physician-hospital integration, including ACOs, bundled payments, and the patient-centered medical home (PCMH). Along with co-management, each model addresses payment reform differently, but they all facilitate physician-hospital integration, as described below:

- **Accountable care organization.** An ACO's providers — medical groups, integrated delivery systems, and independent practice associations

**Figure 1. The Evolution of Physician-Hospital Integration in California: A Summary View**




*PPM = physician practice management companies.

Source: The Camden Group.

(IPA)—assume responsibility for both cost and quality for a defined population. Collaboration is essential between physicians and hospitals, with aligned incentives and governance, though formal integration is not required. Challenges include structuring control of the organization and developing a formula for shared savings.

- **Co-management.** Created around specific service lines, co-management focuses on achieving operational efficiencies and organizational savings. The model allows physicians and hospitals to remain independent, but requires an effective management team that includes both physician and hospital personnel.
- **Bundled payment.** This payment methodology covers pre-acute, acute, and follow-up care for patients undergoing specified procedures. Because it is procedure-specific, it does not facilitate system-wide integration. It requires coordination between physicians and a hospital, though not necessarily integration, and the hospital may wind up taking most of the risk.
- **Patient-centered medical home.** With a PCMH, coordinated care is provided by a physician-led, multi-disciplinary team, making extensive use of technology. Its capital requirements may drive formal hospital-physician integration. Barriers to implementation include a need to redesign the patient care model.

## Current Challenges to Physician-Hospital Integration

Much has been learned about physician-hospital integration during the past 20 years, especially that successful integration requires a common vision and goals, plus an effective governance structure. Physicians must play a key leadership role, and the governance structure must facilitate ongoing physician involvement in decision-making.

Despite the success of many integration projects, both physicians and hospitals still have concerns about whether integration can achieve its goals, since the perspectives and expectations of physicians and hospitals are not always aligned. However, both recognize that it will be difficult to significantly affect quality or costs unless providers across the continuum work together. At the same time, some industry stakeholders are cautious about embracing physician-hospital integration, because there is data to suggest that integration may lead to higher costs through increased market leverage with payers.[1]

The costs of integration, which include practice acquisition, administration, information technology, operating infrastructure development, and ongoing practice support, can pose a barrier. Also, given that most current reimbursement methodologies do not substantially reward for efficiency or quality, it is difficult for most organizations to begin the necessary care redesign without reducing revenue.

As physicians increasingly seek income and lifestyle predictability as shelter from the demands and declining economies of private practice, the attractiveness of group practice or direct employment grows. At the same time, shortages in primary care providers—needed to coordinate care in most new models—increase competition for these physicians and allied professionals. This competition may mean that some hospitals are able to integrate with a large base of physicians while other hospitals cannot afford or do not have a structure to do so.

Laws and regulations designed to prevent physician self-referral, kickbacks, and undue influence on medical decisions, as well as concerns about antitrust, can affect how new relationships are structured. California's corporate practice of medicine ban is also perceived by some as limiting integration

options, especially for smaller and rural hospitals. Others, however, feel that current options provide enough flexibility to achieve integration.

## Future Physician-Hospital Integration Efforts

As has been the case historically, the actual structures, degree, and financial relationships of integration will depend on market factors and on statutory and regulatory requirements that apply to the various models. The size and strength of physician groups and existing hospital integrated groups will influence whether physicians or the hospital lead any particular integration effort. In some markets, physician groups that have already invested in the care management tools required for ACO success may have a head start on the process. In other markets, hospitals with existing integrated groups may be able to more quickly create a value-based organization. The speed with which integration occurs will depend upon how quickly payers implement new value-based payment methodologies, and perhaps more importantly, how quickly all participants embrace collaboration and shared decision-making.

## Implications for Policymakers

While there are many potential benefits from health care reform and physician-hospital integration, there are a number of matters that California policymakers will need to consider with regard to their interrelationship.

- Market concentration often brings with it the power to demand higher prices without any demonstrably better quality. Unless market competition based on benefit design alternatives and financial incentives can control the use of such power by integrated hospitals and/or physician groups, policymakers may have to explore other methods to ensure that potential cost savings from integration are not eroded.
- Small hospitals and those in underserved areas may not have sufficient financial or management resources to develop the infrastructure required for effective physician-hospital integration. Where available, federal and state financial resources, such as those being made available through the Center for Medicare and Medicaid Innovation, should be coordinated to encourage effective integration efforts without artificially sustaining marginal providers.
- Some hospitals, especially those in rural and/or underserved areas, might be helped by greater flexibility in the state's corporate practice of medicine law, so that the hospitals can more easily recruit and retain physicians to address provider shortages and other access to care challenges. While there is currently a pilot to allow district hospitals to directly employ a limited number of physicians, it will expire on January 1, 2011.
- Given projected shortages in primary care and certain specialties, especially in rural areas, new approaches to care delivery will be needed to fill the gaps. Provisions in ACA partially address this problem by providing for training of increased numbers of physicians and other primary care providers, but these efforts will likely take many years to bear fruit. California policymakers will need to consider efforts to expand primary care access that go beyond those in ACA. These might include incentives to encourage hospitals and physicians to collaborate in applying technology solutions, such as telemedicine, home monitoring, and e-visits. The legislature might also revisit scope of practice laws for non-physician primary care providers, such as nurse practitioners and physician assistants, to allow them to practice to the fullest extent of their training.

# II. Introduction

Among its myriad effects on the nation's health care delivery system, the 2010 Patient Protection and Affordable Care Act (ACA) may usher in a new era in hospital-physician integration. The ACA's introduction of accountable care organizations (ACO) and other "value-based" payment methodologies requires increased collaboration and financial integration between physicians and hospitals. It may also create competition among providers about who will lead the new entities.

Physicians and hospitals have always been interdependent with regard to patient care: Physicians need hospitals in order to deliver inpatient and complex outpatient care to their patients, and hospitals need physicians to provide care to patients while in the facilities. But competitive aspects to these roles have also developed, particularly as outpatient care has expanded. Physician groups now directly provide many diagnostic and treatment services in their offices that historically have been provided in hospitals. In addition, since the advent of health maintenance organizations (HMOs) in the 1980s, with providers having to take on financial risk, hospitals have needed to work with organized physician groups rather than the traditional approach of working with individual physicians who act as "volunteer" hospital medical staff. This creates a dynamic between hospitals and physician organizations in which there is a need to collaborate toward clinical and economic alignment at the same time there is competition for control of certain aspects of patient care services.

Over the past 20 years, these issues, coupled with other economic and demographic factors, have led physicians and hospitals to engage in a variety of efforts to achieve greater alignment, with varying degrees of success. In general, the trend has been toward greater integration, despite a concurrent tendency toward competition. As illustrated in Figure 2 on the next page, four distinct periods in physician-hospital integration can be identified within this time-frame, each of which was defined

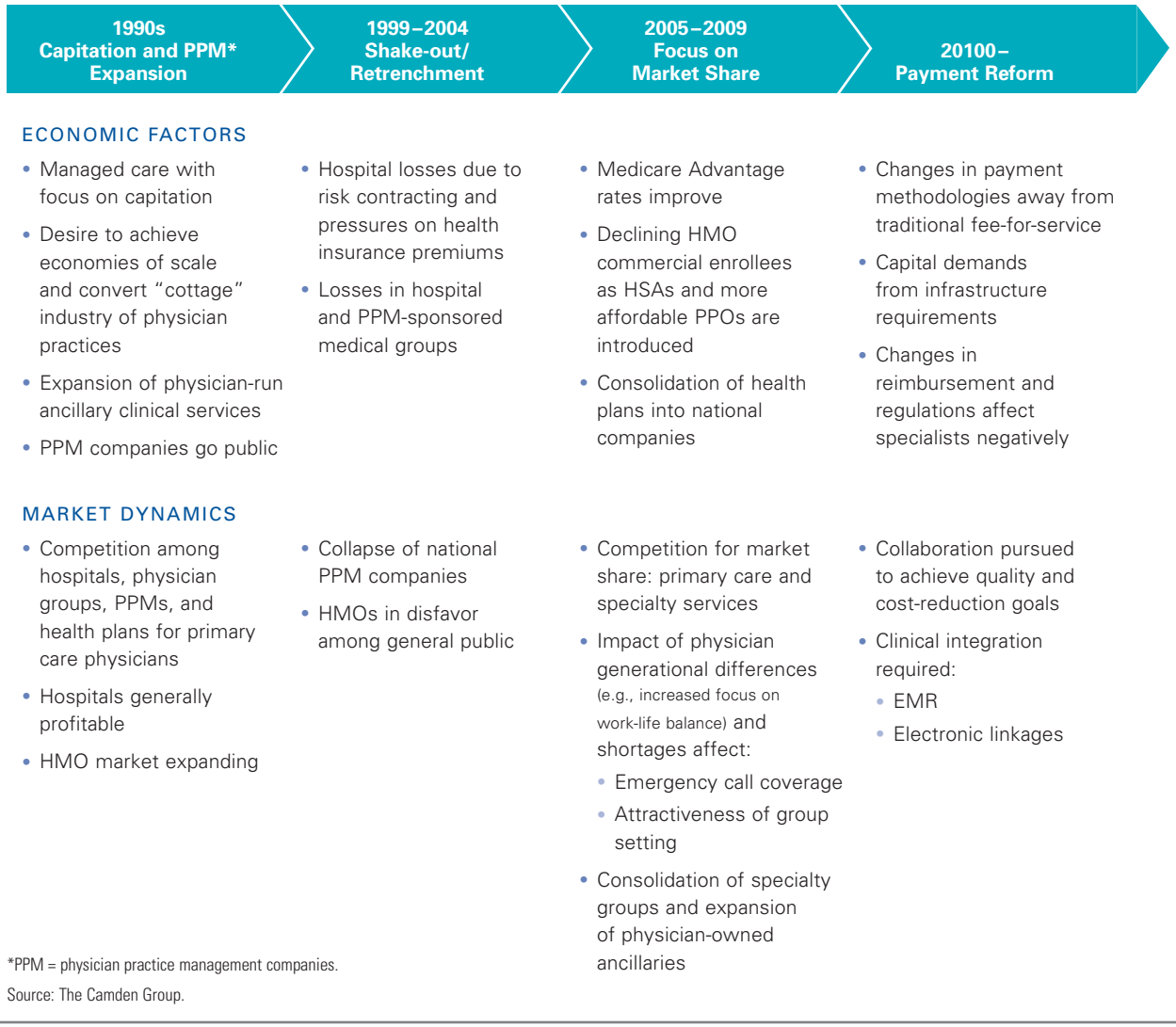
### Glossary

**Accountable care organization (ACO).** As defined by the ACA, ACOs are provider-based organizations (medical groups, hospitals that employ physicians, integrated delivery systems, physician-hospital organizations, and independent practice associations) that take responsibility for the health care needs of a defined population, e.g., Medicare patients. Requirements for ACOs under the ACA include:

- Responsibility for overall costs and quality of care for a population;
- Formal legal structure for receiving and distributing payments for shared savings;
- Processes to promote evidence-based medicine and patient engagement, report on quality/cost measures, and coordinate care; and
- Capacity to provide health care for at least 5,000 Medicare beneficiaries.[2]

**"Value-based" payment methodologies.** Approach to payment to providers that includes incentives for achieving identified quality standards and cost management targets.

**Figure 2. The Evolution of Physician-Hospital Integration in California**




*PPM = physician practice management companies.

Source: The Camden Group.

by economic and market dynamics at play during the era.

The need for collaboration has increased over time as market requirements for success have demanded it. Payment methodologies now place more emphasis on the total cost of care for an identified population as compared to traditional fee-for-service structures, resulting in an upsurge in physician-hospital integration, with increased care coordination and alignment of financial incentives. Likewise, as capital and human resources have become more scarce, the need to pursue collective solutions has increased.

