CALIFORNIA HEALTHCARE FOUNDATION

ACOs, Provider Integration, and Health Reform's Impact

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December 8, 2010

Key Questions

- What have the historical relationships been between physicians and hospitals?
- What factors impact physician-hospital integration?
- What is the current state of physician-hospital integration?
- How is the 2010 Patient Protection and Affordable Care Act ("ACA") impacting physician-hospital integration trends?
- What challenges still confront physician-hospital integration?
- What state-related policy issues could facilitate or hinder future integration efforts?

Approach

- Analysis of industry data: e.g., Cattaneo and Stroud, other published data
- Conducted an internet-based survey with members of the California Hospital Association and the California Association of Physician Groups (CAPG) to identify current activities and potential trends
- Conducted individual interviews with representatives of a cross-section of physician groups, hospitals and integrated health care systems, and payers to gather more detailed information
  - Included CEOs and senior executives from IPAs, medical groups, hospitals and integrated delivery systems, and payers
  - Most areas of the state were represented, with a mix of rural and urban, as well as a mix by size of the organization
  - Payers interviewed offer both PPO and HMO products, with one focusing on the Medi-Cal market

New Era of Physician-Hospital Integration

- 2010 Patient Protection and Affordable Care Act ("ACA")
  - Payment reform and ACOs
- Need for capital for new capabilities or infrastructure
- Supply and demand for specific clinical skills
- Workforce expectations and stability

