

# **Hospital-Physician Alignment: *Options and Strategic Implications Following the SCOTUS Decision***

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## About the Presenter



**Todd A. Zigrang**, MBA, MHA, ASA, FACHE is a Senior Vice President of HEALTH CAPITAL CONSULTANTS (HCC), where he focuses on the areas of valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the evaluation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.

Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia. He is a member of the American College of Healthcare Executives and Healthcare Financial Management Association. He has co-authored “Research and Financial Benchmarking in the Healthcare Industry” (STP Financial Management) and “Healthcare Industry Research and its Application in Financial Consulting” (Aspen Publishers). He has additionally taught before the Institute of Business Appraisers and has presented healthcare industry valuation related research papers before the Healthcare Financial Management Association; St. Louis Business Valuation Roundtable; and, Physician Hospitals of America (f/k/a American Surgical Hospital Association).

## About the Presenter



**Anne P. Sharamitaro, Esq.**, is a Senior Vice President of HEALTH CAPITAL CONSULTANTS (HCC), where she focuses on the areas of Certificate of Need (CON); regulatory compliance, managed care, and antitrust consulting. Ms. Sharamitaro is a member of the Missouri Bar and holds a J.D. and Health Law Certificate from Saint Louis University School of Law, where she served as an editor for the Journal of Health Law, published by the American Health Lawyers Association, and has been admitted to the Missouri Bar. She has presented healthcare industry related research papers before Physician Hospitals of America (f/k/a American Surgical Hospital Association) and the National Association of Certified Valuation Analysts and co-authored chapters in Healthcare Organizations: Financial Management Strategies, published in 2008.

# History and Evolution of Hospital-Physician Alignment

# History of Hospital-Physician Alignment

*“The only thing new in the world is the history you don’t know.”*

- Harry S. Truman

# History of Hospital-Physician Alignment

1990s

The Go-Go  
Days

2000-2004

The  
Aftermath

2005-2009

Competition  
for Market  
Share

2010-Present

Healthcare  
Payment  
Reforms

***Incentives for  
hospitals and  
physicians are  
finally aligning***

# History of Hospital-Physician Alignment

## 1990s

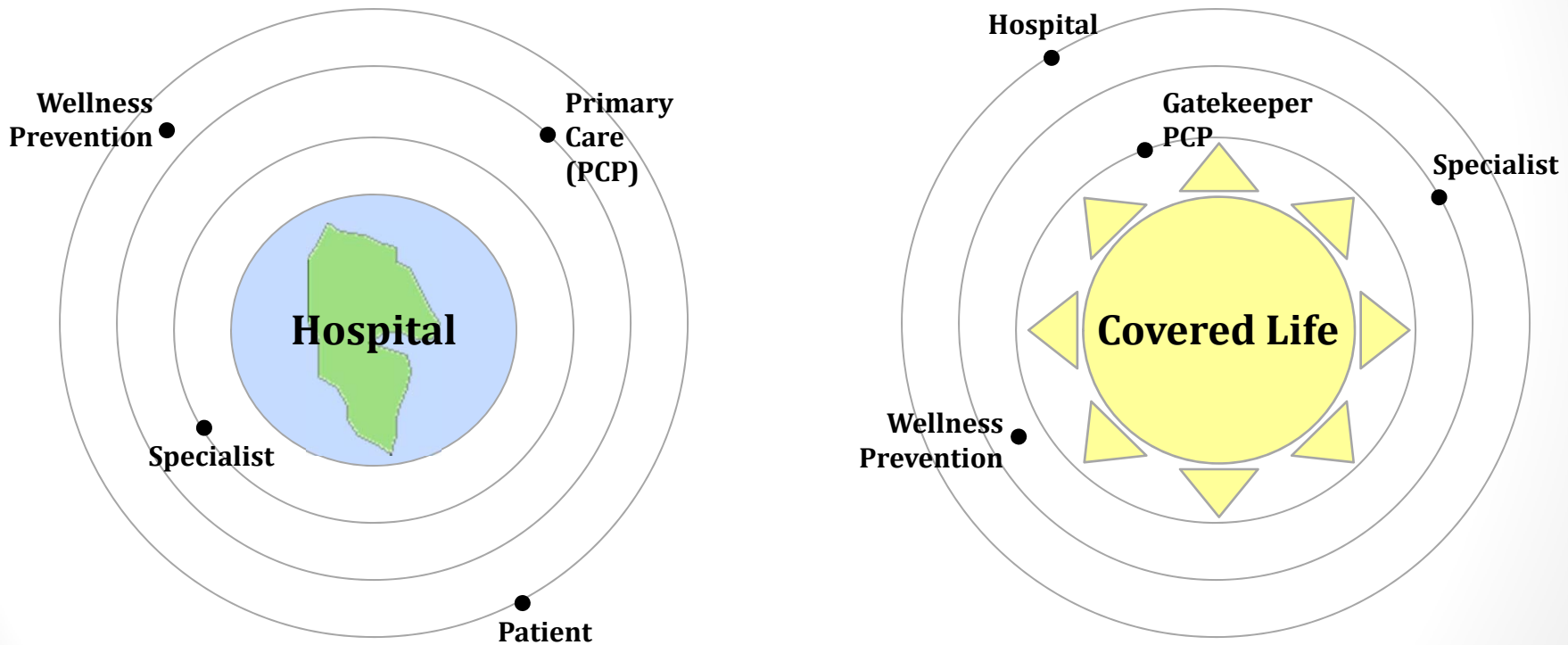
### *The “Go-Go” Days of Practice Acquisitions*

- The emergence of the “*Gatekeeper System*” of managed care
- Patients required to obtain a referral from a “*gatekeeper*” primary care physician (PCP) for specialist or surgical services
- Acting as “*gatekeepers*” elevated the value of PCP practices because PCPs controlled costs by limiting which providers the enrollee could access
- Gatekeeping medicine lead to the decline of patient volumes for hospitals

# History of Hospital-Physician Alignment

## 1990s

### *The “Go-Go” Days of Practice Acquisitions*



**The Shifting Universe of Healthcare Delivery  
From “Hospital-Centric” to “Patient-Centric”**



# History of Hospital-Physician Alignment

## 1990s

### *Healthcare as a Fungible Commodity*

- Environment drove the “*corporatization*” of the physician practice enterprise
- At the same time, physician services have been “*unitized, protocolized, and homogenized*” to facilitate their sale on the open market like any other fungible commodity, e.g., soy beans or pork bellies
- This sea-change in the U.S. healthcare delivery system during the 1990’s time period continues to present both challenges and opportunities for healthcare professional providers and investors alike

# History of Hospital-Physician Alignment

## 1990s

### *Healthcare as a Fungible Commodity*

*"...[I]f health care is 'fungible,' then by implication the parts of health care are also interchangeable. Practically speaking, this also includes providers and patients as they are simply reduced to their identity and purpose within the confines of a business relationship. Just as the seller is interested only in providing that which the buyer needs (or desires) in so far as there is sufficient financial reward, the buyer is only concerned with obtaining the desired object (or service). Who they are makes no real difference. Commodification dictates that a physician is like any other, as long as they are matched with respect to specialty. He or she ceases to be the indispensable community caregiver, and instead becomes the link between company and profit, or shareholder and dividend. Patients, by the same token, are no longer seen as individuals with unique personalities and health care needs but as a source of revenue; they become "covered lives" and a "business asset whose value is inversely proportional to the cost of health care resources their care is predicted (statistically or otherwise) to consume."*

# History of Hospital-Physician Alignment

## 1990s

### *Healthcare as a Fungible Commodity*

***“Money is the classic example of the fungible product. It represents recognized value, but one dollar bill is just as good as the next...the doctor-patient visit as a fungible commodity? Why not?”***

# History of Hospital-Physician Alignment 2000-2004

## *The Aftermath of the Practice Transaction Frenzy*

- Failure of hospital-affiliated medical groups
  - From 1994 through 1997, hospitals acquired 5,000 doctor's primary care practices per year, spending \$100,000 per physician on average
  - A 17-hospital survey by Coopers & Lybrand found that, on average, hospitals were incurring annual losses of \$97,000 per acquired physician due to high purchase prices and low productivity

# History of Hospital-Physician Alignment 2000-2004

## *The Aftermath of the Practice Transaction Frenzy*

**Shifting Risk to Providers**

**FROM**

**TO**

HOSPITAL SPECIALTY CARE CENTERED	→	OVERALL PHYSICIAN STAFF FOCUSED
MICRO-MANAGEMENT	→	PROVIDER SELF MANAGEMENT
INDIVIDUAL PROVIDER PERFORMANCE	→	SYSTEM PERFORMANCE
COORDINATING SERVICES	→	ACTIVELY MANAGING QUALITY
TREATING ILLNESS	→	MAINTAINING WELLNESS
ACUTE PATIENT CARE DRIVEN	→	CONTINUUM OF CARE\OUTPATIENT
OPEN SPECIALTY PANELS	→	MORE SELECTIVE CONTRACTING

**INSURERS BEAR RISK**

**PROVIDERS BEAR RISK**

# History of Hospital-Physician Alignment 2000-2004

## *The Aftermath of the Practice Transaction Frenzy*

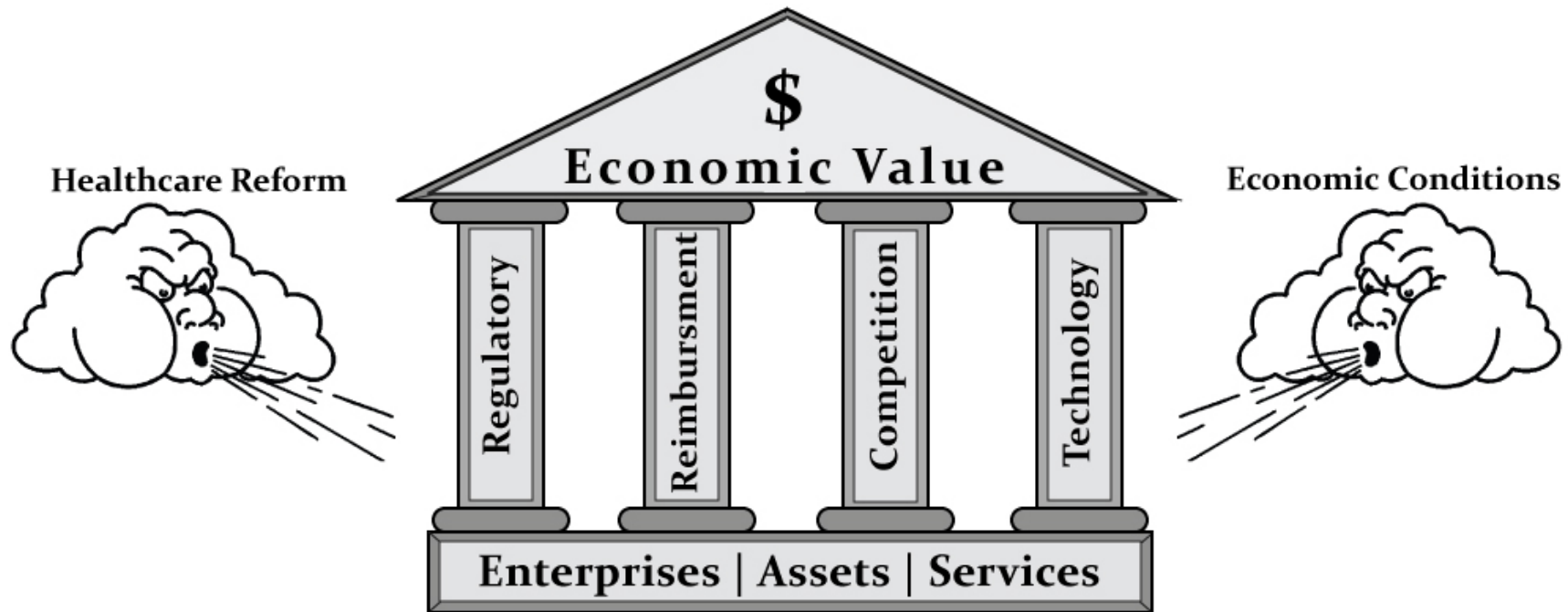
- Many organizations only consolidated in order to survive the reimbursement yield consequences of managed care, and underestimated the complexity of effective practice management and the requirements for a more long term capital investment horizon
- The pace of practice acquisitions significantly slowed and, in most markets, Physician Practice Management Companies (PPMCs) and hospitals began divesting previously acquired practices
- In light of this misalignment, increased integration only furthered the ***fragmentation of healthcare delivery***

# History of Hospital-Physician Alignment 2005-2009

## *Competition for Market Share in a Changing Landscape*

- Changes in market supply and demand in the mid to late 2000s fueled the diversification of healthcare professional practices
- The competitive market changed significantly in response to the favorable expansion of services reasonably within the scope of office-based practices
- Hospitals concerned that by “*cherry-picking*” and “*cream-skimming*” the most profitable patients and procedures, specialty and niche providers would become an insurmountable market threat