Passage of ACA is now accelerating interest in physician-hospital integration. Physicians and hospitals now face ACA requirements to demonstrate improved population health and quality outcomes while reducing the rate of increase in overall cost.

ACA introduces ACOs and other "value-based" payment methodologies that require a greater degree of collaboration and financial integration than currently exists in most settings. This not only moves physicians and hospitals toward increased integration but also produces new competition among providers. Some physician groups with a track record in managed care and hospital systems with integrated medical groups believe that they already meet the requirements for ACOs and that therefore they should lead the response to health care reform in their markets. Other factors that historically have influenced either physician-hospital collaboration or competition, or both, will continue to do so alongside ACA-influenced changes. These include:

- Changes in reimbursement for specific services;
- The need for capital for new capabilities or infrastructure;
- Supply and demand for specific clinical skills; and
- Workforce expectations and stability.

This white paper explores the landscape of physician-hospital integration through an examination of its historical development and an assessment of the new health care reform law and other current dynamics. Observations by hospital, physician group, and health plan leaders provide insight into their perspectives on the state of physician-hospital integration. (For further information about the input from health care leaders for this paper, see the Appendix.) The paper concludes with a look at the potential effect on patients of further physician-hospital integration, expected challenges with future integration, and implications for policymakers.

# III. Recent History of Physician-Hospital Integration Efforts

## Medical Group Development

In the 1990s, physicians formed group practices and independent practice associations (IPAs) in order to respond to managed care (through capitation and other risk contracting), enhance their market attractiveness to capture referrals and payer contracts, facilitate expansion of ancillary services (e.g., laboratory and radiology), and achieve economies of scale. Clinics organized under California's Health and Safety Code (community clinics, medical foundations, and hospital outpatient departments) provided other models through which physicians organized.[3] Academic medical centers (the University of California and others) and county governments also have developed organized physician models specially permitted by California law.

The Cattaneo and Stroud inventory of physician groups (funded by the California HealthCare Foundation), which includes those physician groups with at least six primary care physicians and at least one contract with an HMO, provides a picture of the physician group structures now in use in California (see Figure 3 on page 9).[4] Many of these organizations were formed during the 1990s in response to managed care, and over 98 percent of current physician groups still participate in risk contracting. Of the various types of physician organizations, the IPA structure (51.2 percent) is the most common. While the IPA can be an effective vehicle for HMO contracting, it is not permitted to contract as one entity for preferred provider organization (PPO) fee-for-service contracts unless it can demonstrate that it is clinically integrated. Also, as an association of independent physician practices — typically smaller private practices — it

### Glossary

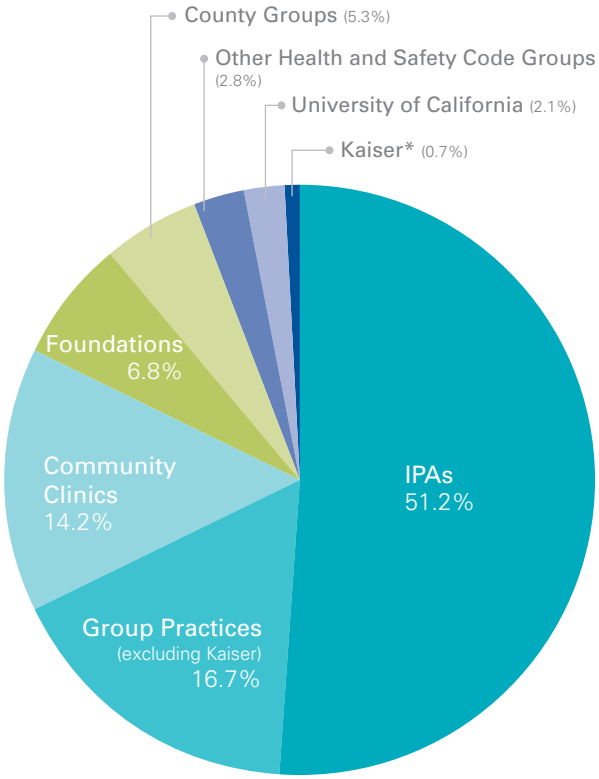
**Capitation.** A fixed amount paid to doctors or hospitals by HMOs, on a monthly basis, for each member of the health plan assigned to that provider, for a defined set of services.

**Clinical integration.** The Federal Trade Commission defines clinical integration as the ability of an organization to monitor and control costs, selectively choose its physician participants, and demonstrate a significant investment of monetary or human capital. IPAs must demonstrate clinical integration capability in order to contract with PPO plans. Within a hospital setting, clinical integration requires information technology that allows physicians to review and share clinical information, participate in clinical protocols, and take accountability for patient outcomes and costs of care.

**Physician practice management (PPM) companies.** PPMs purchase physician practices and provide practice management services and capital for practice expansion, equipment, information technology, and facilities. They are typically for-profit companies, and in the 1990s many became publicly traded.

**Risk contracting.** Providers are responsible for providing all patient care for a population for a fixed price. They receive no additional payment if the cost of care is greater than the fixed price, and they keep any savings. Capitation is the most common form of risk contracting.

**Figure 3. Physician Groups, by Organizational Type, 2010**




*Although they have many physicians, there are only two Permanente (Kaiser) medical groups, one in Southern California, one in Northern California, so they represent only a very small percentage when looking at types of organizations.

Notes: Physician group is defined as at least six primary care physicians and at least one HMO contract. N=281.

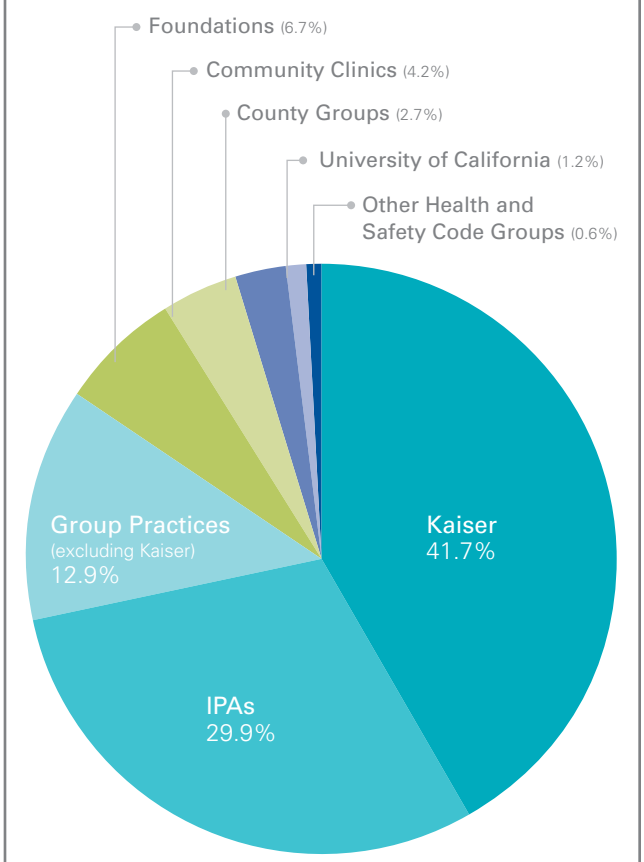
Source: Cattaneo and Stroud, Inc., *Active Group Practices, Report 18,* October 12, 2010.

fails to provide a solution for those physicians seeking the stability of employment.

Group practices (16.7 percent) and community clinics (14.2 percent) are the next most common structures. Group practices have the advantages of being able to provide physicians with the security of employment and to contract with PPOs. The primary mission of community clinics is to serve Medi-Cal and uninsured patients, so they do not typically focus on commercial HMO or PPO contracting, except as a subcontractor to a larger IPA.

IPAs serve the most HMO-enrolled patients (29.9 percent), exclusive of Kaiser Permanente (Kaiser) members (see Figure 4). Group practices, exclusive of the two Kaiser medical groups, serve an additional 12.9 percent of HMO enrollees.

**Figure 4. Physician Group Patient Enrollment, by Organization Type, 2010**




Notes: Physician group is defined as at least six primary care physicians and at least one HMO contract. N=15,435,050.

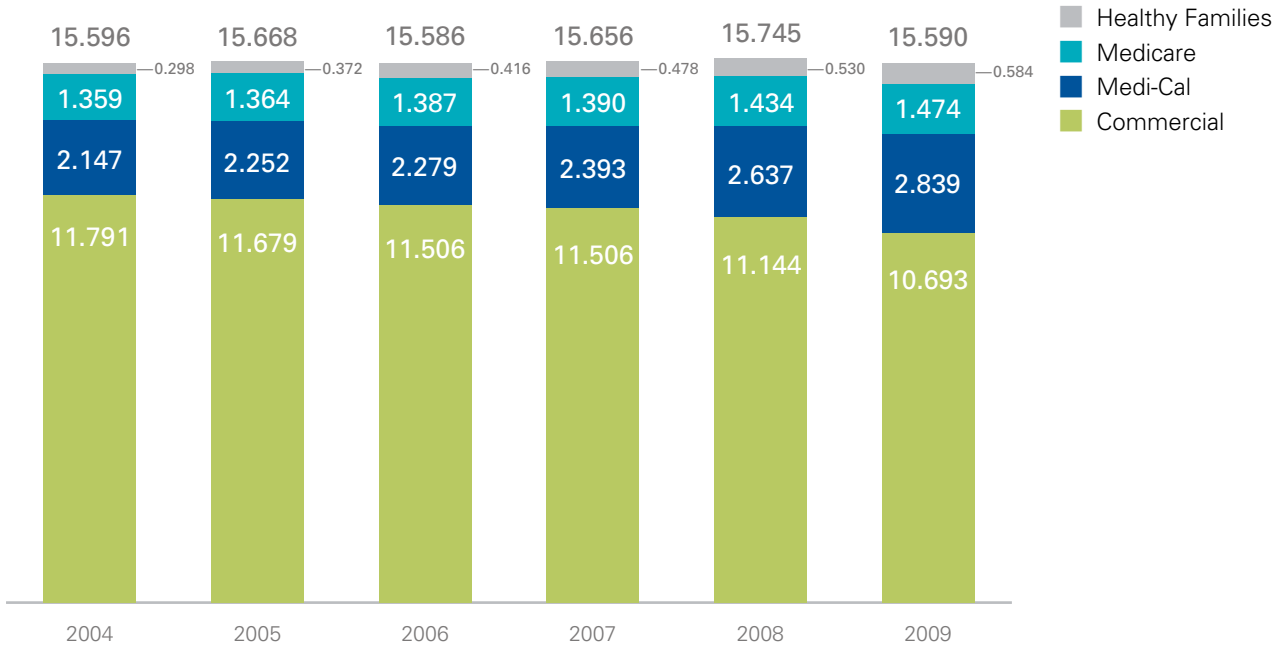
Source: Cattaneo and Stroud, Inc., *Active Group Practices, Report 18,* October 12, 2010.

## Consolidation in a Changing Financial Landscape

As of 2009, California physician groups serve over 15.5 million HMO enrollees, the majority of whom are enrolled in HMO commercial plans (see Figure 5). However, commercial HMO enrollment has steadily decreased since 2004 among California physician groups, while Medicare (Medicare Advantage plans), Medi-Cal, and Healthy Families managed care plans have experienced increases. Physician groups have targeted increased Medicare Advantage enrollment because of historically favorable Medicare Advantage reimbursement rates, and to counteract the decline in commercial enrollment. Medi-Cal enrollment continues to grow as the state expands Medi-Cal managed care. Because of generally lower reimbursement rates for Medi-Cal, many physician groups did not contract for this population in the past. However, as one health plan executive reported, with the decrease in commercial enrollees, some physician groups have now decided to serve the Medi-Cal population.