The Evolution of Physician-Hospital Integration in California

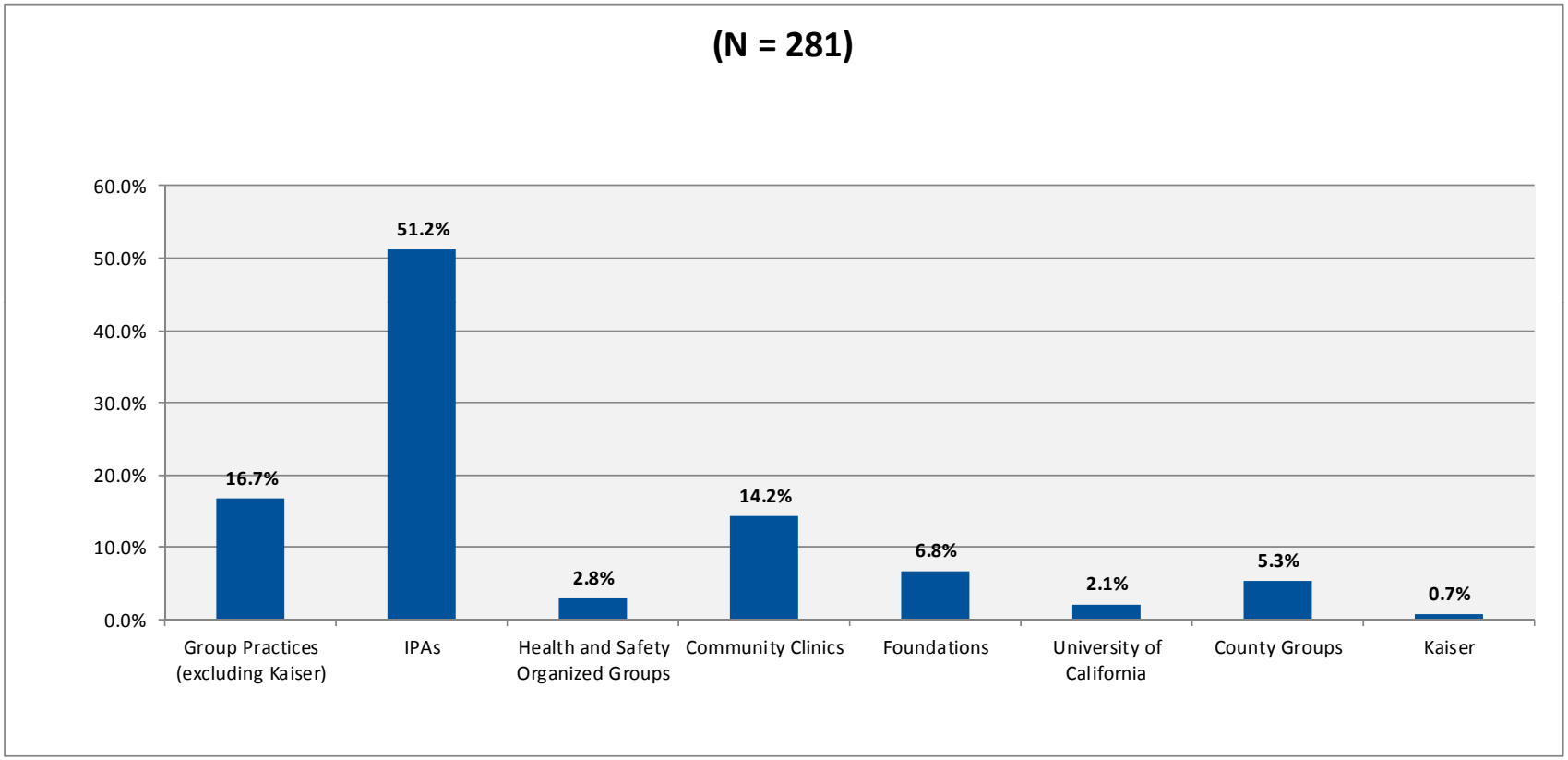
	1990s Capitation and PPM Expansion	1999-2004 Shakeout/Retrench	2005-2009 Focus on Market Share	2010+ Payment Reform
Economic Factors	■ Managed care with focus on capitation ■ Desire to achieve economies of scale and convert "cottage" industry of physician practices ■ Facilitate expansion of ancillaries ■ PPM companies go public	■ Hospital losses due to risk contracting and pressures on health insurance premiums ■ Losses in hospital and PPM-sponsored medical groups	■ Medicare Advantage rates improve ■ Declining HMO commercial enrollees as more affordable PPOs are introduced ■ Consolidation of health plans into national companies	■ Changes in payment methodologies away from traditional fee-for-service ■ Capital demands from infrastructure requirements ■ Changes in reimbursement and regulations affect specialists negatively
Market Dynamics	■ Competition among hospitals, physician groups, PPMs, and health plans for primary care physicians ■ Hospitals generally profitable ■ HMO market expanding	■ Collapse of national PPM companies ■ HMOs in disfavor among general public	■ Competition for market share: primary care and specialty services ■ Impact of generational differences (e.g. ,increased focus on work-life balance) and shortages affects: ‣ Emergency call coverage ‣ Attractiveness of group setting ■ Consolidation of specialty groups and expansion of physician-owned ancillaries	■ Collaboration pursued to achieve quality and cost reduction goals ■ Clinical integration required: ‣ EMR ‣ Electronic linkages