# Drivers of Emerging Trends in Alignment



*The Four Pillars of the Healthcare Industry*



# Drivers of Emerging Trends in Alignment Restructuring Reimbursement *Two Revenue Streams in Healthcare*

## Professional Component (wRVU)



Medicare reimbursement for wRVUs has been stagnant or decreasing for physician professional fees since the 1990s

## Ancillary Services & Technical Component (ASTC)



Professional practice physician owners looked for *supplementary profits* via the ASTC revenue stream

***There has been a persistent effort to restrict physician ownership/investment in ASTC revenue stream enterprises***

# Drivers of Emerging Trends in Alignment Restructuring Reimbursement

## *Attack on Physician Ownership of Technical Component (ASTC) of Revenue Stream*

- Federal and State legislative and regulatory efforts to *restrict physician ownership/investment in ASTC revenue stream enterprise*
  - e.g., Surgical/Specialty Hospitals, Ambulatory Surgery Centers (ASCs), Independent Diagnostic Testing Facilities (IDTFs)
- As a result, independent physicians in private practice relegated to
  - Receiving only professional fee component revenues (to the status of “*sharecroppers*” or “*hired help*”)
  - Accepting employee status under the substantial control of hospital systems or large corporate players

# Drivers of Emerging Trends in Alignment Restructuring Reimbursement *The Sustainable Growth Rate*

## *1997-2010: Proposed and Actual Updates to the MPFS Conversion Factor (CF)*

Year	Formula Update	CF Update
1997	2.0%	0.6%
1998	2.2%	2.3%
1999	2.3%	2.3%
2000	2.4%	5.5%
2001	2.1%	5.0%
2002	-4.8%	-4.8%
2003	-4.4%	1.4%
2004	-4.5%	1.8%

Year	Formula Update	CF Update
2005	-3.3%	1.5%
2006	-4.4%	0.2%
2007	-5.0%	0.0%
2008	-10.1%	0.5%
2009	-15.1%	1.1%
2010	-21.3%	1.3%
2011	-27.7%	0.9
Avg.	-6.0%	0.5%

**Avg. Formula Update 1997-2011: -6.0%**

**Avg. CF Update 1997-2011: 0.5%**

# Drivers of Emerging Trends in Alignment

## Restructuring Reimbursement

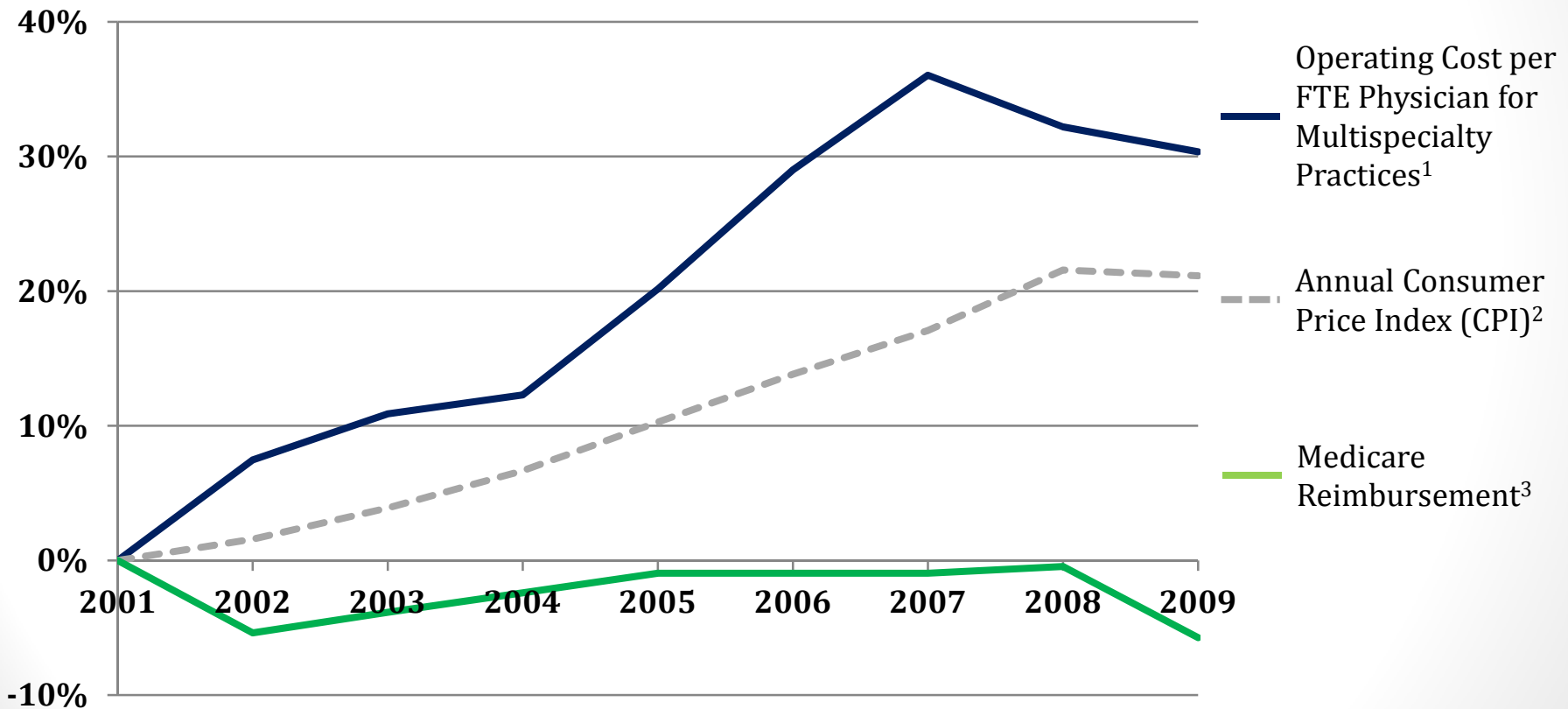
### *The Sustainable Growth Rate*

- Congressional action to suspend the impending cuts to payments every year since 2003 has resulted in a widening gap between the cumulative spending and cumulative target each year the proposed cuts were overridden
- A current House bill would delay the threatened 28% cut set to go into effect in January 2013
- Congress could simply pass another short-term "*doc fix*," as it did most recently in February 2012
- On September 15, 2011 the Medicare Payment Advisory Commission (MedPAC) proposed a controversial permanent repeal to the SGR, funded by \$300 billion in cuts to provider reimbursement and increases in beneficiary costs

# Drivers of Emerging Trends in Alignment

## Restructuring Reimbursement

### *Medicare Reimbursement vs. Operating Costs*



1. "Cost Survey for Multispecialty Practices", 2010 Report Based on 2009 Data, Medical Group Management Association; "Cost Survey for Multispecialty Practices", 2009 Report Based on 2008 Data, Medical Group Management Association.
2. "Consumer Price Index", U.S. Department of Labor, Bureau of Labor Statistics, Washington D.C., <ftp://ftp.bls.gov/pub/special.requests/cpi/cpiiai.txt>, (Accessed 8/9/2011).
3. "History of Medicare Conversion Factors", American Medical Association, <http://www.ama-assn.org/ama1/pub/upload/mm/380/cfhistory.pdf> (Accessed 8/9/2011).

# Drivers of Emerging Trends in Alignment

## Increasing Regulatory Pressures

### *Increased Agency Scrutiny of Fraud and Abuse*

- Office of Inspector General (OIG) of the Department of Health and Human Services (HHS)
- Department of Justice (DOJ)
- Internal Revenue Service (IRS)
- Health Care Fraud Prevention and Enforcement Action Team (HEAT)

# Drivers of Emerging Trends in Alignment

## Increasing Regulatory Pressures

### *Increased Use of Payment Recapture Audits*

- Process of identifying improper payments made to contractors or other entities, in which third-party private companies receive a percentage of the improper payments they recover
- Recovery Audit Contractors (RACs) were created as a result of the Tax Relief and Healthcare Act of 2006 to assist with overhaul of CMS claims payment contractors
- Other audits
  - Comprehensive Error Rate Testing (CERT)
  - Medicare Administrative Contractor (MAC) / Medicaid Integrity Contractor (MIC) Audits

# Drivers of Emerging Trends in Alignment

## Increasing Regulatory Pressures

### *Increased Enforcement of Key Regulations*

- Anti-Kickback Statute (AKS) - anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health care program business, including Medicare and Medicaid, can be held accountable for a felony
- Stark Law - prohibits referrals from physicians to a provider of Designated Health Services if the referring physician (or a members of her immediate family) have a financial relationship with the entity
- False Claims Act (FCA) - prohibitions against those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds **1-800-QUI-TAM**
- Fraud Enforcement and Recovery Act - passed in 2009, this law expands provider liability under the FCA



# Drivers of Emerging Trends in Alignment

## Increasing Regulatory Procedures

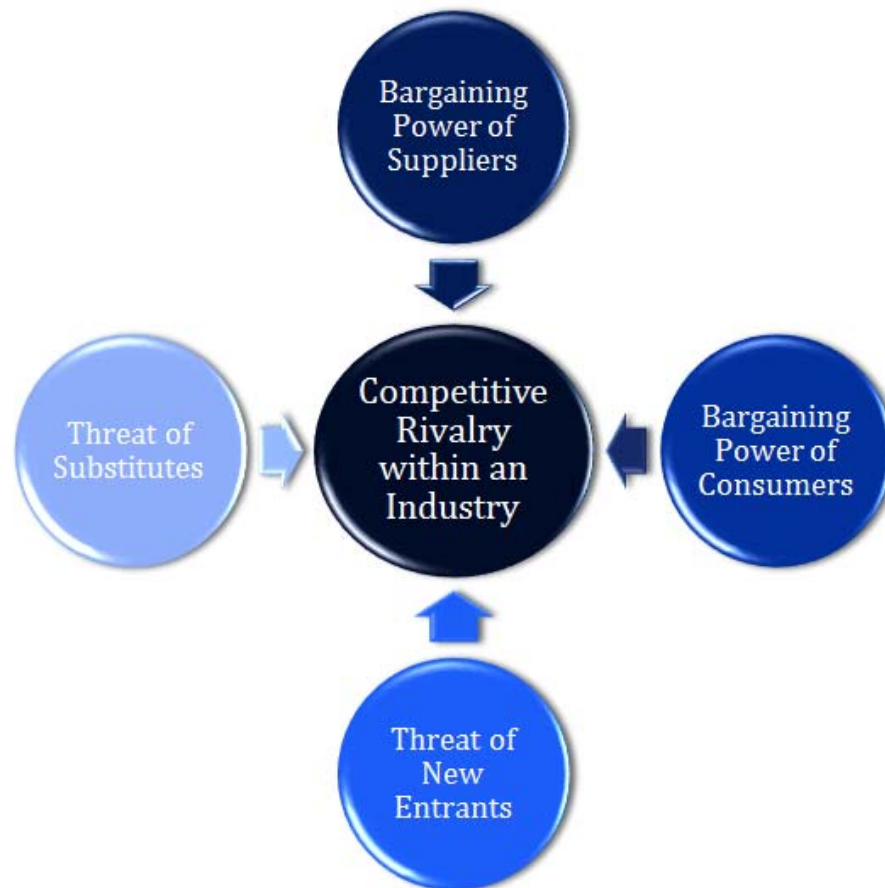
### *Increased Fraud and Abuse Activities*

- Increased Rate of Payment Recapture Audits
  - Process of identifying improper payments made to contractors or other entities, in which third-party private companies receive a percentage of the improper payments they recover
    - RACs, MICs, MACs, and ZPICs
    - Comprehensive Error Rate Testing (CERT)
- Increased Enforcement of Key Regulations
  - Anti-Kickback Statute
  - Stark Law
  - False Claims Act
  - Fraud Enforcement and Recovery Act

# Drivers of Emerging Trends in Alignment

## Changing Competitive Landscape

### *Porter's Five Forces*



# Drivers of Emerging Trends in Alignment

## Changing Competitive Landscape

### *The Four Phases of Managed Competition*

1<sup>st</sup>

2<sup>nd</sup>

3<sup>rd</sup>

4<sup>th</sup>

#### Managed Access

#### Managed Benefits

#### Managed Care

#### Managed Outcomes

Utilization Review firms using limitations on benefits to contain costs and/or HMOs introducing administrative barriers

- Precertification required
- Significant co-pays
- Emphasis on managing/restricting patient access
- Reliance primarily on non-clinical reviewers
- Physician totally outside system

Utilization Review with discounted fee-for-service networks:

- Emphasis on managing benefits
- Precertification primary and treatment planning secondary
- Cost Containment emphasized over clinical management
- Traditional treatment models employed
- Physicians "included", but their care delivery "inspected"