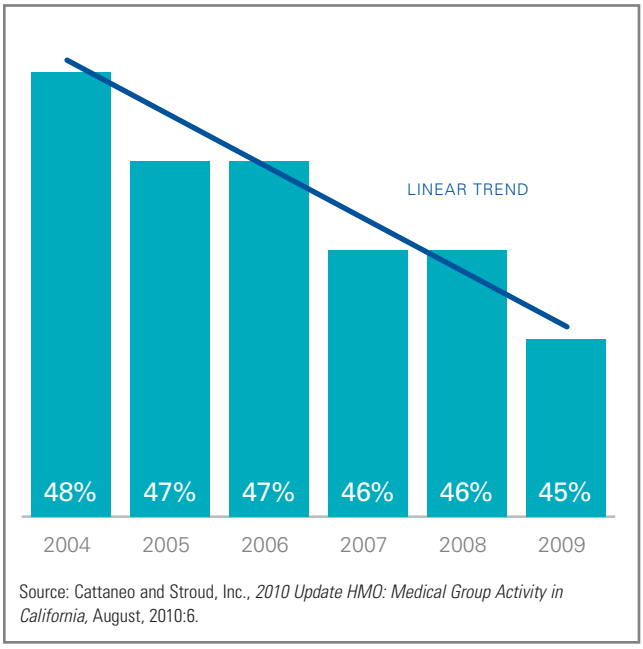
In spite of these increases in some HMO markets, total HMO enrollment as a percent of the total California population has trended downward since 2004 (see Figure 6). For 2008 to 2009, total HMO enrollment was approximately 52.2 percent of the total insured.[5] This overall decrease threatens the financial stability of IPAs, which depend on HMO capitation payments as virtually their sole source of revenue. The problem of IPAs' declining revenue is exacerbated by increasing costs for the more sophisticated infrastructure necessary to improve pay-for-performance scores, assure compliant hierarchical condition categories coding, meet health plan audit requirements, and facilitate network migration to electronic medical records (EMR).

**Figure 5. Physician Group HMO Enrollment (in millions), by Payer, 2004–2009**




Source: Cattaneo and Stroud, Inc., *2010: Special Report, Medical Group Activity in California*, 2004–2009.

**Figure 6. HMO Enrollment as Percent of Total California Population, 2004–2009**

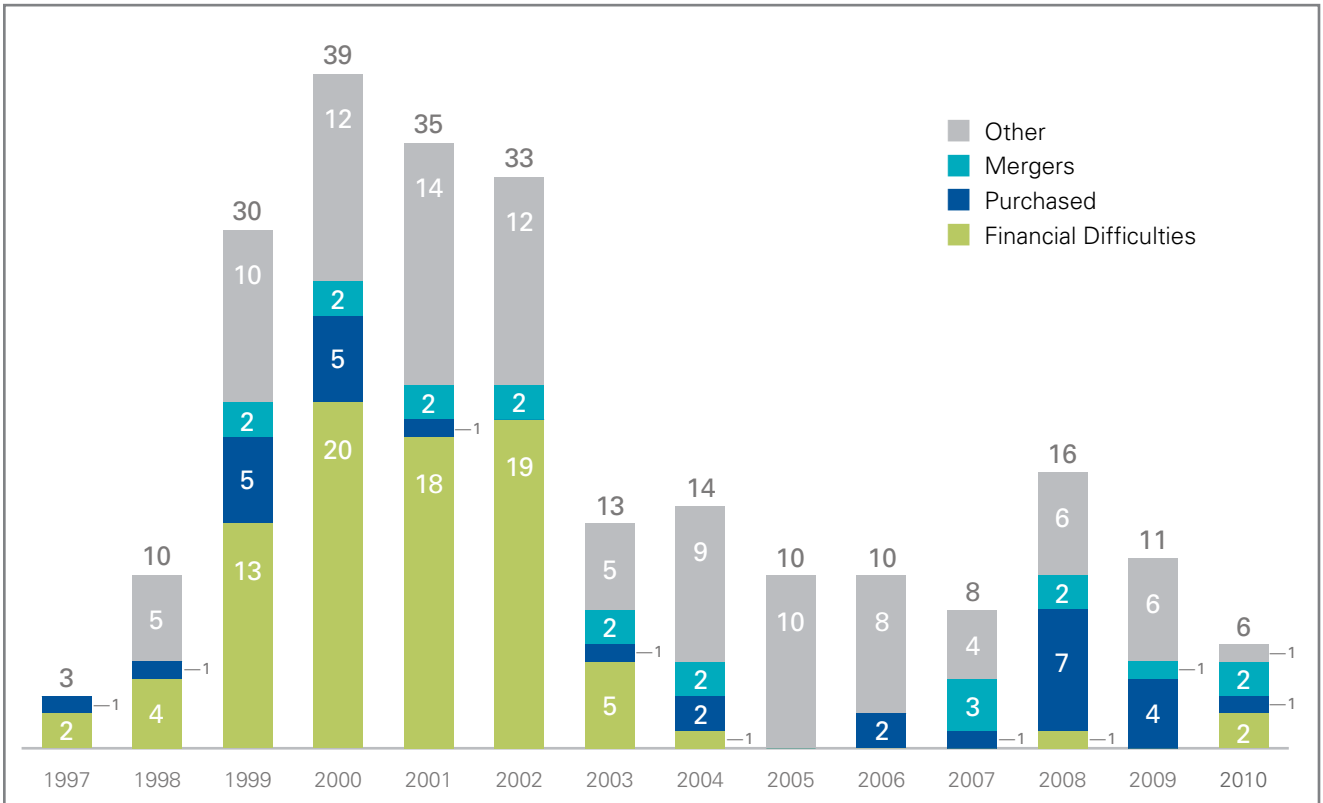



Source: Cattaneo and Stroud, Inc., *2010 Update HMO: Medical Group Activity in California,* August, 2010:6.

This combination of pressures places small IPAs at risk and propels mid-size and large IPAs to seek acquisitions or mergers to grow their membership so as to increase their revenue base. Smaller group practices are facing the same economic pressures and, in response, have also been turning to acquisitions or mergers. The recent cut to Medicare Advantage reimbursement (projected to be approximately 10 percent) included in ACA will increase the financial strain experienced by some IPAs and medical groups.

Physician group closures peaked between 1999 and 2002 (see Figure 7). These were the years when managed care premium increases stalled, publicly-held physician practice management (PPM) companies imploded, and medical groups that were not prepared to engage in risk contracting

**Figure 7. Physician Group Closures, 1997–2010**




Note: Other reasons for closing were: small enrollment, ceased HMO contracting, closed with no reason given, and other.

Source: Cattaneo & Stroud, Inc., *2010: List of Closed Medical Groups.*

ran into financial difficulties. This was also prior to implementation of state regulatory requirements to monitor physician group financial solvency, which introduced greater financial stability into the risk-bearing physician group market.[6]

Mergers and acquisitions once again became common in 2008 and 2009 as market dynamics fostered consolidation, with financially weak IPAs and medical groups finding partners who wanted to capture market share. During 2010 there has been a number of large mergers, including Lakeside Health with Heritage Provider Network, Healthcare Partners with Talbert Medical Group and Northridge IPA, and Mills Peninsula Medical Group with Palo Alto Medical Foundation, as well as consolidation of smaller and single-specialty medical groups to gain economies of scale and/or market leverage. Some smaller groups also have chosen to join large national provider companies, such as U.S. Oncology and Pediatrix.

While consolidation may have improved the stability of physician groups that take managed care risk, some health plan representatives expressed concern regarding the increased costs brought about by some of these mergers. When smaller groups are acquired by larger ones with greater market presence (and often better contracted rates), payer executives interviewed noted that the fees paid to the acquired groups often increase. But this does not always result in improved patient care or cost management, at least in the short term. Other health plan representatives argue that still more consolidation is needed in some markets to ensure that the financial base is sufficient to undertake risk, improve care coordination, and maintain the infrastructure needed to measure and monitor quality.

# IV. Evolution of Hospital-Physician Relationships

The relationships between hospitals and physician medical staff have changed considerably over the past 20 years. Historically, hospitals relied on voluntary medical staff, with physicians serving on hospital committees and providing specialty coverage in emergency departments. As medical practice shifted to ambulatory settings, physicians became less connected to the hospital on a daily basis. Also, as physicians began to seek additional revenue streams outside their practice, direct competition increased between physicians and hospitals. As a result, hospitals have had to seek structures other than the traditional voluntary medical staff in order to align with physicians.

Another aspect of the evolving relationships between hospitals and physicians developed in the 1990s, when many hospitals found themselves in markets that were "overbedded." Hospitals responded by focusing more on maintaining or gaining market share in key service lines. This made them more willing to negotiate with payers on price, consider new forms of payment such as risk contracting, and seek new ways of relating to their medical staff, including integrating primary care physicians into their systems as a response to managed care. Hospitals also were defending against possible acquisition of physician practices by competitors or PPMs. At the same time, physicians were seeking protection from the impact of managed care through practice acquisitions and employment arrangements with minimum income guarantees.

### Glossary

**Gainsharing.** Gainsharing is an arrangement between a hospital and physicians that allows them to share in any savings in a particular hospital service line realized through physicians participating in medical management of the operational costs of that service line.

**Knox-Keene Act.** The Knox-Keene Health Care Service Plan Act of 1975, as amended, is a set of state laws that regulates HMOs within California, including financial standards that plans must meet.[7] The California Department of Managed Health Care has the responsibility to oversee licensure and plan compliance with state regulations.

**Management services organization (MSO).** An MSO provides practice management and administrative support services to individual physicians or group practices. The primary function of an MSO is to relieve physicians of non-medical business functions such as billing, support staff recruitment and supervision, supply and equipment purchasing, and financial reporting.

**Physician-hospital organization (PHO).** A PHO is a legal entity formed by a hospital and a group of physicians to contract directly with employers or health plans. The PHO serves as a collective negotiating and contracting unit.

**Physician liaison.** A physician liaison is someone retained by a hospital/health system to communicate with physicians on its medical staff. The liaison educates physicians about hospital services, troubleshoots problems, and facilitates physician interactions with the hospital or system.

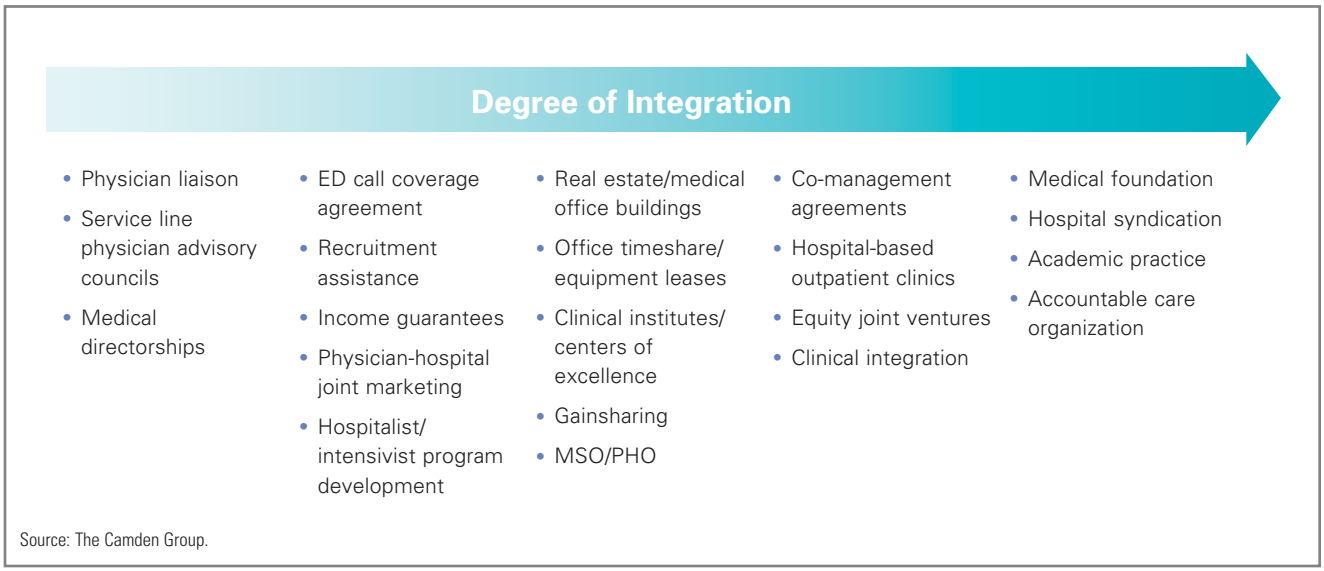
## Specific Hospital Integration Strategies

Hospitals have used a variety of strategies to align with physicians. Some of these, such as medical directorships, require little integration, but as economic interests demanded closer alignment, many hospitals turned to strategies that involved greater integration (see Figure 8).