Source: The Camden Group

Growth of Group Practice and IPAs

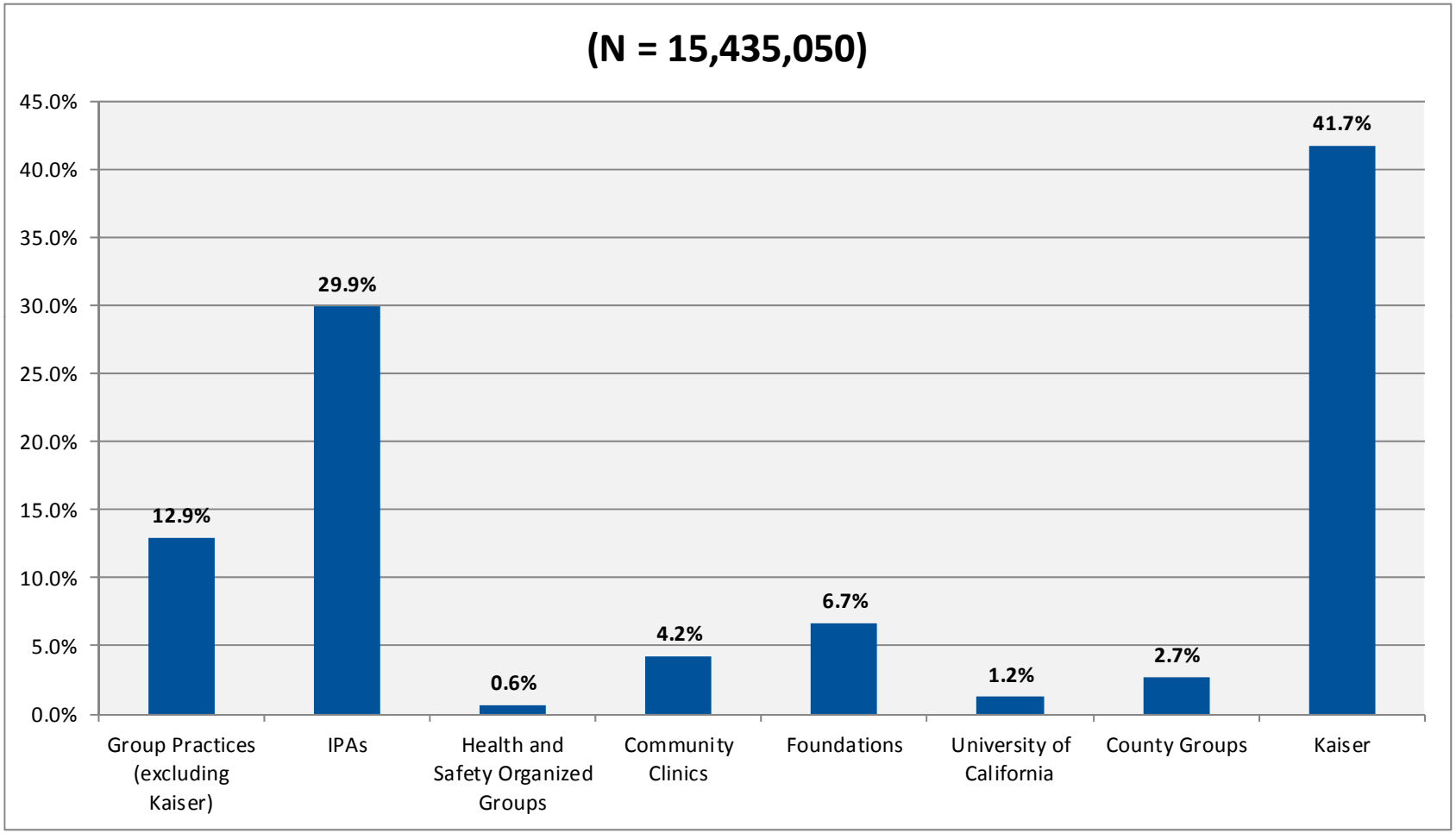
- Response to managed care
- Enhance market attractiveness/ competitiveness
- Facilitate service expansion/revenue opportunities
- Achieve economies of scale