Utilization Review with quality-based network

- Greater emphasis on treatment planning and quality management
- Focus on most appropriate care in most appropriate setting
- Patients managed through continuum of care
- Clinical management of network; provider-care manager collegiality
- Shift toward improving access and benefits to reduce costs

An integrated management healthcare system **requires:**

- ☑ *A system integrator offering a spectrum of operational, clinical, financial systems*
  - Meet the needs of all buyer markets, benefit payors and beneficiaries
- ☑ *Locally responsive delivery systems and services based on national standards and capabilities*
- ☑ *Mutually beneficial partnerships with the physician community*
- ☑ *Effective use of technology to measure/report and enhance quality and outcomes*
- ☑ *Full accountability for service/savings through financial guarantees*
- ☑ *Proof of value for customers*

# Drivers of Emerging Trends in Alignment

## Changing Competitive Landscape

### *Healthcare Provider Manpower*

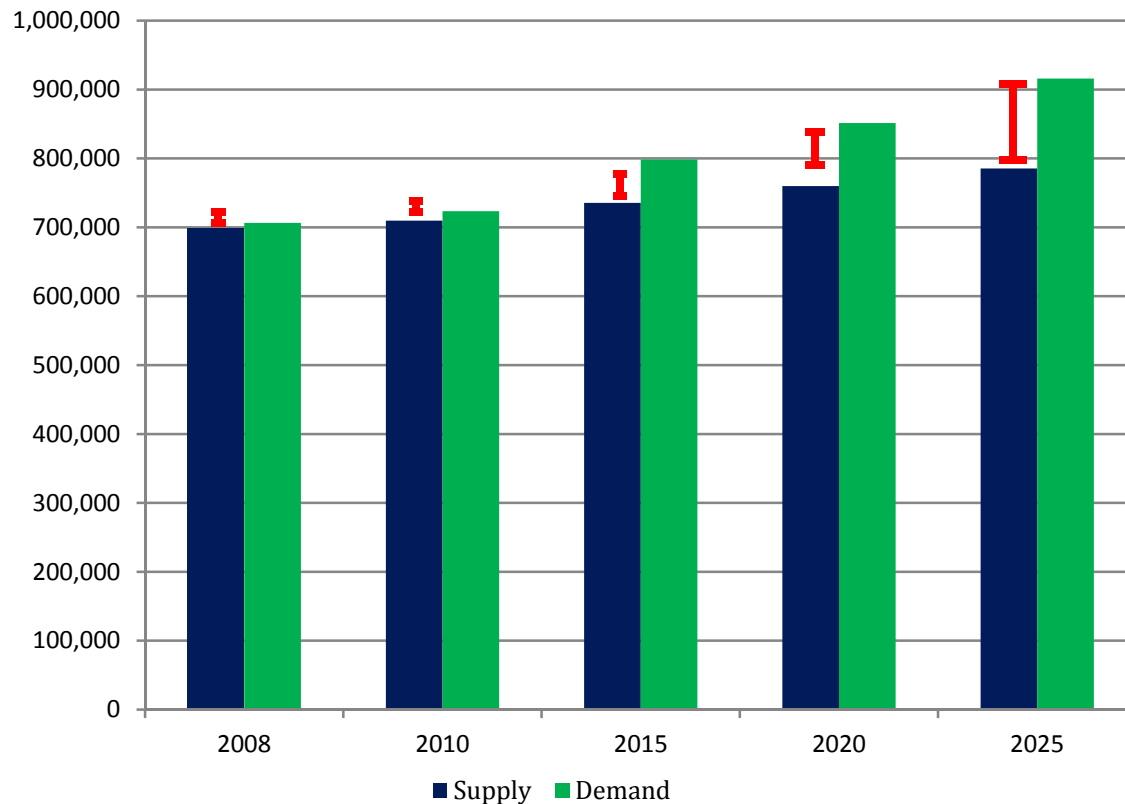
- Shortages in physician supply
- Cap on medical school enrollment
- Aging physicians
  - One-third of all physicians are 55 and older
- Younger physicians less likely to
  - Take call coverage
  - Work longer hours
  - Undertake the entrepreneurial challenge of opening private practice vs. collecting a salary

# Drivers of Emerging Trends in Alignment

## Changing Competitive Landscape

### *Healthcare Provider Manpower*

### Physician Supply and Demand



**I**-The difference between supply and demand represents the anticipated physician shortage.

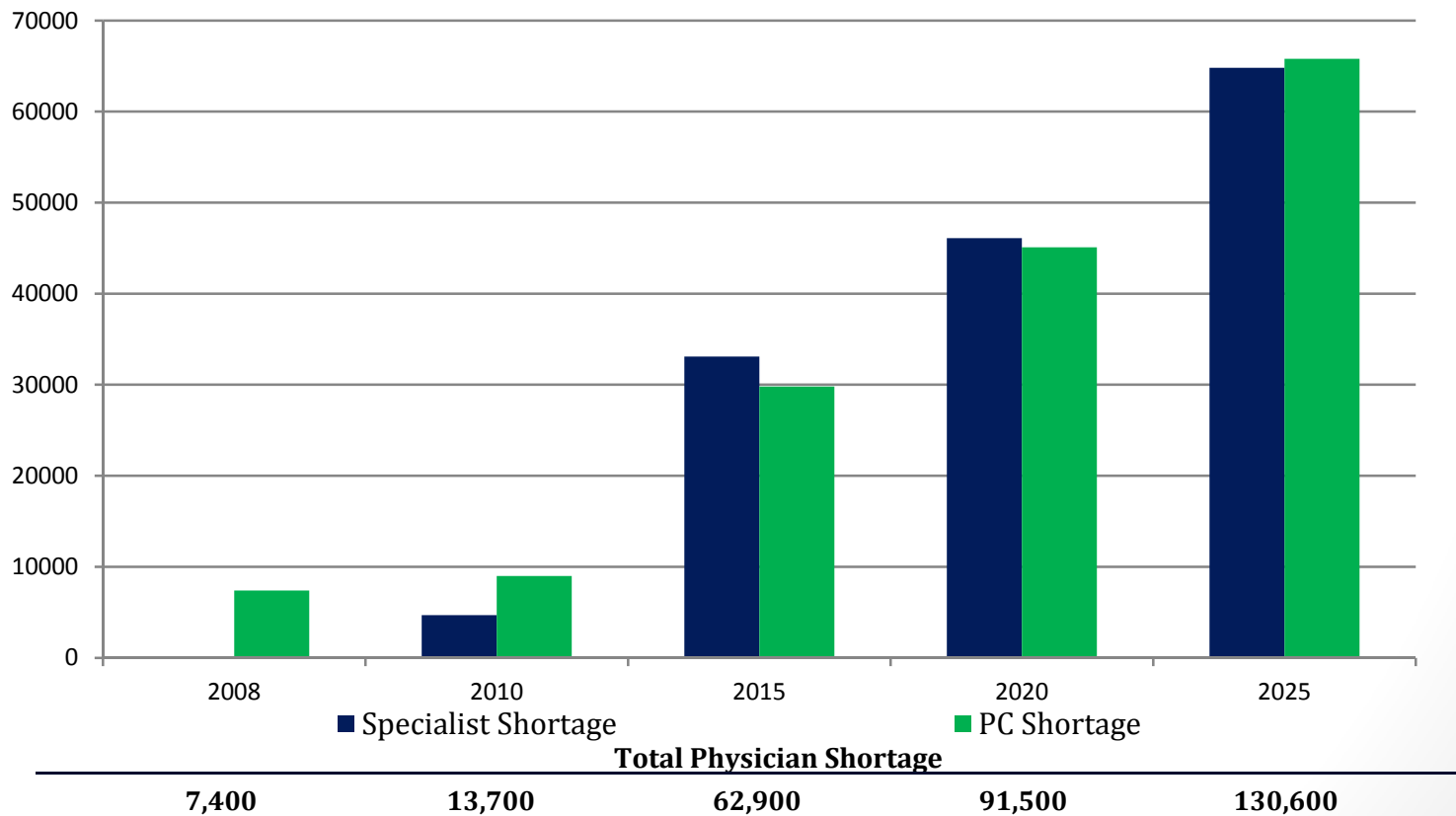
“Physician Shortages to Worsen Without Increases in Residency Training” Association of American Medical College

# Drivers of Emerging Trends in Alignment

## Changing Competitive Landscape

### *Healthcare Provider Manpower*

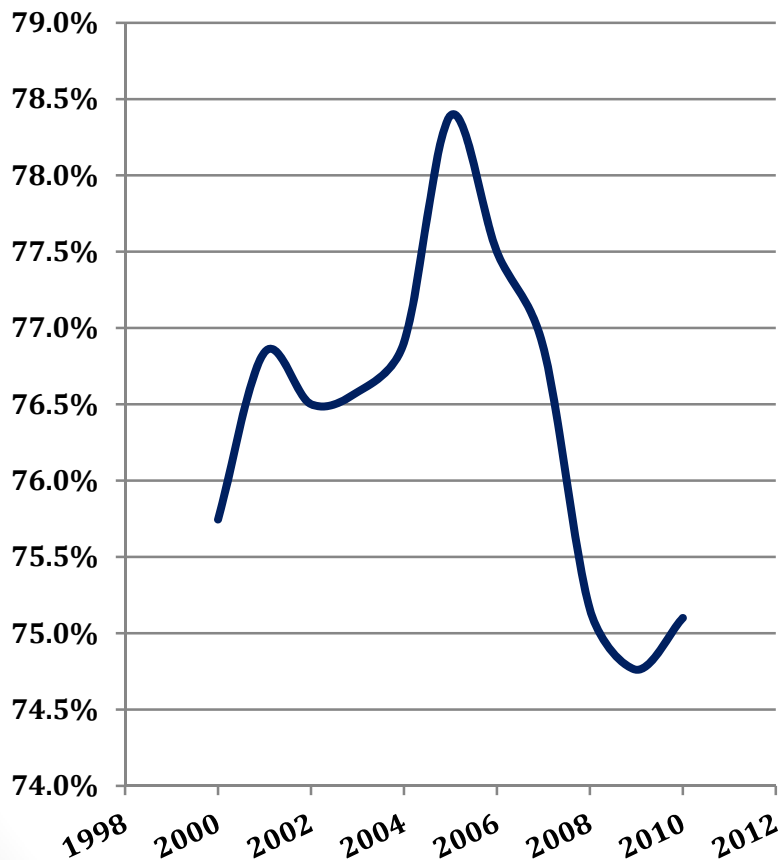
### Physician Shortage



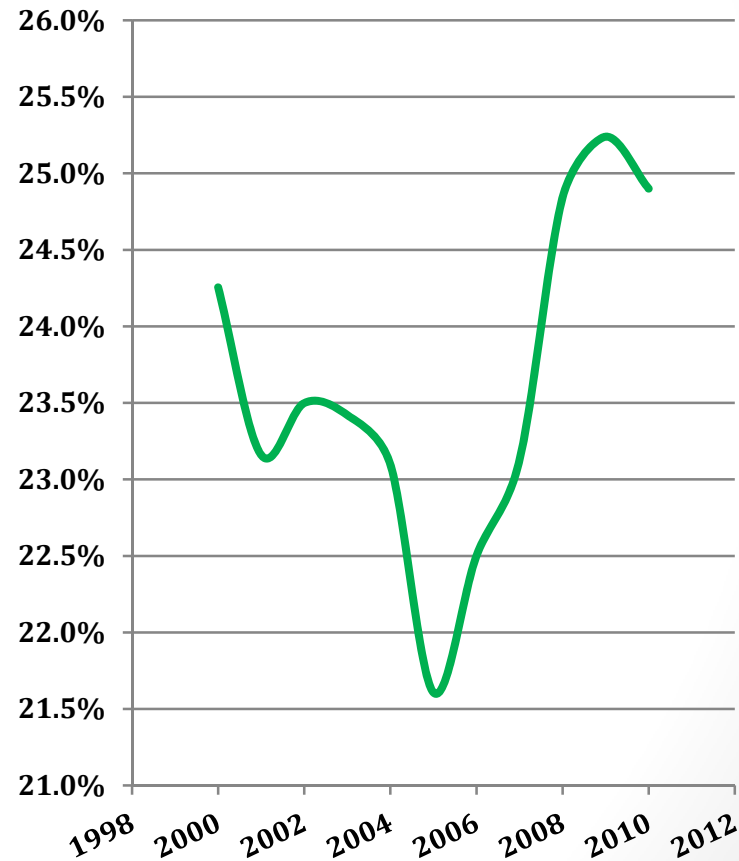
"Physician Shortages to Worsen Without Increases in Residency Training" Association of American Medical College

# Drivers of Emerging Trends in Alignment Practice Transitions

### Office-Based Practice



### Hospital-Based Practice



"Physician Characteristics and Distribution in the US" American Medical Association, 2002-2003 edition (p. 329); 2003-2004 edition (p. 320); 2004 edition (p. 322); 2005 edition (p. 311); 2006 edition (p. 311); 2007 edition (p. 311); 2008 edition (p. 403); 2009 edition (p. 406); 2010 edition (p. 438); 2011 edition (p. 436); 2012 edition (p. 440).