Some of the first efforts at physician-hospital integration in response to managed care were physician-hospital organizations (PHOs), in which hospitals entered into contractual arrangements with physician groups to accept risk for specific patient populations. But in California, the Knox-Keene Act requires a PHO to have an HMO license if it is to take "global" or full risk for institutional and professional services, and the statutory requirements for reserves under such a license made the PHO impractical in the state. However, physician groups and hospitals did take risk independently through separate contracts with health plans. Because both the timeliness and availability of data at that time were limited and approaches to medical management were still in their infancy, hospitals often suffered significant financial losses under those arrangements. As a result, many hospitals terminated these capitated arrangements. Physician groups that were successful in managing risk continued to do so, but often they had limited incentives under these arrangements to manage hospital utilization.

Other strategies have led to further integration or new relationships to better address issues. For example, as it became more difficult for hospitals to meet their emergency department (ED) physician staffing needs through volunteer specialty coverage, they entered into ED coverage contractual relationships with physicians on their medical staffs. However, these arrangements often created a financial burden for the hospitals, so they have turned to recruitment of contracted physicians who specialize in the particular inpatient services that meet some of their ED needs. Contractual relationships with specialist physicians, such as hospitalists (for inpatient coverage), laborists (for obstetric coverage), and traumatologists (surgeons for trauma coverage), often, though not always, lower the cost for such coverage.

**Figure 8. Continuum of Physician-Hospital Integration**




Source: The Camden Group.

Hospitals also entered into joint ventures with physician medical staff, including equipment acquisition and the development and operation of ambulatory surgery centers, imaging centers, and medical office buildings, in part to preempt physicians from establishing competing entities. As this trend escalated, however, federal and state governments became concerned about the potential for anti-competitive and conflict of interest abuses, so laws and regulations were promulgated to restrict these relationships, and some joint ventures had to be discontinued. Others failed because of poor management or changes in reimbursement, which resulted in increased tension between hospitals and the physicians involved. In some cases, physicians chose to initiate or carry on the projects themselves.

## Employment-Like Models of Hospital-Physician Integration

As hospitals faced the need to recruit and retain physicians to address physician shortages and ED coverage issues, to gain market share, and to respond to physicians seeking a hospital relationship, they looked for models that created greater integration. Hospitals cannot directly employ physicians in California, so they looked to models that create an employment-like practice environment: medical foundation; hospital outpatient clinic; academic practice; community clinic; and rural health center. Each of these models is specifically permitted under the California Health and Safety Code or the federal Social Security Act.[8]

### Medical Group Models in California

**Academic practice.** An academic practice must be affiliated with a university that has a medical school; this can be within a community hospital that has an established relationship with a medical school. It must be accredited by the Accreditation Council for Graduate Medical Education and approved by the state.

**Community clinic.** Community clinics must be operated by a not-for-profit entity. Also, they must charge patients based on their ability to pay, using a sliding scale fee schedule for patients not covered by third-party payers.

**Independent practice association (IPA).** An IPA is a network of physicians that contracts with HMOs and other managed care plans. Under this structure, physicians own their practices and manage their own offices, while the IPA negotiates and administers managed care contracts for its physician members.

**Government clinic.** The federal government, the state, counties, and cities may directly operate clinics.

**Hospital outpatient clinic.** A hospital provides clinic infrastructure, including facilities, staff, equipment, and supplies. It contracts with individual physicians or groups of physicians to provide medical services in the clinic.

**Medical foundation.** A medical foundation must have at least 40 physicians in ten board-certified specialties, with at least 27 of the physicians working full time. In addition to providing medical care, the foundation must participate in medical research and health education. Under this model, the hospital forms a 501(c)(3) not-for-profit corporation that purchases the assets of physician practices. The physicians create a professional corporation with which the foundation contracts to provide medical care for the foundation.

**Rural health clinic (RHC).** RHCs are federally designated clinics located in rural, medically underserved areas. Medicare payments to RHCs are based on reasonable and allowable costs; for hospitals under 50 beds with RHCs, there is no cap on costs. Under this model, the hospital provides the clinic infrastructure and provides management of the RHC. The hospital contracts with individual physicians and/or physician groups to provide medical services in the RHC.

## Medical Foundation

The medical foundation model has been used primarily by larger hospitals and hospital systems, providing a successful vehicle to recruit and attract physicians and in some cases to jointly (with the physicians) manage risk under managed care arrangements. However, creation of a medical foundation can be complex and costly. Along with initial costs, the high threshold requirements for the number of physicians and specialties (see "Medical Group Models in California" on the previous page) creates a barrier to use of this model by smaller hospitals and those located in rural areas. There are initiatives currently underway, structuring medical foundations with multiple hospital participants, to respond to this constraint. (For a list of major medical foundations operating in California in 2010, see Table 1.)

## Hospital Outpatient Clinic

The hospital outpatient clinic has not been as attractive as the medical foundation for the growth of a large physician base because of the complexity of its billing process and its impact on patients, as well as the potential complexity of the physician relationship. This model can increase costs to patients since they are charged two deductibles and copayments (the hospital bills a facility fee and the physicians bill for their professional services). This model also creates added complexity for individual physicians in that they are responsible for securing their own benefits and paying their own payroll taxes. In spite of these drawbacks, the model is used widely to ensure Medicare and Medi-Cal patient access to care in key specialties (e.g., children's subspecialty care, primary care), as well as to facilitate recruitment of specialty service providers in some markets. (For an example of a hospital system that has used this model very successfully to attract physicians and improve access to care for Medi-Cal patients, see the sidebar on page 17.)

**Table 1. Major California Medical Foundations, with Number of Physicians, 2010**

| | PCPs | SPECIALISTS | TOTAL |
|---|---|---|---|
| Arch Health Partners | 36 | 325 | 361 |
| Bright Health Physicians of PIH | 174 | 219 | 393 |
| Cedars-Sinai Medical Care Foundation | 106 | 659 | 765 |
| CHW Medical Foundation* | 166 | 420 | 586 |
| Facey Medical Foundation | 92 | 157 | 249 |
| Huntington Medical Foundation | 50 | 10 | 60 |
| John Muir Physician Network | 253 | 674 | 927 |
| Oakland Medical Foundation | — | 90 | 90 |
| Providence Medical Institute | 60 | 25 | 85 |
| Rady Children's Medical Foundation | — | 150 | 150 |
| Sansum Clinic | 63 | 66 | 129 |
| Scripps Clinic | 130 | 345 | 475 |
| Scripps Coastal Medical Centers | 104 | 11 | 115 |
| Sharp Rees-Stealy Medical Centers | 147 | 213 | 360 |
| St. Joseph Heritage Healthcare | 346 | 922 | 1,268 |
| Sutter Medical Foundations† | 915 | 1,397 | 2,312 |
| ValleyCare Medical Foundation | 20 | 24 | 44 |
| **Total Physicians in All Foundations** | **2,662** | **5,707** | **8,369** |

*The medical groups that comprise the panel of CHW Medical Foundation are: Dominican Medical Foundation, Mercy Medical Group, Sequoia Physicians Network, and Woodland Clinic Medical Group.

†The medical groups that comprise the panel of Sutter Medical Foundation are: Sutter East Bay Medical Foundation, Sutter Gould Medical Foundation, Sutter Medical Foundation-Central Div, Sutter Medical Foundation-Central Div/Sutter West, Sutter Medical Foundation-West Div/Solano Regional, Sutter Pacific Medical Foundation, and Palo Alto Medical Foundation.

Source: Cattaneo & Stroud, Inc., 2010: *Report 18* and The Camden Group.

### Case Study: Creating an Effective Hospital Outpatient Clinic Model

Over the last ten years, a Central California hospital has developed a successful outpatient clinic system. The hospital began with one clinic ten years ago and has now expanded to a network of 12 clinics; the number of physicians involved in the clinics has grown from three to 44. The initial clinic was created to improve access to obstetric services for Medi-Cal patients but quickly expanded to include primary care services (family practice, pediatrics, and internal medicine), including urgent care. During the past five years, the system integrated other specialties (including orthopedics and cardiology) into its clinics and is now implementing its first single-specialty clinic. The system continues to serve Medi-Cal patients, but the clinics now attract a growing number of commercial patients as well.

The hospital has entered into professional services agreements (PSA) with individual physicians and medical groups to provide medical services in the clinics. The hospital CEO credits this approach with allowing the hospital to greatly expand the primary care base in the community, thereby improving access, especially for Medi-Cal patients: "It has been an attractive model for recruitment, as it frees physicians from the business of practice." However, over the last two years, the hospital has found it more difficult to recruit physicians because the PSA is more complex for the physician than employment. According to the CEO, "the physician is responsible under a PSA for creating and securing his/her own benefits (health, life, retirement), which seems unpopular with young physicians. Nonetheless, the model continues to generate interest among more experienced physicians who are tiring of running their practice." Although this hospital is exploring other models as well, it anticipates continuing the outpatient clinics for the foreseeable future.

## Rural Health Clinic

Hospitals in rural areas have used the rural health clinic (RHC) model to recruit and retain physicians. The CEO of a small rural hospital in northern California explained that the hospital, which implemented an RHC in order to retain physicians in the community, not only has accomplished that goal but also has found the RHC to be an effective recruitment vehicle as it provides an employment-like structure sought by new physicians.

## Community Clinic and Academic Medical Practice

Community clinics and academic medical practices also provide the advantage of employment-like arrangements with physicians. Community clinics, which can be operated by tax-exempt, nonprofit hospitals and other nonprofit organizations, are not technically hospital outpatient clinics, so there is also the advantage of patients not receiving two bills. This model has been used successfully by some hospitals to recruit new physicians, especially in primary care. Some hospitals also have used this approach to address the needs of an underserved population and/or to provide follow-up care after ED visits or hospitalizations. Other hospitals have formed relationships with independent community clinics to provide follow-up care and have provided those clinics with grants or other funding to help recruit new physicians and to provide services. Academic practices are costly ventures for hospitals, given the infrastructure demands to achieve accreditation, and so have had limited use beyond academic medical centers.

Hospitals had mixed success with their integration strategies during the 1990s. Given the often intense competition for physician practices among PPMs (which offered stock payouts), payers (who at the time were also creating integrated

structures), and hospitals, practice purchase prices were often high. Also, many hospitals underestimated the expertise required to effectively manage physician groups and tried to use hospital personnel to manage them as an add-on responsibility. Further, physician compensation was frequently salary-based or had high guarantees so there was little monetary incentive for physicians to maintain productivity. Hospitals often added costs to the acquired practices by moving practice personnel to hospital salary and benefit levels, and moving practices to new, larger facilities in the hopes of expansion and growth. Consequently, many hospitals and hospital systems experienced losses of $100,000 or more per physician, and so during the early 2000s many chose to divest themselves of their physician practices. Those hospitals that persevered, adding experienced physician managers and improving their financial relationships, now have robust medical groups that can recruit and support large numbers of physicians.