Physician Group by Organizational Type: 2010



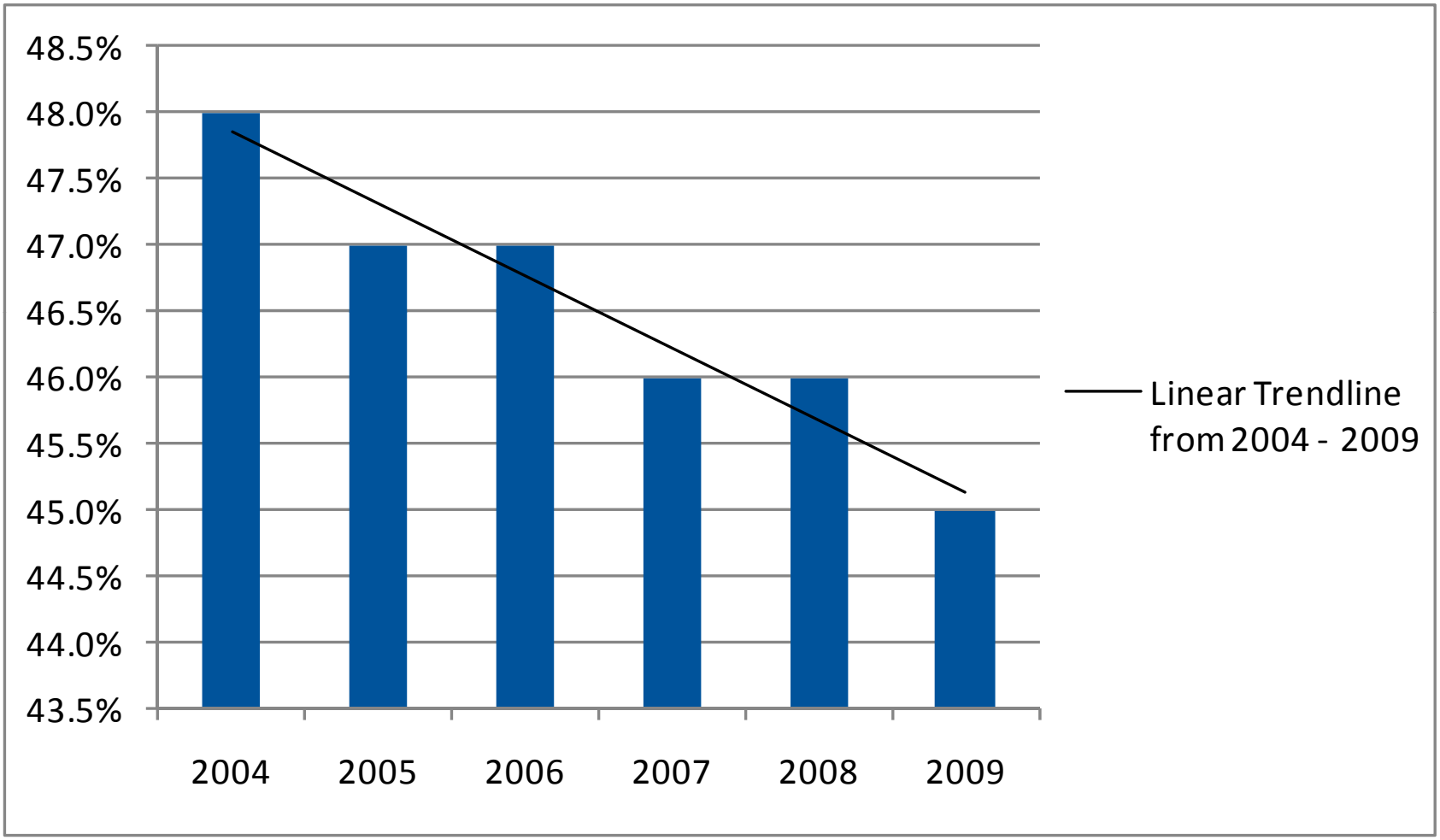
Source: Cattaneo and Stroud, Inc., Special Request: Active Group Practices, Report 18, 10/12/10
Note: Physician Group is defined as at least six primary care physicians with at least one HMO contract