# Drivers of Emerging Trends in Alignment Practice Transitions

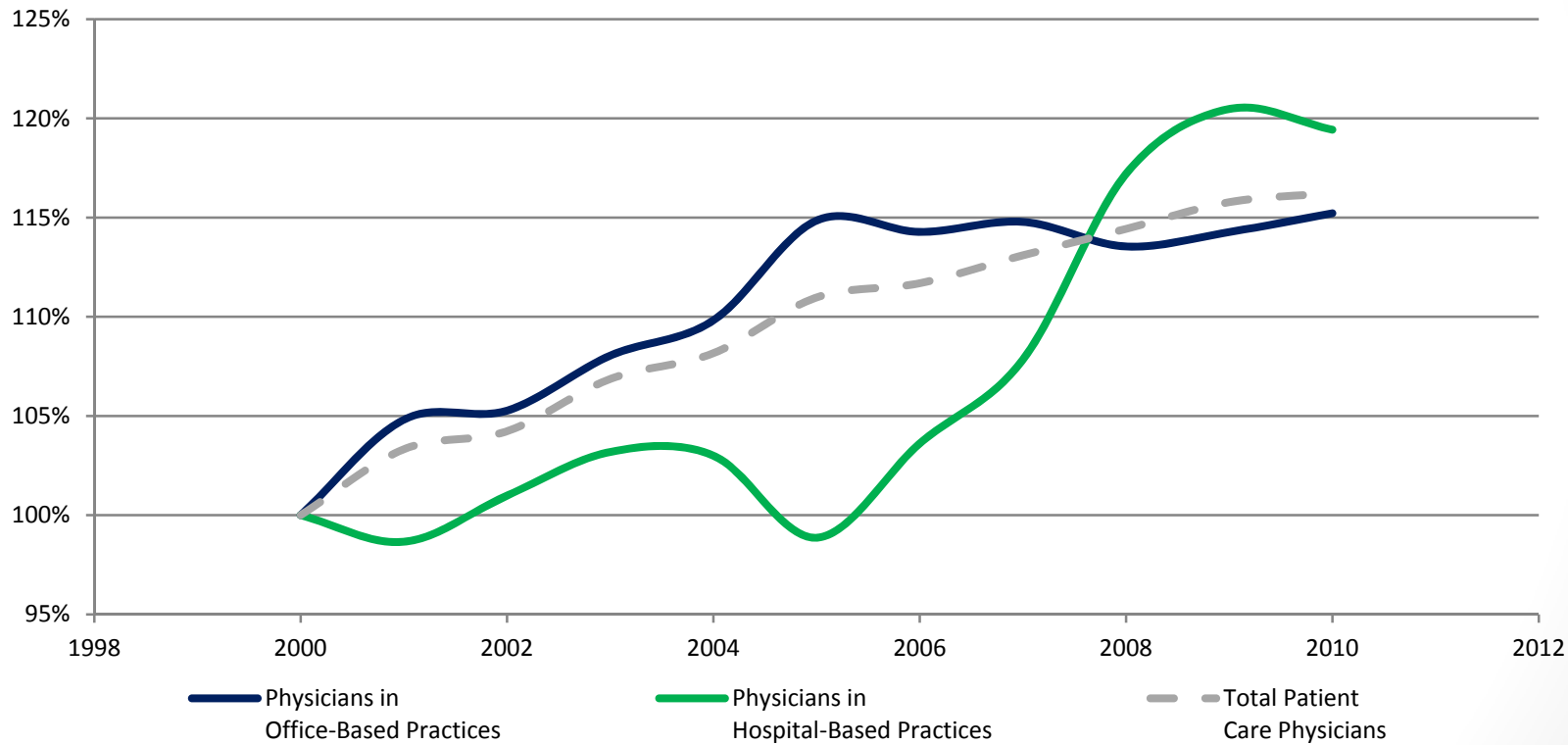
## *2009 Physicians by Practice Setting*

Type of Practice	Physicians	% of Total Physicians
<b>Self employed</b>	<b>356,031</b>	<b>61.1</b>
<b>Employee</b>	<b>226,153</b>	<b>38.9</b>
<b>Office-based employee</b>	<b>83,543</b>	<b>14.4</b>
Physician office, single specialty	43,560	7.5
Physician office, multi-specialty	39,983	6.9
<b>Institutional employee</b>	<b>123,410</b>	<b>21.2</b>
Teaching hospital	60,597	10.4
Non-teaching hospital	34,755	5.9
Other institutional employee	28,058	4.8
<b>Other unspecified employee</b>	<b>19,200</b>	<b>3.3</b>
<b>Total</b>	<b>582,184</b>	<b>100%</b>



# Drivers of Emerging Trends in Alignment Practice Transitions

## *Percent Change by Practice Setting Since 2000*



"Physician Characteristics and Distribution in the US" American Medical Association, 2002-2003 edition (p. 329); 2003-2004 edition (p. 320); 2004 edition (p. 322); 2005 edition (p. 311); 2006 edition (p. 311); 2007 edition (p. 311); 2008 edition (p. 403); 2009 edition (p. 406); 2010 edition (p. 438); 2011 edition (p. 436). 2011 edition (p. 436); 2012 edition (p. 440).

# Drivers of Emerging Trends in Alignment Technological and Clinical Innovation

## *Healthcare Information Technology*

- Electronic Health Records (EHR)
  - American Recovery and Reinvestment Act – allocates several billion dollars to ensure every patient has complete, interoperable EHR by 2014
  - *Health Information Technology for Economic and Clinical Health Act (HITECH)* of ARRA – creates incentives for implementation of EHR that meets “*Meaningful Use*” criteria
  - Help eliminate silos and increase continuity of care
- Computerized Physician Order Entry (CPOE)
  - Allows electronic ordering of lab, pharmacy, and radiology services
  - Goal of minimizing ambiguity, inefficiency, and errors associated with hand-written orders

# Drivers of Emerging Trends in Alignment Technological and Clinical Innovation

## *Clinical Advancements*

- Advancements seen in several areas of clinical technology
  - Genetics, Genomics, and Genome Technology
  - Stem Cell Research
  - Diagnostic Technology - Molecular Diagnostics and Personalized Medicine, Imaging Technology
  - Therapeutic Technology - Molecular Pharmacology, Radiation Therapy
  - Robotics and Surgical Technology - Laparoscopic Surgery, Minimally Invasive Surgery, Robotics (The Da Vinci System)
- While contributing to a higher quality of care, advances in pharmaceutical (e.g., Purple Pill), surgical, and management technology (e.g., EHRs) may drive up healthcare costs

# Drivers of Emerging Trends in Alignment

## Technological and Clinical Innovation

### *Clinical Division Support Systems (CDS)*

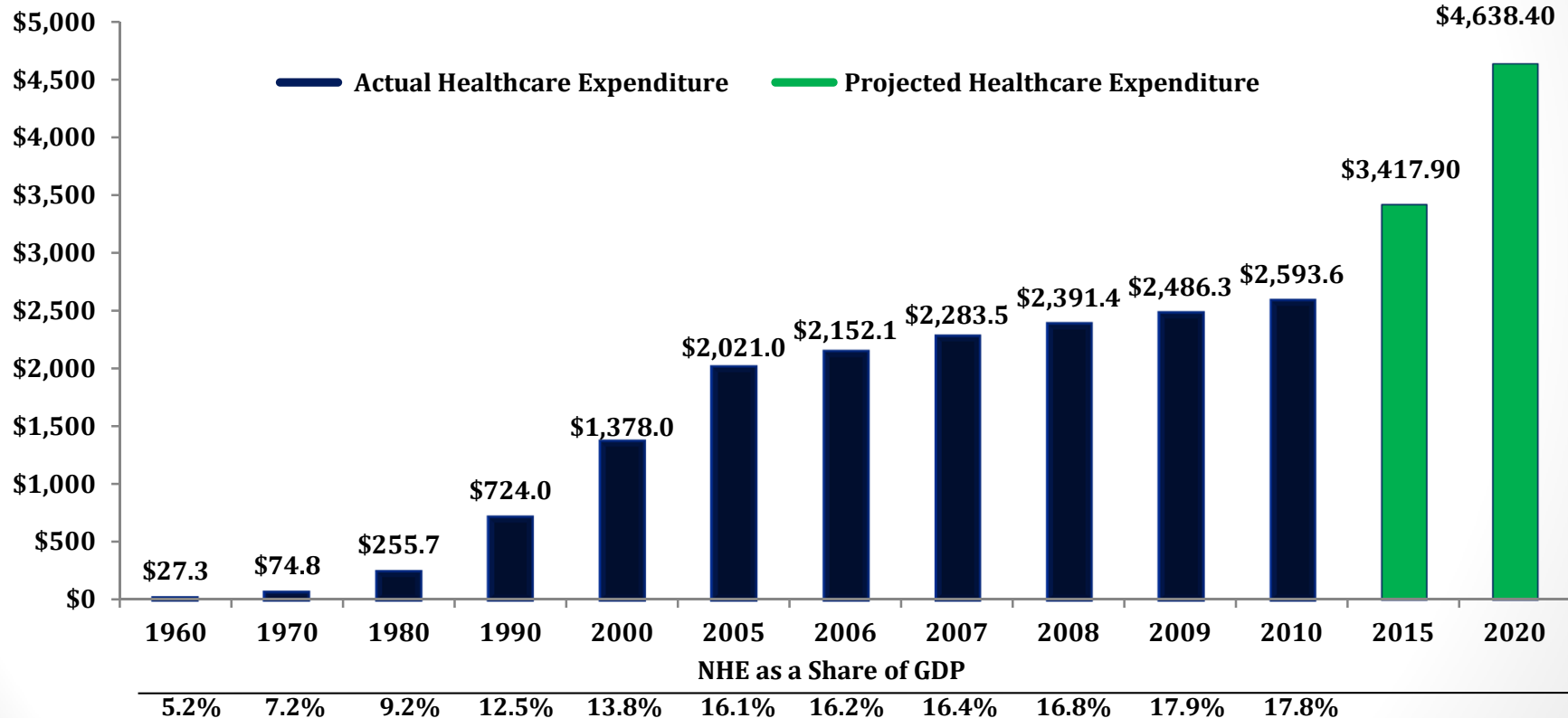
- Used in conjunction with Computerized Physician Order Entry (CPOE)
  - Allows electronic ordering of lab, pharmacy, and radiology services
  - Goal of minimizing ambiguity, inefficiency, and errors associated with hand-written orders
- Utilizes quality metrics and clinical data to facilitate patient care
- EHR, CPOE, and CDS integration and alignment among integrated model participants is critical to ensure benefits of HIT utilization are obtained

# Drivers of Emerging Trends in Alignment

## Additional Factors

### *Rising Healthcare Expenditures*

Dollars in Billions:

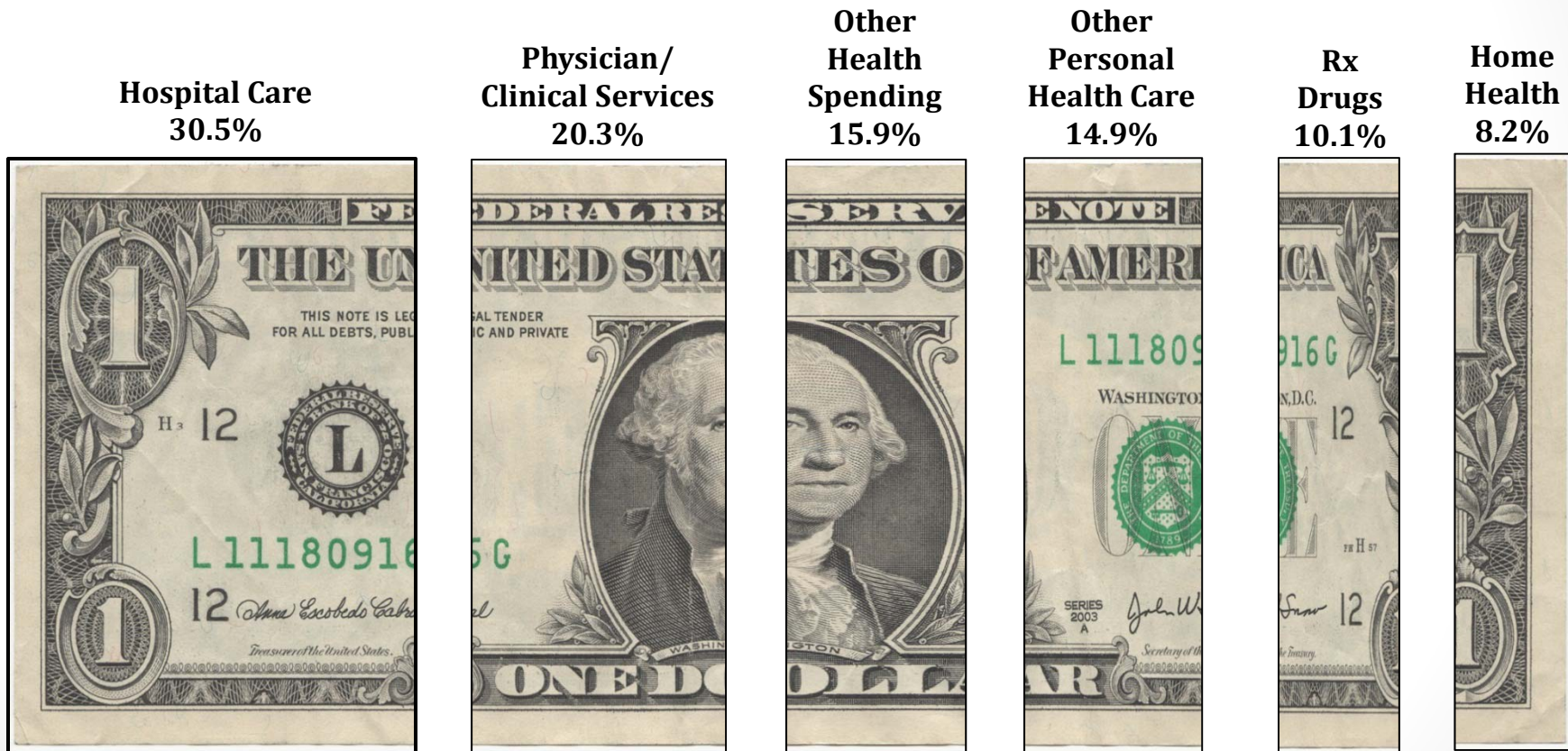


"National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change: Selected Calendar Years 1960-2010," By Center for Medicare and Medicaid Services, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/margintables.pdf> Accessed (05/3/2012).

"National Health Expenditure Projections 2001-2020- Updated and Extended," By Center for Medicare and Medicaid Services, June 29, 2009, <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf> (Accessed 10/27/2011).

# Drivers of Emerging Trends in Alignment Additional Factors

## *Imbalanced Allocation of Healthcare Dollars?*

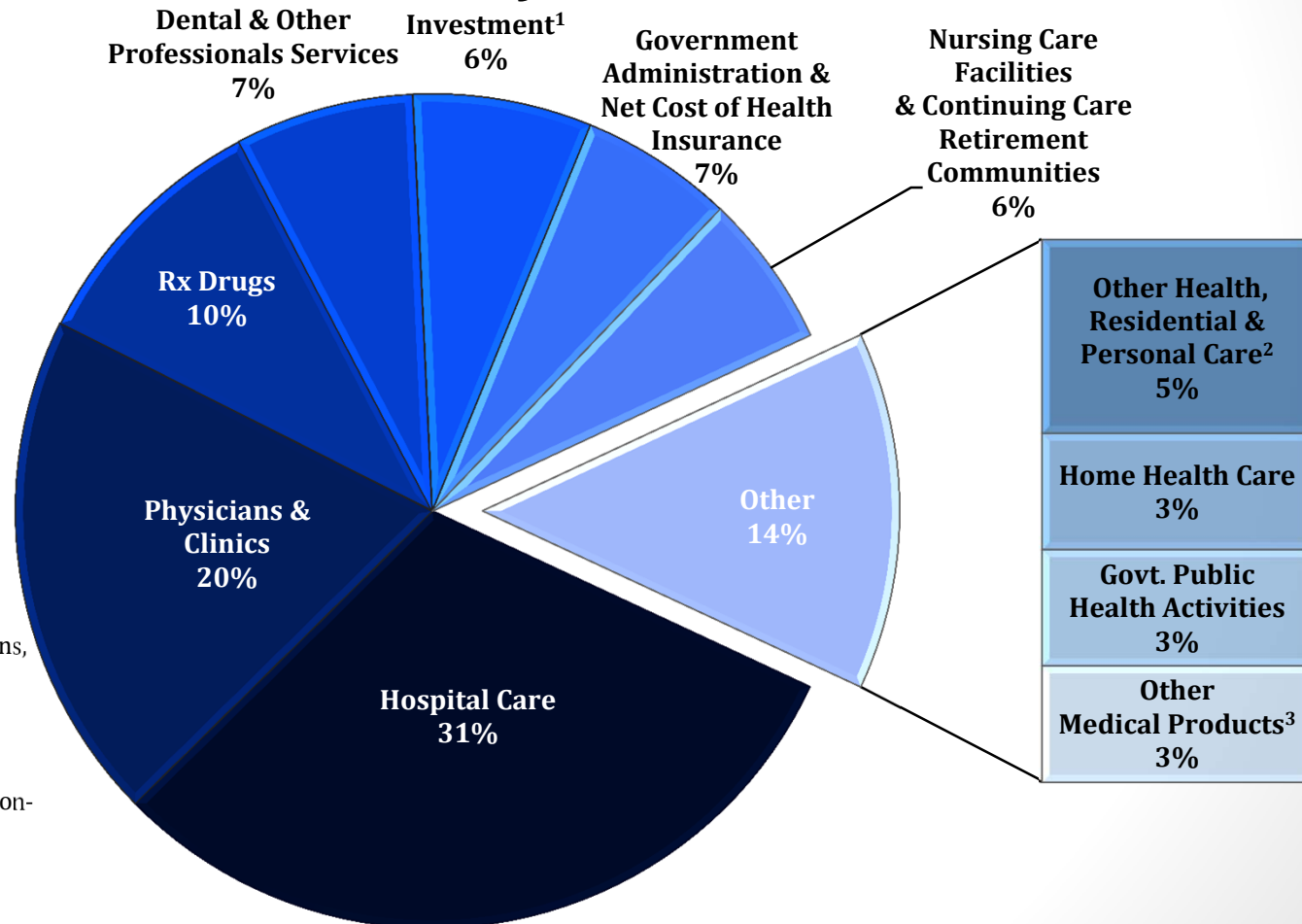


\*Note: Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc.. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc..  
Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2009; file nhe2009.zip).



# Drivers of Emerging Trends in Alignment Additional Factors

## *Imbalanced Allocation of Healthcare Dollars?*



1. Includes Research (2%) and Structures and Equipment (4%)
2. Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations, and expenditures for Home and Community programs under Medicaid
3. Includes Durable (1%) and Non-durable (2%) goods

Note: Sum of pieces may not equal 100% due to rounding.  
Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

# Drivers of Emerging Trends in Alignment

## Additional Factors

### *Population Transitions: Demographic Time Bomb*

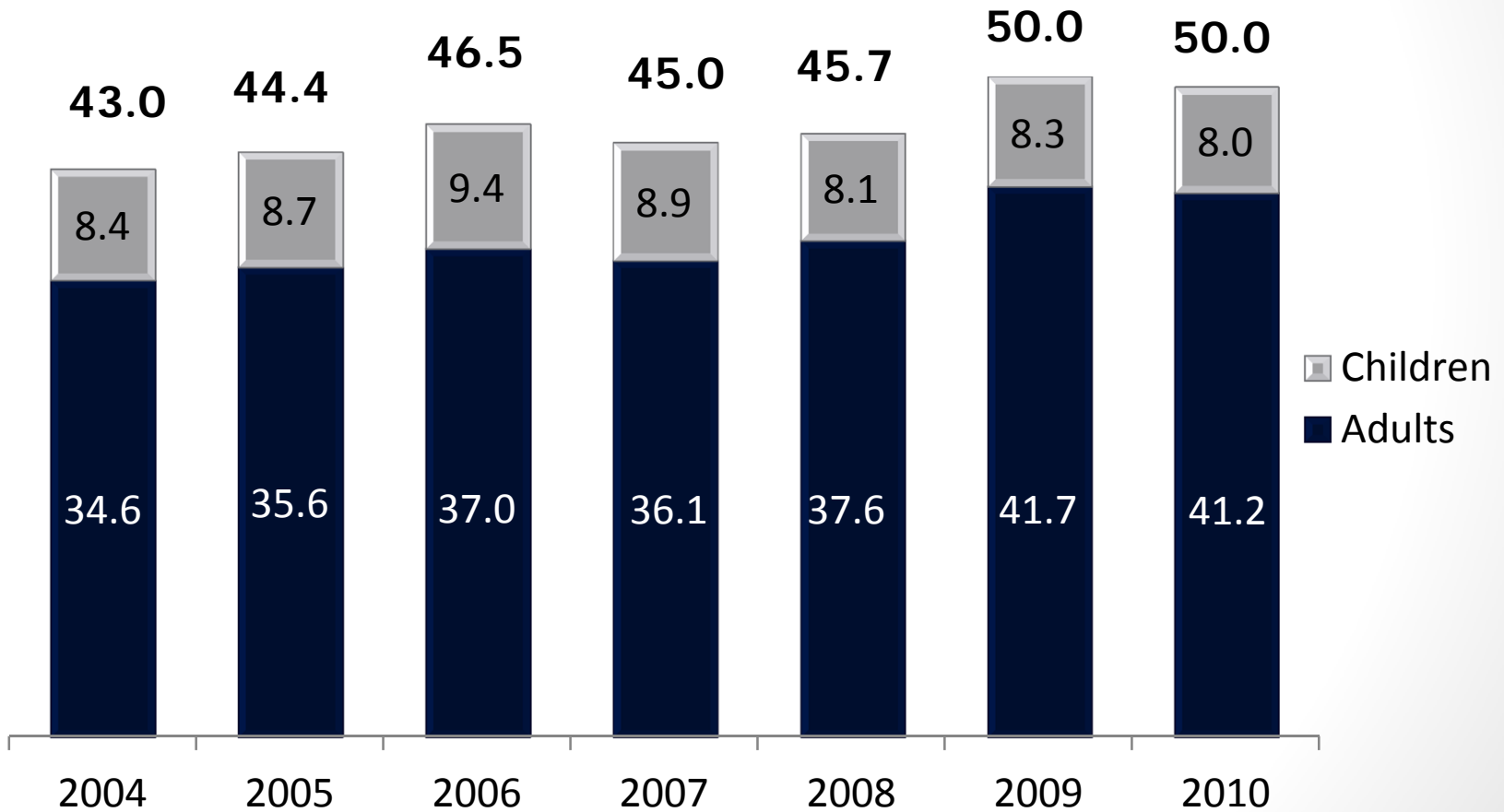
- Growth of aging baby-boomer population:
  - Population of people age 65 and older, who utilize twice the amount of medical services of those under 65, will double to 71 million by 2030
- Growth in immigration over several years
  - Increase in the overall birth rate and number of newborns, as well as the total population requiring healthcare
- Increased demand for healthcare services
  - Estimated 49.1 million people in the United States are uninsured
  - The ACA is expected to cut this number in half



# Drivers of Emerging Trends in Alignment

## Additional Factors

*Population Transitions: Uninsured (in millions)*



Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of March CPS for each year.

# Drivers of Emerging Trends in Alignment

## *“No Bucks, No Buck Rogers” – Tom Wolfe*

- Who will pay for hospital-physician alignment
  - Government Funds
    - ARRA
    - HITECH
    - ACA financial incentives (i.e., Value-based Purchasing, ACOs, etc..)
  - Insurers
    - Pay-for-Performance initiatives
    - Commercial ACO incentives
    - Transition from fee-for-service reimbursement models
  - Hospitals
    - Capital Infusions

# Overview of Alignment Models

# Hospital-Physician Alignment in an Era of Reform

## The SCOTUS Decision

- June, 28, 2012, the Supreme Court of the United States (SCOTUS) handed down its decision which upheld most of the 2010 healthcare reform act, the Patient Protection and Affordable Care Act (ACA)
- This opinion held that the individual mandate was constitutional, relying on a narrow interpretation of Federal taxing authority
- One ACA provision was modified by the ruling; this modification stipulates that Medicaid expansion in the states is no longer mandatory and that states can decide not to receive the expansion with no Federal penalty
- The Court's 5 to 4 ruling to uphold the Law will allow those provisions driving hospital-physician alignment, and most of the provisions of the reform law, to continue implementation as planned

# Hospital-Physician Alignment in an Era of Reform

## *The Patient Protection and Affordable Care Act of 2010*

- Healthcare reform goals for a “*continuum of care*” delivery system
  - Reduce healthcare costs
  - Improve patient quality of care
  - Improve patient access to care
  - Maintain provider accountability
- Driving factors have further enforced the significance of integration, and may usher in a new era in hospital-physician alignment
- Imperative that collaborative relationships with aligned objectives are established between hospitals and physicians

“Health Reform: Getting the Essentials Right,” By Victor R. Fuchs, Health Affairs, Vol. 28, No. 2, January 16, 2009.