## Hospital Closures and Consolidation

As some hospitals were exploring integration strategies with their medical staffs, others were struggling with financial pressures, which resulted in substantial market consolidation. Between 2001 and 2007, 27 hospitals (6.8 percent of the state's total) closed, resulting in a loss of approximately 3,500 beds (4.3 percent of the state's total) (see Table 2). Los Angeles County experienced the most closures: 11 hospitals (41 percent of total closures), with a loss of over 2,000 beds. During the same period, six hospitals opened with 373 beds.[9]

Many hospitals have pursued consolidation to respond to increased financial challenges and the need to solidify or increase market share. For the period 1990 through 2005, 40 hospital mergers occurred in the state. Most mergers (63 percent) were between hospitals no more than five miles apart; all but one set of merging hospitals were no more than 15 miles apart.[10] Merger activity slowed from 2005 to 2009, but Irving Levin and Associates reports a 26 percent increase nationally in health care provider merger and acquisition deals in the second quarter of 2010 over the same period in 2009, which it attributes to providers positioning themselves to respond to health care reform.[11] It is anticipated that further consolidation will occur as a response to continued downward pressure on reimbursement, with smaller or less well-capitalized hospitals seeking partners in order to avoid closing.

**Table 2. General Acute Care Hospital Closures, California, by Region, 2001 – 2007**

| | HOSPITALS | | LICENSED BEDS | |
|---|---|---|---|---|
| | NO. | PERCENT OF TOTAL CLOSURES | NO. | PERCENT OF TOTAL CLOSURES |
| Central Coast | 2 | 7% | 420 | 12% |
| Greater Bay Area | 3 | 11% | 276 | 8% |
| Inland Empire | 0 | 0% | 0 | 0% |
| Los Angeles County | 11 | 41% | 2,042 | 58% |
| Northern and Sierra | 3 | 11% | 136 | 4% |
| Orange County | 3 | 11% | 284 | 8% |
| Sacramento Area | 0 | 0% | 0 | 0% |
| San Diego Area | 1 | 4% | 162 | 5% |
| San Joaquin Valley | 4 | 15% | 172 | 5% |
| **Total Closures** | **27** | **100%** | **3,492** | **100%** |
| 2001 Total Hospitals and Beds Statewide | 400 | 6.8% | 80,616 | 4.3% |

Source: California HealthCare Foundation, *California Health Care Almanac, California Hospital Facts and Figures,* April 2010.

# V. Health Care Reform and Physician-Hospital Integration

Health care reform under ACA addresses three issues that affect physician-hospital integration: (1) demand for services, through expansion of health insurance coverage; (2) provider workforce shortages, especially in primary care; and (3) payment reform.

## Expansion of Coverage

Under ACA, most individuals will be required to have health insurance in 2014. Individuals who do not have coverage through their employers will be able to obtain coverage through a health insurance exchange. Premium and cost-sharing credits will be available to some, making coverage more affordable. Subsidies will be available for those whose income is up to 400 percent of the federal poverty level. In addition, Medi-Cal will be expanded to all individuals under 65 with income less than 133 percent of the federal poverty level.

While coverage ultimately will depend upon federal and state actions to implement the legislation, current projections under these programs show Medi-Cal coverage extended to approximately 3.3 million currently uninsured Californians, with another 2.7 million offered subsidies to purchase insurance.[12] One payer representative interviewed for this paper suggested that "this influx of new enrollees could make Medi-Cal managed care plans more attractive to both physician groups and hospitals." However, he also recognized that this will "depend on reimbursement levels and their need to cover costs." As physicians and hospitals enter into more managed Medi-Cal contracting, the lower reimbursement rates offered by Medi-Cal plans will mean that physician groups and hospitals must collaborate to manage the costs of care for these newly insured individuals.

## Physician Workforce Shortages

Health care reform includes a number of provisions to increase the number of primary care physicians. ACA, in several sections, provides funding to expand the number of residency slots for which priority is given to primary care; California recently was awarded $18.2 million in ACA funding to expand residency programs.[13] Additional flexibility in laws governing graduate medical education funding also is provided to promote training in outpatient settings and ensure the availability of residency programs in rural areas. ACA 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 operating primary care residency programs. ACA also increases support through scholarships and loans.

Additional support to primary care is provided through a 10 percent bonus payment to primary care providers by Medicare from 2011 through 2015 and improved coverage of preventive health services by both Medicare and Medicaid. General surgeons also will be eligible for a 10 percent bonus if their services are provided in a designated health professional shortage area.

While these efforts are intended to help mitigate the physician shortage in primary care, most physician leaders acknowledge that there is still likely to be a significant shortage in primary care providers for the foreseeable future. Structures that facilitate the use of advanced practice nurses (e.g., nurse practitioners, midwives) and physician assistants are being considered with increasing frequency by hospitals and medical groups. Also, as solutions for

the primary care physician shortage are addressed, the scope and independence of practice for these non-physician providers is also being considered.

## Support for Community Clinics

ACA provides additional funding for community clinics, recognizing the important role to be played by these clinics in providing access to services, especially for those newly covered by Medi-Cal. Thus far, California community health centers have received $263,239,500 in funding from ACA to increase access, health information technology implementation, and capital improvements.[14] This funding can strengthen the ability of community clinics to assist hospitals in meeting primary care needs and providing access for follow-up for ED patients and those discharged from inpatient care. As community clinics expand the number of patients they serve, hospitals will need to develop relationships with these clinics to manage the patients they jointly serve.

## Payment Reform Drives New Relationships

There is a growing consensus that the current fee-for-service payment methodology is a major driver of health care costs and that care provided under this structure is disjointed, resulting in duplication of effort and cost plus other inefficiencies. Many proposed solutions emphasize greater care coordination, including some form of physician-hospital integration. For example, a reduction in Medicare hospital payments by 1 percent for certain readmissions gives hospitals an incentive to work with physicians to reduce those readmissions.

ACA includes several initiatives that may foster physician-hospital integration through changes in provider reimbursement, in particular its move to value-based purchasing structures. ACA encourages

### Glossary

**Anti-kickback and fraud and abuse prevention laws.** These federal laws and regulations prohibit filing false claims, paying or receiving kickbacks for referrals, and self-referral schemes. Violations can result in criminal and/or civil punishment.

**Bundled payments.** This methodology involves a single payment covering pre-hospital, acute, and follow-up care for specified high-volume procedures. It includes payment for hospital, physician, and ancillary services. Specific quality standards must be maintained to be eligible for the bundled payment.

**Co-management agreements.** These structures are generally created for specific service lines, such as cardiology, oncology, or orthopedics. Under this structure, a new management company is created to provide administrative and clinical support for the service line. The hospital provides operational infrastructure and support, while physicians co-manage the clinical environment. Governance is typically split between the hospital and the physicians. Quality, operational efficiency, and financial targets are established and any savings are shared between the physicians and the hospital.

**Patient-centered medical home.** In this model of care, each patient has a personal physician who leads a team that takes collective responsibility for the patient's care. The physician-led care team is responsible for meeting all the patient's health care needs, including arranging for appropriate care with other qualified physicians.[15]

the use of ACOs, bundled payments, and patient-centered medical homes (PCMH), with each providing opportunities for physician-hospital integration. Each of these models addresses payment reform differently, creating different requirements for physician-hospital integration. Table 3 (at the end of this section) summarizes each of these models, as well as co-management arrangements (discussed further, below), and its impact on key characteristics related to physician-hospital integration.

## Accountable Care Organizations

ACA's establishment of ACOs has generated considerable excitement about physician-hospital integration because it calls for a national, voluntary shared savings program involving collectives of health care providers that formally assume responsibility for the cost and quality of health care for a defined population of patients.

Every physician group and hospital surveyed for this paper reported that it is exploring its options for becoming an ACO, including discussions about how each can work with the other. All of the hospital CEOs interviewed expressed their willingness to collaborate with physicians in the creation of ACOs. However, there is skepticism on the part of some physician group leaders; as one physician group CEO commented, there are "varying degrees of willingness on the part of hospitals to talk seriously about ACOs with us. I am not sure if that is because they feel they can do it without us, or they still don't feel that they really have to change their current model of care." As physician groups and hospitals examine how to achieve savings across the continuum of care, it is becoming clear that hospitals and physicians will need to work collaboratively to cost-effectively manage patient care. While an ACO can be formed by a variety of organizations, its success will be determined by its ability to ensure appropriate, efficient, cost-effective care.

There is still much to be determined about how the Centers for Medicare & Medicaid Services (CMS) will define the ACO structure. However, based on surveys and interviews, as well as consensus from industry leaders, there are a number of critical factors that will need to be present for an ACO to be successful, regardless of the final details. These include:

- While an ACO need not be physician-owned, it must be physician- and clinician-led.
- Strong infrastructure and IT capability is required.
  - An ACO must have the capability to efficiently gather, analyze, report, and provide alerts, based on clinical data and financial information in real time.
  - Systems and work flows must support care providers by facilitating immediate, high quality care, enabling follow-up and feedback.
- Uniform metrics must exist across the system to evaluate quality of care and cost effectiveness; evidence-based protocols must be identified and enforced in order to improve care and demonstrate value.
- There should be an incentive system that physicians and hospitals control and understand, and that facilitates desired results.
- There should be ongoing redesign of clinical care delivery across the continuum to improve efficiency, patient experience, and quality of care.

Although ACOs have generated the most interest, there are three other models that also facilitate

physician-hospital integration: co-management, bundled payments, and the PCMH.

## Co-Management Model

While the co-management model was not included in ACA, it provides a viable structure for facilitating collaboration on the cost-effective delivery of care. The focus of co-management is operational efficiency and savings within the organization itself. Thus, this model can be implemented without renegotiating payment methodologies or otherwise involving payers. Co-management structures have proved effective in engaging physicians to improve service line performance and aligning the interests of the hospital and physicians without requiring full integration. To be successful, physician and hospital leaders must create an effective team to manage both the operational and clinical processes of the service line. Careful consideration must be given to the financial arrangements between the hospital and physicians given the framework of anti-kickback and fraud and abuse prevention laws and regulations.

## Bundled Payments

ACA requires expansion by 2013 of the Medicare pilot project on bundled payments. This will build on the initial pilot that began in 2009–2010 with five hospitals: Exempla Saint Joseph Hospital, Denver, CO (cardiac care); Baptist Health System, San Antonio, TX (cardiac and orthopedics); Hillcrest Medical Center, Tulsa, OK (cardiac and orthopedics); Lovelace Health System, Albuquerque, NM (orthopedics); and Oklahoma Heart Hospital, Oklahoma City, OK (cardiac). To succeed under the bundled payment methodology, hospitals and physicians need to jointly engage in developing best practices in cost, efficiency, and effectiveness. While results have not yet been released by CMS, initial findings suggest that it may be possible to achieve savings of 3 to 5 percent for the designated procedures. Participants also have achieved increased efficiency, improved quality, and greater patient satisfaction.

In addition to Medicare, the Integrated Healthcare Association is testing a bundled payment approach, with financial support from CHCF, and a number of commercial payers are considering offering such an approach for high-cost procedures with expensive medical devices. In addition to potential cost savings, bundled payments also provide a structure in which hospitals and physicians can learn to collaborate and jointly manage care for a specific clinical episode, in preparation for broader population management. As one physician leader noted, however, "this approach doesn't really address the fragile patient where many of the costs are," while another stated that bundled payments may be too narrow in focus to "significantly impact costs." Nonetheless, some industry leaders see the bundled payment model as an intermediary step which could lead to broader payment reform.

## Patient-Centered Medical Home

PCMH is a delivery model that is increasingly being promoted as a key building block to achieve the cost and quality improvement that will be required under health care payment reform. ACA has mandated that medical homes be given priority under grants to develop and operate physician training programs, provide financial assistance to trainees and faculty, enhance faculty development in primary care and physician assistant programs, and establish, maintain, and improve academic units in primary care. Also, Medicaid programs have a new state option to permit some Medicaid enrollees to designate a provider as a medical home. Funding for the Center for Medicare and Medicaid Innovation created under ACA

incorporates medical homes on its list of projects to consider.