Physician Group Enrollment by Organizational Type: 2010



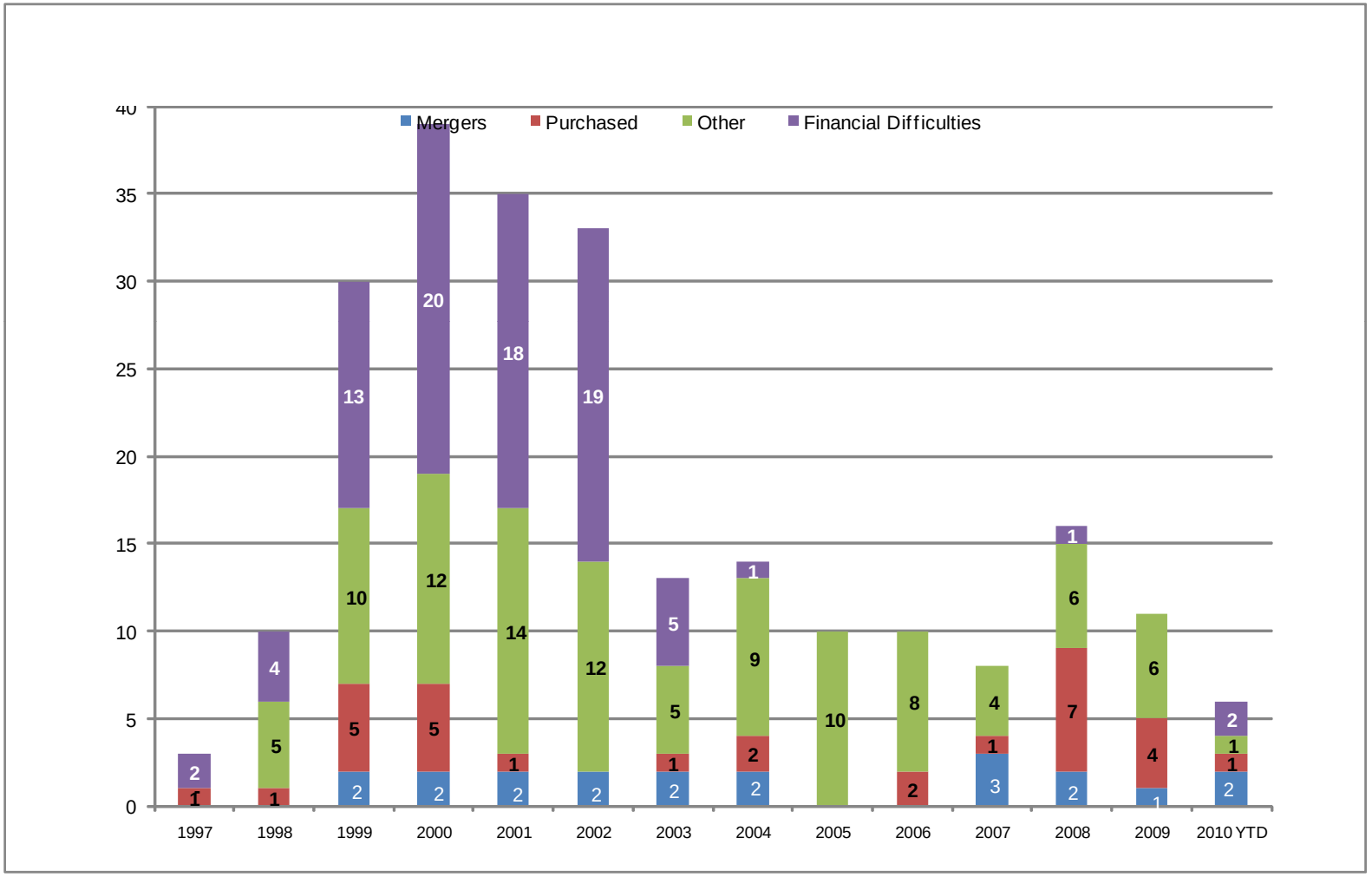
Source: Cattaneo and Stroud, Inc, Special Request: Active Group Practices, Report 18, 10/12/10
Note: Physician Group is defined as at least six primary care physicians and at least one HMO contract.

HMO Enrollment as Percent of Total California Population



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

Physician Group Closures Between 1997 and 2010



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

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

Hospital Closures 2001-2007

	HOSPITALS		LICENSED BEDS	
	Number	Percent of Total Closures	Number	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%	2042	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%**
2001Total Hospitals and Beds Statewide	**417**	**6.8%**	**83,734**	**4.3%**

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

Hospital Integration Strategies

- Physician Liaison
- Service Line Physician Advisory Councils
- Medical Directorships

- ED Call Coverage Agreement
- Recruitment Assistance
- Income Guarantees
- Physician-Hospital Joint Marketing
- Hospitalist/ Intensivist Program Development

- Real Estate/ Medical Office Buildings
- Office Timeshare/ Equipment Leases
- Clinical Institutes/ Centers of Excellence
- Gainsharing
- MSO/PHO

- Co - management Agreements
- Hospital-based Outpatient Clinics
- Equity Joint Ventures
- Clinical Integration

- Medical Foundation
- Hospital Syndication
- Academic Practices
- Accountable Care Organization

Source: The Camden Group

Employment-Like Models of Integration

- Community clinic
- Hospital outpatient clinic
- Medical foundation
- Rural health clinic
- Academic practice
- Government clinic