# Hospital-Physician Alignment in an Era of Reform

## Value Based Purchasing

### *The Patient Protection and Affordable Care Act of 2010*

- VBP refers to any concept that links payments to quality of care
  - Rewards providers for providing high quality, efficient clinical care
- The ACA establishes several VBP demonstration programs
  - Hospitals (§3001)
  - Home health agencies (§ 3006)
  - Ambulatory surgery centers (§ 10301)
- The Medicare Shared Savings Program (MSSP), that governs Federal ACOs, is one form of VBP linking provider payments to efficient coordinated care of Medicare beneficiaries that meets standards set within CMS's Final Rule (Published Nov. 2, 2011)

# Types of Integration

- **Vertical Integration:** “[T]he aggregation of dissimilar but related business units, companies, or organizations under a single ownership or management in order to provide a full range of related products and services.”
- **Horizontal Integration:** “[T]he acquisition and consolidation of the organizations or business ventures under a single corporate management, in order to produce synergy, reduce redundancies and duplication of efforts or products, and achieve economies of scale while increasing market share.”
- In the current healthcare climate, horizontal arrangements are necessary alongside the vertical integration of condition-specific healthcare organizations and entities

# Different Approaches to Managing the Entire Continuum of Care

## *Organizational Models of Alignment*

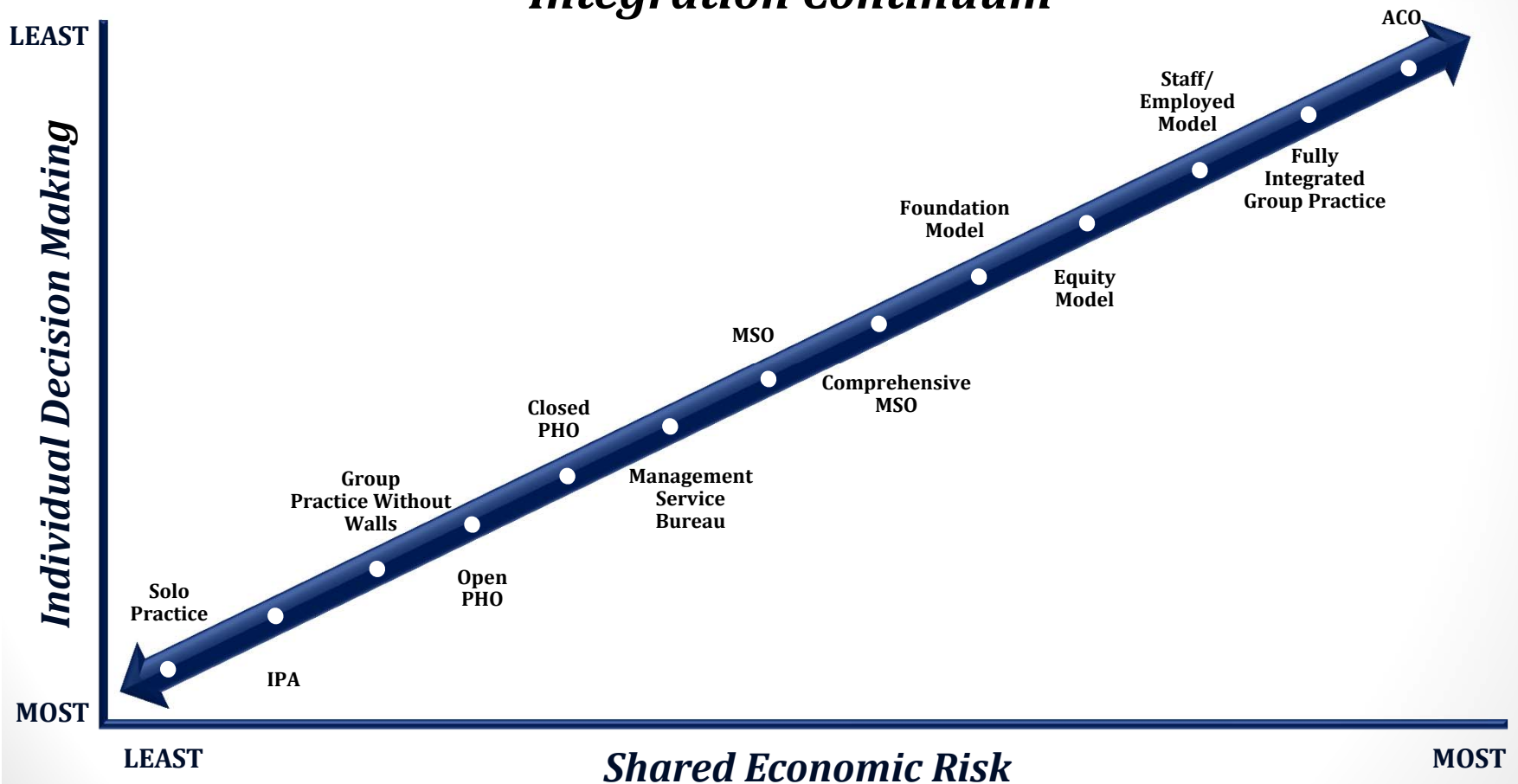
	Resistors	Cost Containers	True Integrators
Horizontal Integrators	Independent Practice Associations	Physician Practice Management Companies	Fully-Integrated Medical Groups
Vertical Integrators	Physician Hospital Organizations	Managed Service Organizations	Integrated Delivery Systems

"A Guide to Consulting Services for Emerging Healthcare Organizations," by Robert James Cimasi, John Wiley & Sons, Inc. 1999.



# Different Approaches to Managing the Entire Continuum of Care

## *Integration Continuum*



# Organizational Models of Alignment

## Emerging Models in an Era of Reform

- Certain organizational models have emerged independent of the traditionally recognized Emerging Healthcare Organizations
- Some resist healthcare demand and implications, while others try to remediate the current and impending healthcare “*crisis*” by serving as a vehicle for reform

# Organizational Models of Alignment

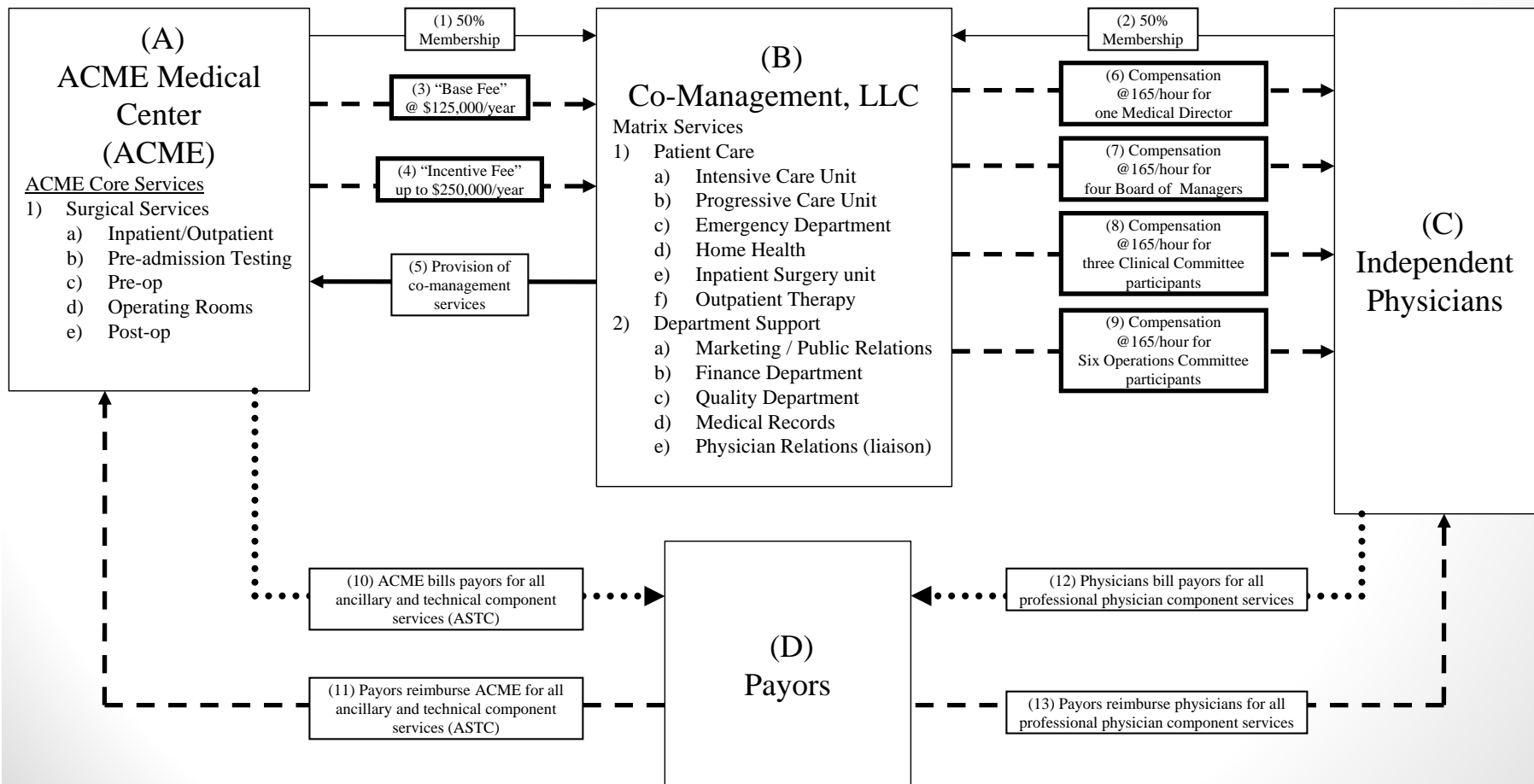
## Emerging Models in an Era of Reform

<p><b>Direct employment model</b></p>	<ul style="list-style-type: none"> <li>• Physicians have standard employment agreement with the hospital</li> <li>• Physicians and hospital use separate legal entity to manage the practice</li> </ul>
<p><b>Captive-group or equity and foundation models</b></p>	<ul style="list-style-type: none"> <li>• Physicians are employees of hospital subsidiary</li> <li>• Physicians and hospital use separate legal entity to manage the practice;</li> </ul>
<p><b>Hospital-owned clinic staffing model</b></p>	<ul style="list-style-type: none"> <li>• Physicians maintain ownership of practice</li> <li>• Physicians create professional Services Agreement with the hospital</li> </ul>
<p><b>Co-Management / Joint ventures</b></p>	<ul style="list-style-type: none"> <li>• Hospital enters into agreement with an organization that is either jointly or wholly owned by a physician to provide the daily management services for the inpatient and/or outpatient components of a medical specialty service line</li> </ul>
<p><b>Accountable Care Organizations/Bundled Payments</b></p>	<ul style="list-style-type: none"> <li>• Health care organizations in which a set of providers, usually physicians and hospitals, are held accountable for the cost and quality of care delivered to a specific local population</li> </ul>

# Organizational Models of Alignment

## Emerging Models in an Era of Reform

### *Co-Management, LLC Summary of Relationships*



# Organizational Models of Alignment

## Emerging Models in an Era of Reform

### *Bundled Payments*

- Recently, several proposals have been advanced by legislators to reduce Medicare costs by various methods of bundling payments to hospitals and physicians for services provided over the course of a patient's treatment plan
- This trend is demonstrated by the Senate Finance Committee's "*Proposals to Improve Patient Care and Reduce Health Care Costs*," a plan to use the bundled payments for inpatient and post-discharge care
- Further, CMS has also created a pilot program to examine the benefits of bundling Part A and Part B Medicare payments

"Administration News – President Obama's Budget Request Includes \$828B for HHS" By Kaisernetwork.org. p. 2. May 8, 2009. [http://www.kaisernetwork.org/daily\\_reports/print\\_report.cfm?DR\\_ID=58379&dr\\_cat=3](http://www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=58379&dr_cat=3) (Accessed 5/14/09); "Acute Care Episode Demonstration Fact Sheet," Centers for Medicare and Medicaid Services, March 20, 2009, <http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/ACEFactSheet.pdf> (Accessed 6/1/09); "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs" By Senate Finance Committee. April 29, 2009. p. 15"; Medicare Acute Care Episode Demonstration for Orthopedic and Cardiovascular Surgery," Centers for Medicare and Medicaid Services, p. 1, [http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/ACE\\_web\\_page.pdf](http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/ACE_web_page.pdf) (Accessed 6/3/09).