Studies have shown that the medical home can improve chronic disease management and lower hospital readmissions and ED visits through more effective care coordination and follow-up with patients. For example, both Geisinger Health System and Group Health Cooperative have reported reductions in hospital admissions (20 percent and 6 percent, respectively) from implementation of the medical home. Geisinger also saw an 11.7 percent decrease in readmissions, while Group Health experienced a 29 percent reduction in ED visits.[16]

However, many primary care practices lack the resources necessary to function as a medical home. New staffing configurations and skill mix, as well as additional staff resources, are often required for a practice to serve as a medical home. It may be necessary for a practice to substantially invest in information technology to improve ease of communication with patients, scheduling of appointments, tracking and reporting on patient care metrics and outcomes, and provider efficiency. Given such resource requirements, it is likely that integrated systems and large physician groups with access to capital will lead the development of medical homes unless government and/or payer support is available to assist smaller organizations. A number of state and federal pilot projects have focused on FQHCs to facilitate the development of the medical home infrastructure since FQHCs face many of the same challenges as other primary care practices in becoming medical homes.

Payers in California have been slow to implement reimbursement structures for medical homes, which has inhibited their implementation in the state other than with groups that are capitated for a large percentage of their patient population. However, interviews for this paper with payers and physician groups suggest there is now increasing interest in this model in California.

**Table 3. Comparison of Physician-Hospital Integration Models**

| | CO-MANAGEMENT | BUNDLED PAYMENT | PATIENT-CENTERED MEDICAL HOME | ACCOUNTABLE CARE ORGANIZATION |
|---|---|---|---|---|
| Critical Attributes | Created around specific service lines<br>Focus on achieving operational efficiencies and savings within the organization | Covers pre-hospital, acute, and follow-up care for specified procedures (to date, cardiology and orthopedics) | Delivery of timely, coordinated medical care<br>Care provided by multi-disciplinary team led by physician<br>Makes extensive use of information technology<br>Emphasis on high-risk patients | Involves providers who assume responsibility for cost and quality for defined population<br>Can be medical groups, integrated delivery systems, PHOs, IPAs |
| Provider Payment Methodology | Payment to providers by payers does not change, but providers have access to internally-generated shared savings | One payment for all services (Medicare Part A and B) in an episode of care | Per-member, per-month care coordination payment, increase in fee-for-service rates, or access to savings | Fee-for-service or partial capitation plus sharing of savings generated |
| Impact on Primary Care | None | Limited | Strengthens primary care by incentivizing better care coordination and disease management | Strengthens primary care by providing incentive to focus on disease/care management<br>May incentivize use of medical home |
| Fosters Coordination Among Providers | Yes, for those within the service line | Yes, for those within the bundle | No, for specialists, hospitals, or other providers | Yes, significant incentive to coordinate among participating providers |
| Degree of Physician-Hospital Integration Required | Physicians and hospitals can remain independent | Requires coordination, but not necessarily formal integration, although integration makes it easier | Capital requirements may drive formal integration | Formal integration not required, but incentives, governance have to be closely aligned to maximize savings; collaboration, at least, is critical |
| Benefit to Patients | Little impact; patient unaware of co-management, but could improve quality and reduce costs | Financial benefit to patient to use bundled payment providers<br>Providers must demonstrate quality outcomes | Improved care coordination and access to providers<br>Proactive management of health issues | Improved care coordination<br>Proactive management of health issues<br>Goal of healthier population |
| Challenges to Implementation | Requires effective management team of physicians and hospital personnel | Hospital may take most of downside risk<br>Since focus is on specific procedures, does not facilitate system reform | Capital requirements for IT<br>Does not incentivize specialists, hospitals, other providers<br>Requires care model redesign, which may be difficult to accomplish | Capital requirements<br>Formula for shared savings<br>Determining who is in control |

Source: The Camden Group.

# VI. Today's Physician-Hospital Integration Environment

## Private Practice Physicians Face Economic Pressures

Even without health care reform, physicians face a variety of pressures that are moving them to seek alternatives to the solo or small independent practice. According to the Medical Group Management Association, physicians are seeing a steady erosion in their gross fee-for-service collection percentage as a result of increasing contractual discounts provided to payers and of increasing bad debt during the economic crisis as more patients have become uninsured or have high deductible health plans (see Figure 9 on page 27). From 1999 to 2009, the collection percentage decreased by 12 percent.

Further, there is still no resolution to the impending dramatic drop in physician Medicare payments that will result from Medicare's sustainable growth rate (SGR) formula. Congress has passed a one-month delay in a proposed December 1, 2010 cut of 23 percent in payments. However, if no solution is found, Medicare physician payments are set to be cut by 24.9 percent on January 1, 2011. Figure 10 illustrates the impact of these and further proposed Medicare cuts as compared to projected payment practice expenses (see page 27).

Medicare's elimination of consultation codes and decreases in imaging reimbursement in 2010 have already reduced physician revenue. These Medicare reductions and other economic pressures have led to decreases in median total physician practice revenue for a number of specialties, including pediatrics (5.8 percent), cardiology (8.8 percent), gastroenterology (8.4 percent), and urology (10.8 percent).[20]

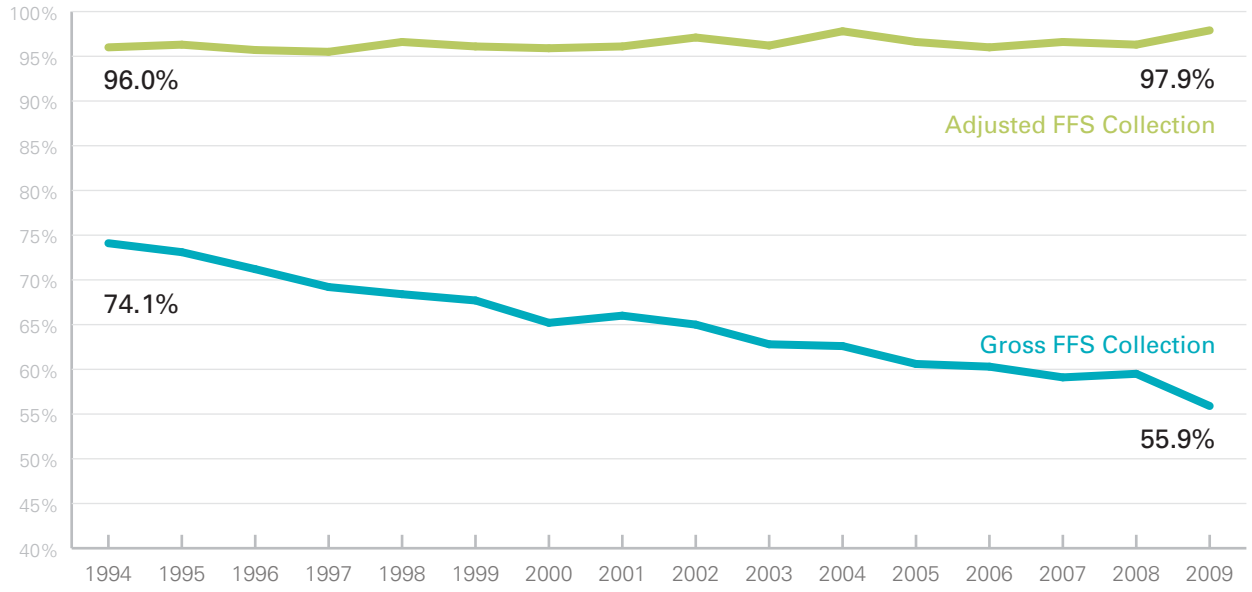
### Glossary

**Medicare sustainable growth rate (SGR) payment formula.** The SGR is a component of the formula CMS uses to calculate physician payments for providing services to Medicare patients. The use of SGR targets is intended to control the growth in aggregate Medicare expenditures for physicians' services. If the target is exceeded, the update to Medicare physician fees is reduced; if it is less than the SGR target, the update is increased.[17]

**Physician Quality Reporting Initiative (PQRI).** PQRI, implemented by CMS, includes an incentive payment for eligible providers who report data on specific quality measures regarding services furnished to Medicare beneficiaries. Beginning in 2010, CMS is required by law to post on its Web site the names of providers who satisfactorily submitted data on quality measures under PQRI in 2009.[18]

**Health information exchange (HIE).** An HIE is a group of organizations that are willing to share the health care information of their populations to enhance the group's population health care management.[19] Increasingly, hospitals, health systems, and physician groups are creating HIEs that create a clinical data repository to which all participants submit data and from which all can access information, in order to facilitate more effective and efficient patient care.

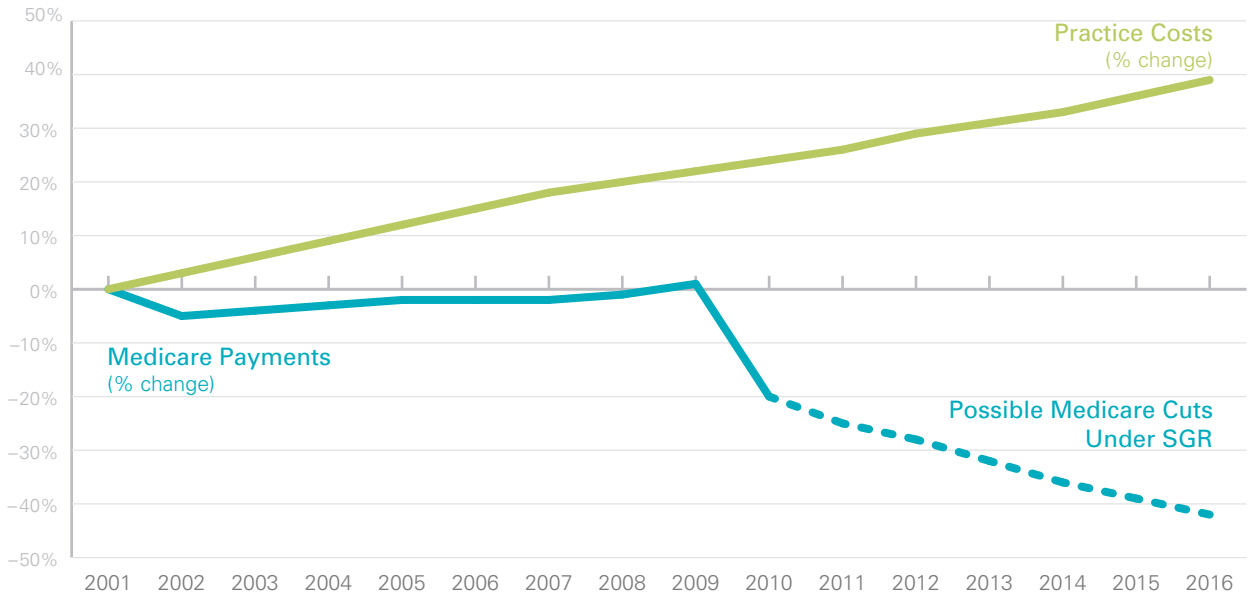
**Figure 9. Mean Gross and Adjusted Fee-for-Service Collection Percentage for Multi-Specialty Practices, 1994–2009**




Notes: Gross collection percentage is payments divided by charges and illustrates what percent of charges were collected. Adjusted FFS collection percentage is the amount collected as a percent of total charges minus contractual adjustments and measures success in collecting actual monies owed.

Source: MGMA. *Cost Survey for Multispecialty Practices: 2010 Report Based on 2009 Data.*

**Figure 10. Payment Practice Costs vs. Medicare Payments, 2001–2016**




Sources: Physician cost data is from the MEI, maintained by CMS. Medicare cuts data are from the 2008 Medicare Trustees report, with adjustments to reflect Sec. 131 of P.L. 110–275. Prepared by American Medical Association, Division of Economic and Health Policy Research, August 2008.