Payment Reform Drives New Relationships

- Co-management
- Bundled payments
- Patient-centered Medical Home (“PCMH”)
- Accountable care organizations (“ACO”)

Comparison of Physician-Hospital Integration Models

	Co-Management	Bundled Payment	Patient-Centered Medical Home	Accountable Care Organizations
Impact on Primary Care	■ None	■ Limited	■ Strengthens by incentivizing better care coordination/ disease management	■ Strengthens by providing incentive for disease/care management, medical home
Fosters Coordination Among Providers	■ Yes, for those within the service line	■ Yes, for those within the bundle, can improve care coordination	■ No, for specialists, hospitals, or other providers	■ Yes, significant incentive to coordinate care
Degree of Physician-Hospital Integration Required	■ Physicians and hospitals can remain independent	■ Requires coordination, but not necessarily formal integration, can make integration easier	■ Capital requirements may drive formal integration	■ Formal integration not required, but requires aligned incentives and governance
Challenges to Implementation	■ Requires effective management team of physicians and hospital personnel	■ Hospital may take most of downside risk ■ Since focus is on specific procedures, does not facilitate system reform	■ Capital requirements for IT ■ Does not incentivize specialists, hospitals, other providers ■ Requires care model redesign	■ Capital requirements ■ Formula for shared savings: who is in control?

Source: The Camden Group

Accountable Care Organizations

- Provider-based organizations (medical groups, integrated delivery system, PHOs, IPAs)
- Take responsibility for overall costs and quality of care of a defined population
- Processes to promote evidence-based medicine and patient engagement, report on quality/cost measures, and coordinate care
- Capacity to provide health care for at least 5,000 Medicare beneficiaries

Other Relevant ACA Initiatives

- Expansion of coverage
- Increased funding for physician and other health care providers
- Additional funding for community clinics

Private Practice Physicians Face Pressures

- Financial pressures
  - Increasing overhead
  - Decreasing reimbursement
- Increasing practice complexity and regulatory restrictions
- Need for sophisticated technology, driving need for access to capital
- Demand for skilled practice administrators which add costs

Changing Physician Workforce

- Fewer physicians choosing primary care
- Projected physician shortages and maldistribution
- Demographics of the work force
- Changing workplace/lifestyle expectations

Current Activity

- Upswing in hospital – physician integration
  - Health care reform
  - Physician coverage
  - Market share
  - Lead quest for value: quality/cost
- Use of variety of models
- Invest in infrastructure to facilitate clinical data exchange

Benefits for Patients

- Use of care protocols will improve safety and reduce inefficiency
- Strengthening of care delivery through care coordination, deployment of electronic medical records, and implementation of new care models (e.g., PCMH) and quality initiatives
- Potential to lower costs
- Patients become more active in their care through shared decision-making

Lessons Learned

- Common vision and goals required
- Physicians must play a key leadership role
  - Governance structure must facilitate active physician involvement in decision-making
  - Culture that fosters true collaboration
- Incentives must be aligned
- Skilled medical practice administrators must manage physician entities
- Physician compensation is performance-based, focusing on quality, productivity, and financial performance

Challenges for Physician-Hospital Integration

- Perspectives and expectations of physicians and hospitals are not always aligned
- Integration may lead to higher costs through increased market concentration
- Costs for practice acquisition/reorganization, information technology, operational infrastructure development, and ongoing practice support may pose a barrier
- Investing in care redesign when current reimbursement largely rewards volume over efficiency or quality
- Barriers posed by laws and regulations, e.g., physician self-referral, anti-kickback, anti-trust, corporate practice of medicine
- Managing multiple relationships: hospital medical staff issues

Policy Implications

- Achieving cost savings
- Supporting integration in underserved or under-resourced settings
- Relieving provider shortages in rural or underserved areas
- Encouraging new approaches to care delivery

Achieving Cost Savings

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.

Supporting Integration in Underserved or Under-resourced Settings

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.

Relieving Provider Shortages in Rural or Underserved Areas

Some hospitals, especially those in rural and/or underserved areas, might be helped by greater flexibility in the 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.

Encouraging New Approaches to Care Delivery

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.