# Organizational Models of Alignment

## Emerging Models in an Era of Reform

### *Bundled Payments*

- Proponents of bundled payments assert that the move towards bundled payments could provide higher coordination between providers and more efficient levels of care.
- Critics articulate concern as to the level of savings and patient care improvement that a blanket bundling of payments will actually generate
- While no actual bundling policy has been implemented, recent actions by both the U.S. Senate and CMS have demonstrated that such initiatives on the healthcare horizon and may soon become a part of the healthcare reimbursement environment

"Effects of Bundled Payment Policy Options," RAND Compare, [http://www.randcompare.org/analysis/mechanism/bundled\\_payment](http://www.randcompare.org/analysis/mechanism/bundled_payment) (Accessed 11/09/11).

"Statement of the American Medical Association to the Committee on Ways and Means Subcommittee on Health, U. S. House of Representatives." p. 6. Sept. 11, 2008.

# Organizational Models of Alignment

## Emerging Models in an Era of Reform

### *Patient-Centered Medical Homes (PCMH)*

- Conceptualized by the American Academy of Pediatrics in the late 1960s, the medical home has since transformed into a healthcare delivery model that is
  - Patient-centric
  - Primary care driven
  - Targeted at payment reform
- The *American Academy of Family Physicians*, the *American Academy of Pediatrics*, the *American College of Physicians*, and the *American Osteopathic Association* established seven principles that constitute the medical home model in light of current and future healthcare reform initiatives

# Organizational Models of Alignment

## Emerging Models in an Era of Reform

### *Patient-Centered Medical Homes (PCMH)*

- The medical home model empowers practices to
  - Promote primary and preventive care services
  - Maximize efficiency by utilizing manpower resources, like independent non-physician practitioners
  - Reevaluate the role of specialty medicine and combat overuse of specialty services
- Widespread and successful implementation remains to be seen
- However, Medicare will likely continue encouraging medical home model implementation by funding state pilot programs that employ primary care physicians and coordinators to facilitate and execute the management of patient care and healthcare expenditures



# Organizational Models of Alignment

## Emerging Models in an Era of Reform

### *Accountable Care Organizations*

#### **Healthcare organization with a coordinated set of providers...**

- Provider mix dependent on whether federal or commercial ACO structure

#### **Who share responsibility and accountability for the continuum of care...**

- Clinical accountability – Quality of care
- Financial responsibility – Cost of Care

#### **By providing the highest possible value of care...**

- Increase quality
- Decrease costs

#### **For financial incentives or “shared savings” ...**

- Value-based payments
- Reimbursement for achieving cost and quality goals

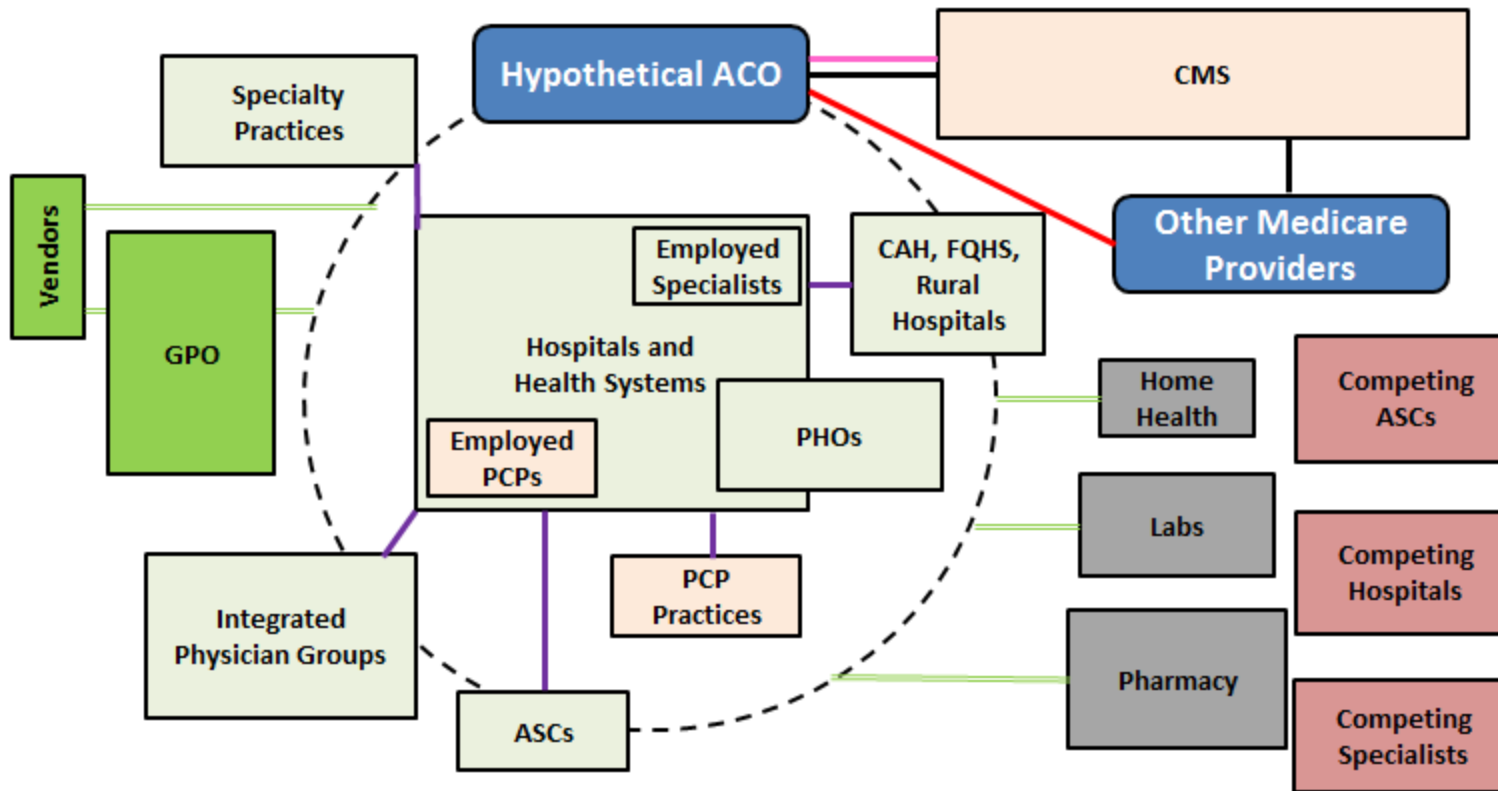
#### **From participating payors**

- Public Payors (e.g., Medicare, Medicaid)
- Commercial Payors (e.g., BCBS of MA)

“The Promise of ACOs” Accountable Care Organization Learning Network, <http://www.acolearningnetwork.org/why-we-exist/the-promise-of-acos>; “Essential Guide to Accountable Care Organizations: Challenges, Risks, and Opportunities of the ACO Model,” The Healthcare Intelligence Network, 2011.

# Potential ACO Structure

## Federal ACOs








# Potential ACO Structure






## Federal ACOs

### *Key*

#### Lines

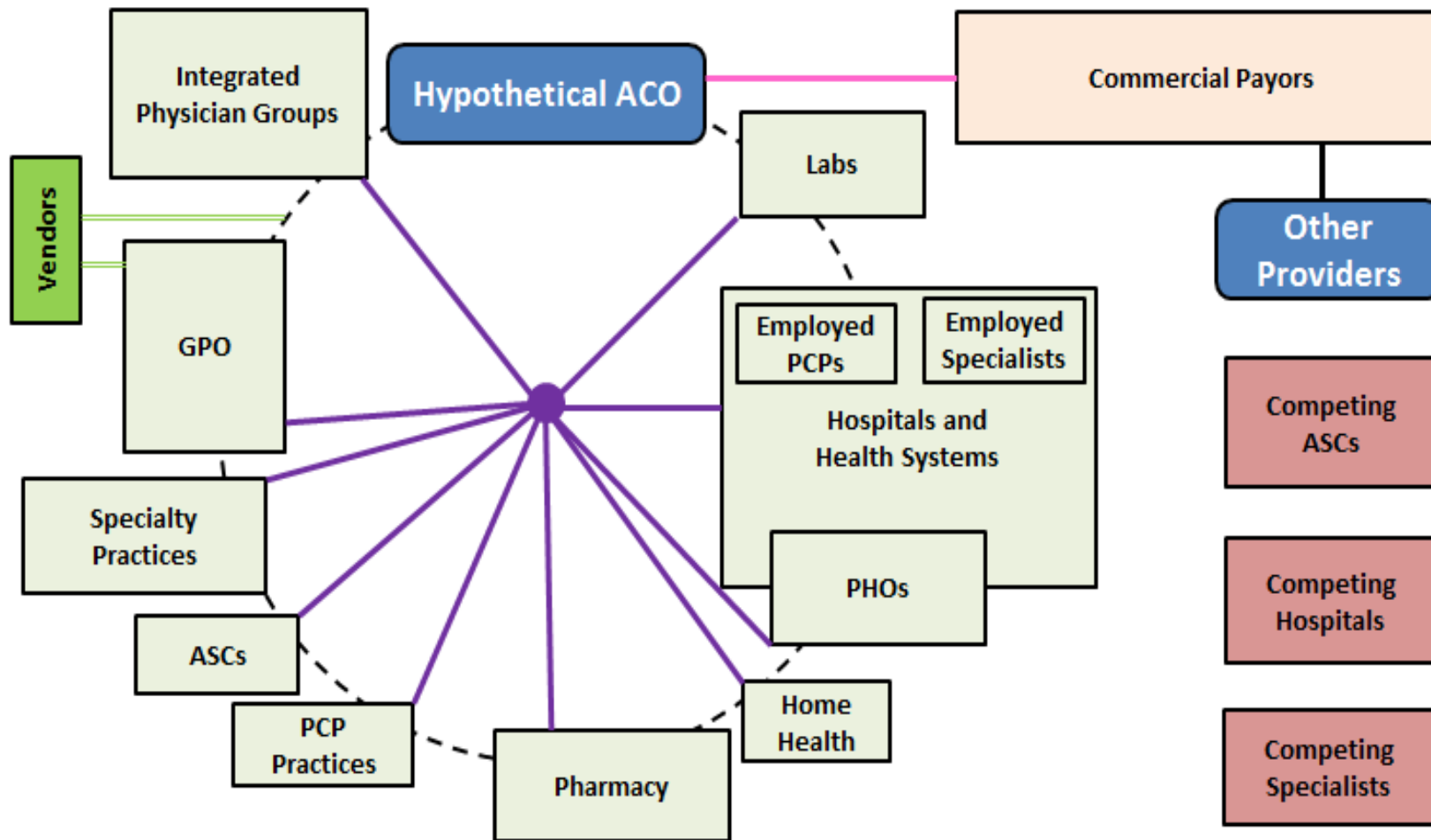
-  Threaten ACO Shared Savings Payments
-  Negotiate Independent Contracts (ACO may include in MSSP payments, but not included in ACO governance)
-  Partnerships or Joint Ventures with designated methodology for distribution of shared saving payments
-  Traditional Fee-for-Service Arrangement
-  Shared Savings Contract

#### Shading

-  Various entities that may partner to form an ACO under MSSP
-  Dictates costs and quality measures that ACO is accountable for (i.e., PCPs and CMS)
-  Not a provider (not included in MSSP)
-  Competition if ACO (most likely hospital) offers similar services, but can also form mutually beneficial contracts to share MSSP payments
-  Direct Competition for ACO

# Potential ACO Structure

## Commercial ACOs







# Potential ACO Structure




## Commercial ACOs

### *Key*

#### Lines

-  Negotiate Independent Contracts (may include portions of value payments)
-  Clinical integration and/or risk sharing agreement (anywhere on the scale from: merger → partnership → joint venture → contract)
-  Traditional Insurance Contract (Most Likely a Fee-for-Service Arrangement)
-  Value-Based Purchasing Contract (Anywhere from Fee-for-Service to Full or Partial Capitation)