At the same time, physician practices are experiencing increases in expenses. For example, implementing electronic medical records requires significant capital investment and ongoing maintenance fees. Employee costs are rising as the administrative complexity of practices increases, and many medical supply costs have increased substantially. Operating cost as a percent of revenue continues to climb, reaching 64.2 percent in 2009 for multi-specialty practices (see Figure 11).[21]

In addition to financial pressures, practice complexity and administrative burdens (e.g., authorizations, coding) are demanding more physician time. Government regulations (e.g., Health Insurance Portability and Accountability Act, ePrescribing) and quality reporting (Physician Quality Reporting Initiative) require more sophisticated technology and work flow processes. Given this complexity, management of today's practice requires more skilled management, which adds additional time burdens and cost to a practice.

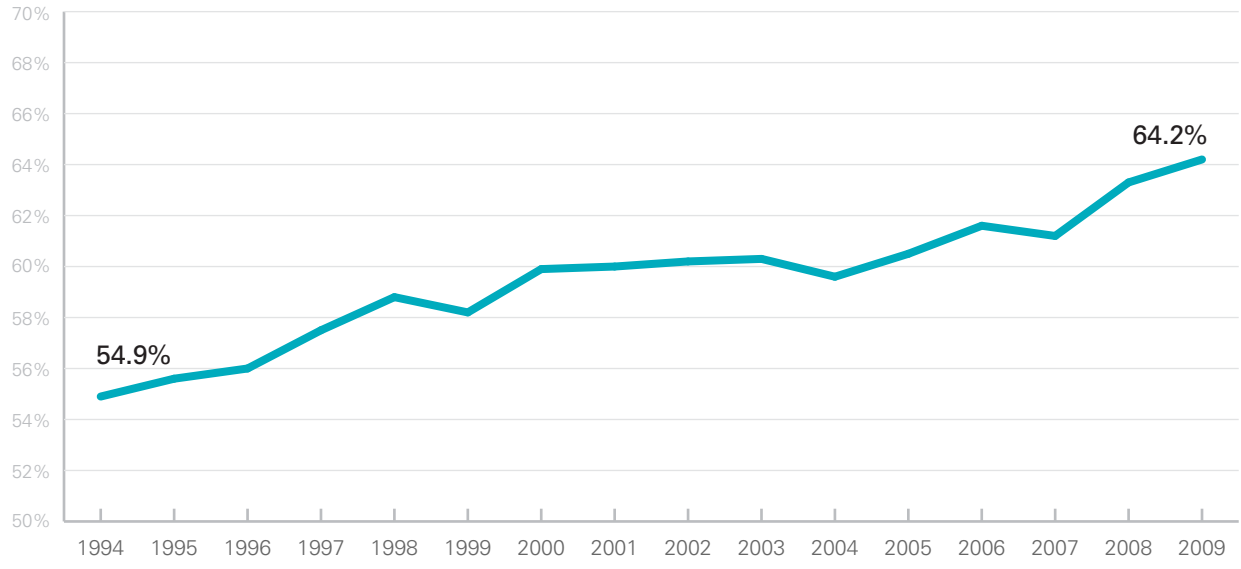
Both primary care physicians and specialists have seen their compensation affected by changes in reimbursement and the increased costs of operating a practice. Specialists have experienced a decrease in income when adjusted for inflation. And while primary care physicians have seen a small increase adjusted for inflation between 2004 and 2008, their base as compared to specialists is still significantly lower, which remains a deterrent to physicians entering primary care.

**Table 4. Physician Compensation, National, 2004–2008**

| | 2008 MEDIAN ANNUAL COMPENSATION | CHANGE ADJUSTED FOR INFLATION (ACTUAL) 2007–2008 | 2004–2008 |
|---|---|---|---|
| All PCPs | $191,401 | 3.2 (2.9%) | 3.6% (13.9%) |
| All Specialists | $325,916 | –3.7% (–4.1%) | –6.3% (2.9%) |

Source: MGMA. *Physician Compensation and Production Survey: 2009 Report Based on 2008 Data.*

**Figure 11. Median Total Operating Costs as Percent of Net Medical Revenue, Multi-Specialty Practices, 1994–2009**




Source: MGMA. *Cost Survey for Multispecialty Practices: 2010 Report Based on 2009 Data.*

Given all these challenges, many physicians, especially those in solo or small group practice, or just starting practice, are seeking employment — with its increased security and shared responsibility for administration and management — with a larger medical group or integrated system. Hospitals have been especially successful in attracting physicians nationwide. According to the MGMA, 65 percent of established physicians seeking new positions and 49 percent of physicians hired out of residency or fellowship were placed in hospital-based practices nationwide in 2009.[22]

## Changing Physician Workforce Dynamics

The physician workforce is undergoing significant changes which create opportunities and challenges for medical groups and for physician-hospital relationships. Changes in practice life have increased physician dissatisfaction with their profession: According to a 2008 Physicians' Foundation survey, 78 percent of physicians said medicine was "no longer rewarding" or "less rewarding."[23]

Because of primary care's longer work days, lower pay, more burdensome administrative work, and lower prestige, fewer physicians are choosing to practice primary care. The American Academy of Family Physicians predicts a shortage of 40,000 family physicians in 2020,[24] and a 2009 study of the physician workforce performed for the California HealthCare Foundation found that California faces a shortage of primary care physicians in 42 of 58 counties.[25]

In 1997, 2,340 U.S. medical school students (71.7 percent of total filled slots) selected family medicine, while by 2008 only 1,156 chose family practice (43.9 percent of total filled slots).[26] In 2008, three out of five first-year residents in family medicine were international medical graduates.[27] One of the effects of these primary care shortages is that hospitals are developing integration models that can provide the security and lifestyle sought by today's physicians.

While the number of specialists per 100,000 population in California is well above the upper range of most assessments of need, specialty distribution is not consistent across the population.[28] Rural counties tend to have far fewer primary care and specialty physicians per capita than urban counties. Also, Medi-Cal and uninsured patient access to physicians is severely limited: While over 90 percent of California physicians have patients with private insurance in their practices, only 69 percent have any Medi-Cal patients, and only 65 percent have any uninsured patients.[29] The need to address specialist shortages, including for ED specialty care, is another factor that has led hospitals to seek effective integration models to ensure adequate specialty coverage.

Changing lifestyle expectations, such as the desire for a more balanced, predictable work day and work-life balance, are leading physicians to seek employment options rather than independent practice. Also, the demographics of the physician population are changing. The percentage of female physicians in medicine is steadily increasing: In 1980, 11.6 percent of the physician workforce was female,[30] but by 2008 women accounted for 30 percent of physicians in California.[31] Women are more likely to work part-time than men (57 percent of part-time physicians are female), which can affect patient access.[32] Given these changes, plus the fact that 29 percent of active physicians in California are over 60 years of age, hospitals are actively involved in succession planning.[33] This often means a switch to physician affiliation models, such as employment or foundations. In addition, older physicians who have had to postpone retirement due to the recent

economic climate often find employment an attractive alternative to independent practice, since it can provide an option for cutting back work hours that is difficult to achieve in a small practice.

## Current Physician-Hospital Integration Activity

At the same time that physicians are looking for new practice models, hospitals are seeing an increasing need for alignment with physicians. Given the perpetual desire to increase market share, the need to ensure adequate physician coverage, and the changes brought on by health care reform, many hospitals are again seeking stronger integration with physicians. Moreover, hospitals recognize that to improve quality and reduce costs, hospitals require strong physician leadership and collaboration.

According to a HealthLeaders Media survey of senior health care executives throughout the country, 74 percent plan to employ a greater percentage of physicians in the next 12 to 36 months.[34] While California law does not allow hospitals to employ physicians, 71 percent of senior hospital executive respondents for this paper expect to either continue or accelerate the growth trend in numbers of physicians involved in integrated models. The key drivers of this trend, according to the respondents, are health care reform, physicians coming to them seeking help, and medical staff succession planning. One hospital representative reported that "physicians in solo and small practices concerned about their long-term survival are turning to the hospital for assistance and this is driving increases in the number of physicians in our integrated structure." On the other hand, in some markets hospitals report having a hard time interesting physicians in integration models; for example, a CEO on the state's central coast stated that his medical staff are "still pretty comfortable in their solo or small practices and have not really considered how health care reform may impact them in the future."

Both rural and urban hospital CEOs interviewed for this paper believe that successful hospitals will be those that integrate with their physicians through an ACO or other model. Larger physician groups that have large managed care populations are looking to strengthen hospital relationships to better manage patient outcomes and cost and to prepare for ACOs. One physician group CEO stated that "integration will be key to making an ACO function properly." Another suggested that "it will be increasingly difficult for small and mid-size groups to survive without integrating with a hospital or larger physician group."

According to respondents for this paper, physician group interest in integration activity with hospitals is more likely to focus on shared risk arrangements and clinical integration efforts. This may reflect that integration efforts by physician groups are being driven primarily by their managed care risk contracts and the need to manage care and medical costs. Some IPAs also are seeking clinical integration in order to meet Federal Trade Commission requirements to achieve exemption from anti-trust regulations so that they may negotiate PPO contracts for their members, and also to prepare for ACOs.

Use of the hospital outpatient clinic model is the most common physician integration structure reported by the hospitals surveyed, unless they already used a foundation model. Other current strategies include foundations, shared risk contracting, and co-management agreements. Major strategies that physician groups are now pursuing are internal growth, integration with a hospital/hospital system, and acquisition/mergers with other medical groups/IPAs. The primary expected benefits from these strategies are increased market strength and improved financial performance. One

physician group CEO indicated that success of their foundation model will be primarily measured by physician income. Another physician group executive regards physician-hospital integration as key to its long-term survival, primarily for access to capital.

Many physician groups and hospitals are focused on operational infrastructure enhancement for ACO preparation and EMR/data-sharing implementation. The ability to exchange data is an essential component for ACO success. Many hospitals recognize the importance of providing physicians with timely, easy access to patient information (e.g., laboratory and radiology results, discharge summaries, patient demographics) through hospital Web sites or physician portals. This facilitates timely discharges and provides for more effective care coordination and efficient outpatient visits in the physician's office.

With the creation of a safe harbor for hospital support of physician EMR implementation, more hospitals have begun to provide physicians with access to support for EMR implementation for their practices. Stimulus monies provided to hospitals for meaningful use of EMRs and information exchanges through the American Recovery and Reinvestment Act of 2009 (ARRA) have provided new funding for hospitals seeking to improve their connectivity with physicians and access to data to better manage patient care. ARRA funding also is spurring EMR implementation within physician groups. Some hospitals are going further, working on development of health information exchanges to facilitate the ability to consolidate and report on comprehensive clinical information from physicians and other health care providers.

For hospitals, expanding and/or creating foundations and outpatient clinics are considered key responses to health care reform. IPAs, for their part, are moving toward clinical integration. In two cases, IPA leaders reported that they are creating an employment vehicle within the IPA to address physician concerns for stability and security as well as succession planning.

# VII. Patients Can Benefit

There is a general consensus on the part of the surveyed physician and hospital leaders that physician-hospital integration—done well—will benefit patients. They expect that the consistent use of patient protocols will improve safety and reduce inefficiency. Integration also should facilitate the strengthening of care delivery through the allocation of additional resources for care coordination, the deployment of EMR, implementation of new care models like the PCMH, and implementation of quality initiatives. As one hospital leader put it, "Patients will be the biggest winners; they will experience better quality and more effective coordination of care."

The CEO of a large IPA states that integration should allow us "to make a real impact on cost," but he points out that patients also have a role in managing cost. One approach to introducing joint (provider and patient) accountability for cost is the use of the narrow network approach. Narrow network design consists of the use of restricted panels (as in an HMO or PPO product) and tiered networks, where one tier of providers costs enrollees less, and a higher tier costs as much as 30 percent more. One payer executive suggested that "narrow networks could provide an incentive to hospitals and physicians to lower costs." As narrow network design becomes more prevalent, however, patients may become dissatisfied because their access to physicians and hospitals is limited or could cost them more, as happened with HMOs in the 1990s. One payer representative commented that "payers and providers will need to be more prudent in how they design their narrow network plans so that patients don't become alienated." Of course, as mergers and consolidations occur, patients' provider choices may become more limited anyway.

Despite payer use of risk adjustment and quality metrics, some physicians and patient advocates worry that narrow network selection will be totally driven by cost, and those providers with more complex patients may be penalized regardless of their quality outcomes. One physician group leader describes the process for creating narrow networks as follows: "Meeting a quality baseline will be the initial entry ticket to a narrow network, but cost will be the final determinant."

Patients may be expected to take more active roles in managing their care as the shared decision-making model is introduced through PCMHs. Also, as employers and health plans can better track individual costs related to specific lifestyle behaviors, patients may face pressures and incentives to make better lifestyle choices. As one IPA executive put it, "obesity is more than just a provider and health plan issue."

# VIII. What Has Been Learned about Physician-Hospital Integration

Physician-hospital integration efforts generally increase in response to economic and other market forces. Health care reform, especially the proposed movement to value-based payment, has accelerated the trend toward integration that was already being driven by the desire to increase market share, increased emphasis on quality and pay-for-performance, and physician practice economics.

From over 20 years of experimentation with various integrated models, much has been learned. Successful physician-hospital integration begins with developing a common vision and goals. Expectations must be clarified up front and the necessary time must be taken to create an effective structure to manage the ongoing relationship. A governance structure that provides physicians with key leadership roles and facilitates ongoing physician involvement in decision-making is essential. As a CEO at a rural hospital describes it, success will only occur when "everyone is working together for a common organizational purpose, and everyone has a voice at the table." Physicians and hospitals recognize that it is critical for a new culture to be created that fosters collaboration and the achievement of mutually agreed-upon goals. Both physician and hospital executives stressed the importance of mutually aligned incentives.

Hospitals now understand that physician practice management requires a distinct skill set and experience, so they are hiring skilled medical practice administrators to manage their physician entities. Rather than being salary-based, physician compensation is becoming performance-based, with incentives focused on productivity, quality, and financial performance. Because physicians have such a significant impact on practice operations, they cannot be divorced from the business aspects of physician practice, even when they no longer own it.

# IX. Challenges

Despite considerable enthusiasm about physician-hospital integration, there are still concerns among both physician and hospital leaders about whether physician-hospital integration can achieve its goals. Physician groups worry that hospitals are too focused on filling hospital beds and that they underestimate the need to address underlying costs. As one IPA CEO put it, "Hospitals are still very dependent on volume, which is the 'old' business model." Another contended that "hospitals always want to be bigger."

Hospitals are not sure that physicians understand their part in the cost equation and believe that many physicians may have unrealistic income expectations that can no longer be supported by the economics of health care. As stated by a hospital CEO, physicians may "have high expectations to be made whole" through this process, or as another put it, "physicians may want a greater share of the hospital's revenue."

Given these perceptions, some physician groups and hospitals are rushing to be the first in ACO development so they can control how funding is allocated. Yet, as several physician and hospital leaders admitted, it will be difficult to significantly affect either cost or quality without working together. Thus, as physicians and hospitals seek to become more integrated, some struggle is likely over the development of governance structures that each side feels gives it an equal voice in decision-making and in allocating monies. One physician group representative expressed it thusly: "Everyone has to get over the control issue; collaboration is required to be successful in value-based payment."

## Bending the Cost Curve

Some commentators have recently contended that the California experience suggests that physician-hospital integration models, such as ACOs, may not lower health care costs.[35] These commentators point out that, as providers integrate and consolidate, they often use market power to leverage payers for higher rates. As one payer executive noted, "Consolidations often just increase prices as the rates paid to the acquired group increase, so we pay more for the same thing." Other factors also can contribute to higher rates, such as horizontal hospital integration, the need to contract with "must have" hospitals and physician groups, and the creation of large single- and multi-specialty groups through merger and consolidation. However, physician-hospital integration remains a major concern for policymakers, because whatever benefits they bring in improved quality and efficiency, there is data to suggest that integrated delivery systems, at least in California, can result in higher prices.

## Cost of Integration

A number of hospitals surveyed for this paper expressed concern about the costs of physician-hospital integration. These costs, which include practice acquisition, infrastructure development, and ongoing practice support, may be more than many hospitals, especially smaller ones, can afford. MGMA reports that median losses per physician were $125,000 for primary care and $213,000 for multi-specialty, hospital-owned practices nationally in 2009.[36] Added to these are costs related to the creation of the information technology infrastructure required to collect and report data to manage care.

The CEO of a large integrated delivery system expressed the problem this way: "While national health care reform has made it clear that it is no longer acceptable to work in silos, there are no dollars to pay for restructuring for those organizations that are not already integrated. It is not clear what smaller players can do."

## Managing Through the Transition

Executives of both physician groups and hospitals note that managing through the transition will be difficult, involving "disruption and the risk of damaging an already fragile system," as one hospital CEO expressed it. Since most current reimbursement methodologies do not reward for efficiency in overall care delivery, it is difficult for organizations to begin the care redesign necessary to influence cost and quality without negatively impacting revenue. As one physician leader put it, "It is hard to see how hospitals could possibly re-engineer to really meet the cost challenge since they are still largely on a volume-based business model."

## Legal Barriers

Federal and state laws can affect how hospitals structure their relationships with physicians. The federal anti-kickback and Stark self-referral laws are designed to prevent the use of financial incentives to influence providers' medical decisions.[37] The Civil Monetary Penalties statute prohibits payments by hospitals to physicians that may induce physicians to reduce or limit items or services furnished to their Medicare and Medicaid patients.[38] Also, antitrust issues must be considered by physician groups and hospitals alike. However, both the Federal Trade Commission and the CMS Office of Inspector General have indicated that they will work with providers to facilitate appropriate integration to achieve quality and cost goals.

California is one of the few states to bar the corporate practice of medicine, which means that corporate entities that are not licensed to practice medicine may not directly employ physicians.[39] This law's intent is to prevent corporate entities from influencing physicians' independent medical judgment, which could negatively affect patient care. There are some exceptions to this bar on the corporate practice of medicine, including academic medical centers, county hospitals, community clinics, and Knox-Keene licensed HMOs.

Views differ on the corporate practice of medicine ban. One hospital CEO interviewed feels that "California hospitals are at a distinct disadvantage with the ban on corporate practice of medicine. Smaller California rural and urban hospitals are at a particular disadvantage since their options to utilize other strategies may be limited." The CEO of a large hospital system in Southern California describes the problem as follows: "Corporate practice of medicine [law] makes alignment models overly complicated, driving some physicians to Kaiser as a simple solution." But another CEO of a large integrated delivery system insists that it would not change its model from a foundation even if it could employ physicians, because the model assures physician engagement and leadership. As a senior executive of a county hospital pointed out, "Employment is not a panacea. While county hospitals can employ physicians, those physicians sometimes unionize and that creates its own set of challenges."

## Managing Physician Relationships

Hospitals are concerned that moving toward greater physician-hospital integration can strain or damage medical staff relationships. They report that many medical staff members are reluctant to give up their autonomy and worry about hospital control, while at the same time they worry about being left out

by the hospital as it works with specific physicians through integration. Some hospitals have medical staff who are still successful in small private practice and who fiercely guard their independence. However, they are not necessarily prepared or willing to add new physicians to their practices for succession planning or to assist the hospital in addressing physician shortages. One senior hospital executive with facilities throughout the state explains that "this issue is the biggest challenge we face in many markets; trying to develop relationships that can facilitate care coordination, and improvement in quality and efficiency has not been easily solved." Physician leaders also recognize that establishing closer relationships with specific physician groups can "create medical staff issues."

One consequence is that, as one CEO stated, it may be necessary for hospitals to "exclude some of our high volume doctors from newly aligned structures and cost management incentives." This, however, can create political challenges that are not easily addressed.

As hospitals try to address ED overcrowding and care for increasing numbers of uninsured patients, they have begun to reach out to community clinics, which also are rethinking their hospital relationships. One community clinic system reported that a local county hospital chief medical officer now comes to its physician meetings on a regular basis to foster improved communication, and another county hospital is focusing on improving communication between its employed specialists and the community clinic's physicians.

# X. Conclusion

The initial impact of health care reform on physician-hospital integration has been to stimulate dialogue between physicians and hospitals, since it is clear that neither can achieve the reform's mandated quality, efficiency, improvement in population health, and cost savings independent of one another. Actual structures, the degree of integration, and financial relationships will depend on market dynamics and on statutory and regulatory requirements for the various models, some of which remain to be clarified. The size and strength of existing physician groups also will influence who leads some of the physician-hospital integration efforts—the physician group or the hospital.

Those hospitals with existing, mature integrated groups may have an edge on creating value-based organizations more quickly, with minimal need for new capital. On the other hand, in some markets large physician groups that already have invested in the care management tools necessary for success in ACOs may have the advantage. The speed with which new physician-hospital integration models are implemented will depend upon how quickly payers, including government entities, change their payment structures, and how willing the participants are to engage in effective collaboration and shared decision-making.

## Implications for Policymakers

While there are many potential benefits from health care reform and physician-hospital integration, there are a number of matters that California policymakers will need to consider with regard to their interrelationship.

- Market concentration often brings with it the power to demand higher prices without any demonstrably better quality. Unless market competition based on benefit design alternatives and financial incentives can control the use of such power by integrated hospitals and/or physician groups, policymakers may have to explore other methods to ensure that potential cost savings from integration are not eroded.
- Small hospitals and those in underserved areas may not have sufficient financial or management resources to develop the infrastructure required for effective physician-hospital integration. Where available, federal and state financial resources, such as those being made available through the Center for Medicare and Medicaid Innovation, should be coordinated to encourage effective integration efforts without artificially sustaining marginal providers.
- Some hospitals, especially those in rural and/or underserved areas, might be helped by greater flexibility in the state's corporate practice of medicine law, so that the hospitals can more easily recruit and retain physicians to address provider shortages and other access to care challenges. While there is currently a pilot to allow district

hospitals to directly employ a limited number of physicians, it will expire on January 1, 2011.

- Given projected shortages in primary care and certain specialties, especially in rural areas, new approaches to care delivery will be needed to fill the gaps. Provisions in ACA partially address this problem by providing for training of increased numbers of physicians and other primary care providers, but these efforts will likely take many years to bear fruit. California policymakers will need to consider efforts to expand primary care access that go beyond those in ACA. These might include incentives to encourage hospitals and physicians to collaborate in applying technology solutions, such as telemedicine, home monitoring, and e-visits. The legislature might also revisit scope of practice laws for non-physician primary care providers, such as nurse practitioners and physician assistants, to allow them to practice to the fullest extent of their training.

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## **Appendix:** Methodology

To gather feedback on the current state of physician-hospital integration, the authors of this paper used an internet-based survey with the members of the California Hospital Association and the California Association of Physician Groups (CAPG). CAPG is a statewide professional organization representing physician groups that manage a population of patients under capitation payments from HMOs. Members include group practices and IPAs. In addition to the surveys, personal interviews were conducted with 19 representatives from a cross-section of hospitals, physician groups, and payers to gain more detailed information regarding their perspective on physician-hospital integration. Participants included CEOs and senior executives from IPAs, medical groups, hospitals and integrated health care systems, and payers. Most areas of the state were represented, with a mix of rural and urban. Different size organizations were also represented. Payers were from major health plans that offer both HMO and PPO products, as well as a health plan with a focus on the Medi-Cal market.

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