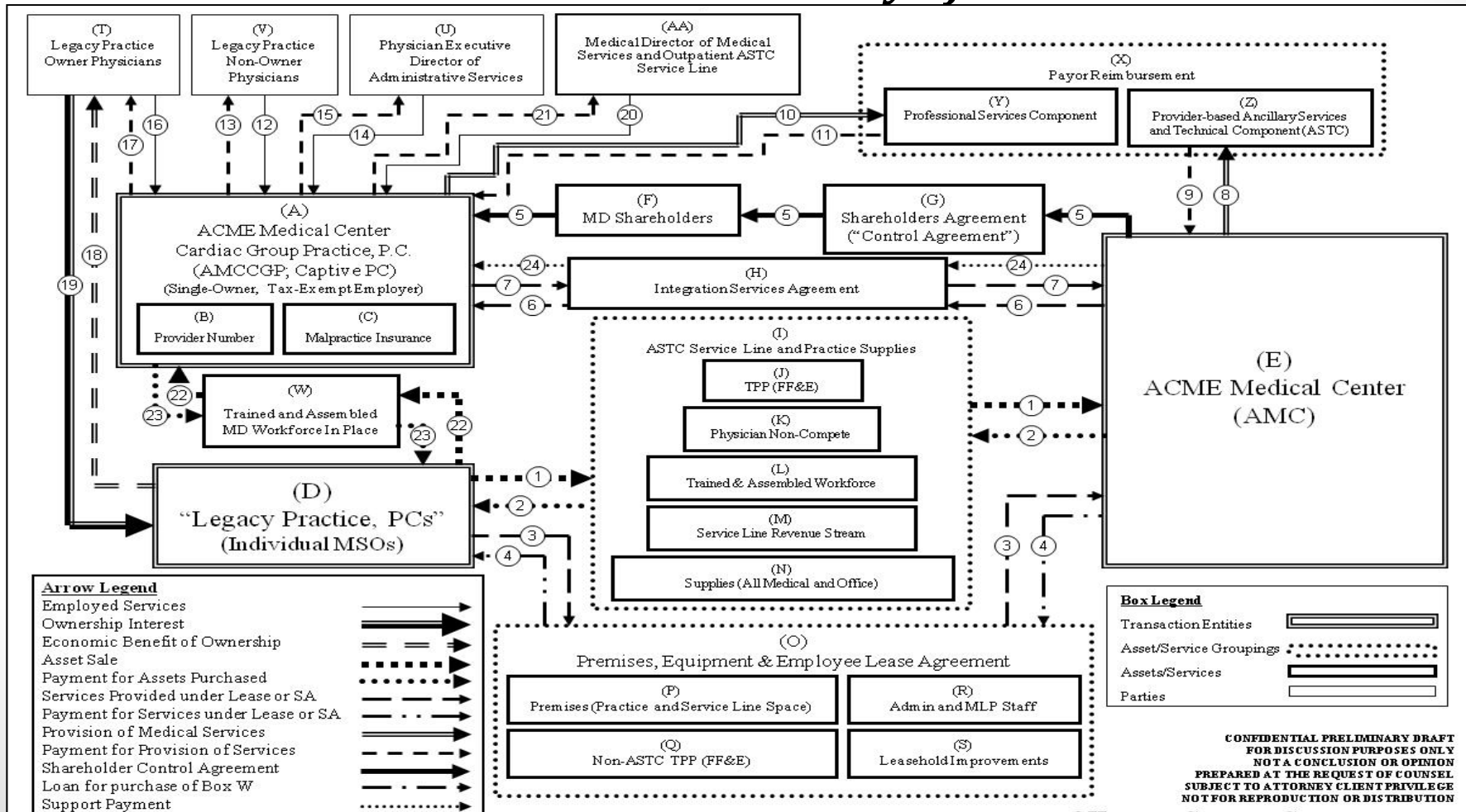
#### Shading

-  Various entities that may partner to form an ACO
-  Not a provider (not competition, but not included in ACO risk sharing)
-  Direct competition for ACO

# Strategic Considerations for Hospital-Physician Alignment

# Key Strategic Considerations

## ACME Medical Center: Summary of Transactions



# Key Strategic Considerations

- Leadership and governance
- Engaged provider network
- Financial and analytical capacity
- IT capabilities
- Administrative infrastructure
- Start-up and operational finances
- Risk management

“Essential Guide to Accountable Care Organizations: Challenges, Risks, and Opportunities of the ACO Model,” By: John Harris, Laurel Karabatsos, Craig Samitt, William Shea, Steven T. Valentine, The Health Intelligence Network, 2010.



# Critical Requirements

## Structures, Systems, and Leadership

### Structures

- Formal legal organization with a governance board
- Coordination and collaboration between physicians and hospitals
- Reimbursement model to incentivize clinical and operational alignment

### Systems

- Capability for patient population and chronic disease management and care coordination
- Capacity to measure performance, report quality, and invest in system improvements
- Adequate infrastructure and skills to support data exchange as well as to manage financial risk

### Leadership

- Foster system-wide success while balancing varying perspectives, e.g. primary care & specialty physicians, physician & hospital, outpatient & inpatient, etc..
- Physician engagement and active participation
- Committed leadership and system of accountability

# Critical Requirements

## Structures, Systems, and Leadership

Funding	Administrative	Organizational
<ul style="list-style-type: none"> <li>• Pooling of funds</li> <li>• Prepaid capitation</li> </ul>	<ul style="list-style-type: none"> <li>• Consolidation or decentralization of responsibilities or functions</li> <li>• Inter-sectoral planning</li> <li>• Needs assessment and allocation chain</li> <li>• Joint purchasing or commissioning</li> </ul>	<ul style="list-style-type: none"> <li>• Co-location of services</li> <li>• Discharge and transfer agreements</li> <li>• Interagency planning and/or budgeting</li> <li>• Service affiliation or contracting</li> <li>• Jointly managed programs or services</li> </ul>
Service Delivery		Clinical
<ul style="list-style-type: none"> <li>• Joint training</li> <li>• Centralized information, referral and intake</li> <li>• Case/care management</li> <li>• Multidisciplinary teamwork</li> <li>• Around-the-clock (on-call) coverage</li> </ul>		<ul style="list-style-type: none"> <li>• Standard diagnostic criteria</li> <li>• Uniform, comprehensive assessment</li> <li>• Joint care planning</li> <li>• Shared clinical records</li> <li>• Continuous patient monitoring</li> <li>• Common decision support tools</li> <li>• Regular patient/family contact and ongoing support</li> </ul>

# The Four Phases of Physician Integration

Phase 1	Phase 2	Phase 3	Phase 4
Feasibility	Review	Consensus	Implementation
<ul style="list-style-type: none"> <li>• Research healthcare market, economic and demographic conditions, physician manpower, managed care, utilization, etc..</li> <li>• Practice location research</li> <li>• Assessment of local catchment area and environment</li> <li>• Preliminary report / recommendations on market and financial feasibility</li> </ul>	<ul style="list-style-type: none"> <li>• Define mission, organizational structure, and capital structure</li> <li>• Propose organizational and governance structure</li> <li>• Develop revenue and expense projections</li> <li>• Identify the range of services</li> <li>• Develop business plan, budget, staffing, and timetable</li> </ul>	<ul style="list-style-type: none"> <li>• Site visit and additional research as needed</li> <li>• Detailed recommendations of organizational structure, governance, compensation, management and financial systems and controls, accounting and computer systems, HR, payor and vendor relationships, etc..</li> <li>• Assist with decision making</li> </ul>	<ul style="list-style-type: none"> <li>• Assist in coordinating HR and administrative functions</li> <li>• Review/analyze charge master, billing, AR, policies, reports, computer systems</li> <li>• Develop process flow for billing and claims resolution</li> <li>• Assess office space and FF&amp;E</li> <li>• Perform ongoing assistance as needed</li> </ul>
<p><b><u>OBJECTIVE</u></b> Report Preliminary Findings/ Make “go/no go” decision</p>	<p><b><u>OBJECTIVE</u></b> Report Findings</p>	<p><b><u>OBJECTIVE</u></b> Finalize organizational structure and governance issues</p>	<p><b><u>OBJECTIVE</u></b> Closing on new practice and commence implementation process</p>



# Choosing an Employment and Compensation Model

## *Employment Compensation Arrangements May Include:*

- Base salary
- Productivity-based compensation
- A combination of equal pay and productivity-based compensation
- Compensation based on a per/RVU method
- Incentive bonus based on productivity
- An annual stipend for performance of administrative services
- Incentive payments based on achieving quality of patient and beneficial outcomes based on agreed upon measures
- Fixed base salary plus an incentive bonus paid based on the enterprise value
- Incentive payments based on specified permissible gainsharing arrangements, e.g., achieving certain cost savings and efficiencies
- Incentive payments paid based on the contributions and economic inputs of the employed physician(s) to achieve specified enhancement of the performance of the enterprise, e.g., development of a “*Center of Excellence*”

# Choosing an Employment and Compensation Model

## *Types of Compensation Arrangements for Physician Services*

A	B	C	D
Type of Compensation Arrangement	Clinical	On-Call	Administrative
Base salary, stipend, or hourly rate	X	X <sup>1</sup>	X
Productivity-based compensation or a combination of equal pay and productivity based compensation	X		
Compensation based on a per/RVU method	X	X	
Incentive bonus based on productivity/effectiveness	X		X
Incentive payments based on achieving quality outcomes, specified permissible gainsharing arrangements, <sup>2</sup> or the contributions and economic inputs of the employed physician(s) to achieve specified enhancement of the performance of the enterprise <sup>3</sup>	X		X
Annual stipend for performance of administrative duties			X
Fixed salary plus an incentive bonus paid phased on the enterprise value	X		X
Payment only after a physician has completed a specified number of uncompensated shifts <sup>4</sup>		X	
Fee-for-Service for underinsured or uninsured patients		X	
Subsidy for malpractice insurance (when called-in)		X	
Locum Tenens		X	
Beeper rates		X	

**Notes:**

1.97% of organizations use this method (i.e., stipend or hourly rate) for non-employed physicians

2.e.g., achieving certain cost savings and efficiencies

3.e.g., development of a "Center of Excellence"

4.Also known as "Excess-call shifts"; 21% of organizations utilize this method

"Physician On-Call Pay Survey Report," Sullivan, Cotter, and Associates, 2009, p. 12, 13, 20, 30

# Choosing an Employment and Compensation Model

## *Compensation Benchmarking Sources*

	A	B	C	D	E
	Name	Publisher	Clinical	Medical Director	On-Call
1	Medical Group Compensation and Financial Survey	American Medical Group Association	x	x	
2	Cost Survey for Single-Specialty Practices	Medical Group Management Association	x		
3	Physician Compensation and Productivity Survey Report	Sullivan Cotter and Associates, Inc.	x	x	x
4	Physician Compensation Survey	National Foundation for Trauma Care	x		
5	Physician Executive Compensation Survey	American College of Physician Executives		x	
6	Physician Compensation and Production Survey	Medical Group Management Association	x		
7	Physician Salary Survey Report: Hospital-Based Group HMO Practice	John R. Zabka Associates	x	x	
8	Survey Report on Hospital and Healthcare Management Compensation	Watson Wyatt Data Services		x	
9	Cost Survey for Multispecialty Practices	Medical Group Management Association	x		
10	Healthcare Executive Compensation Survey	Integrated Healthcare Strategies		x	
11	Physician On-Call Pay Survey Report	Sullivan Cotter and Associates, Inc.			x
12	Management Compensation Survey	Medical Group Management Association		x	
13	Survey of Manager and Executive Compensation in Hospitals and Health Systems	Sullivan Cotter and Associates, Inc.		x	
14	Executive Compensation Assessor	Economic Research Institute		x	
15	Top Management and Executive	Abbott Langer Association, Economic Research Institute, and Salaries Review		x	
16	Executive Pay in the Biopharmaceutical Industry	Top 5 Data Services, Inc.		x	
17	Executive Pay in the Medical Device Industry	Top 5 Data Services, Inc.		x	
18	Hospital Salary & Benefits Report, 2007-2008	John R. Zabka Associates, Inc.		x	
19	US IHN Health Networks Compensation Survey Suite	Mercer, LLC		x	
20	Intellimarker	American Association of Ambulatory Surgery Centers	x	x	
21	Medical Directorship and On-Call Compensation Survey	Medical Group Management Association		x	x

# Implications of Hospital-Physician Alignment

# Benefits of Hospital-Physician Alignment



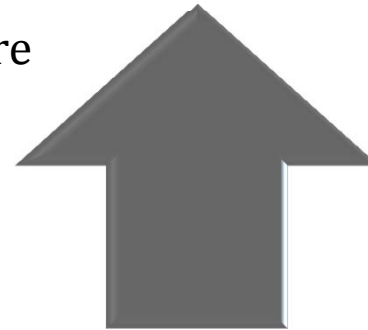
**Good for Hospital**

- Reduce operating expenses
- Steady salary and benefits
- Regulatory buffer
- Work-life balance
- Less financial risk

**Hospital-Physician Alignment**

**Good for Physician**

- More market power / market share
- Clinical integration
- Quality and cost management
- Access to capital





# Reimbursement/Financial Implications

<h2>Provider Positives</h2> <ul style="list-style-type: none"><li>• Possible lower practice costs from increased efficiency</li><li>• Greater market (negotiating) power</li><li>• Possible shared savings payments</li></ul>	<h2>Patient Positives</h2> <ul style="list-style-type: none"><li>• Better quality care</li><li>• More convenient care</li><li>• Possibly fewer physician visits</li></ul>
<h2>Provider Negatives</h2> <ul style="list-style-type: none"><li>• Lower patient volumes equals lower FFS payments</li><li>• High IT costs</li><li>• High capital costs</li></ul>	<h2>Patient Negatives</h2> <ul style="list-style-type: none"><li>• Greater power of providers tends to lead to larger costs for patients</li><li>• Confusing beneficiary assignment</li></ul>

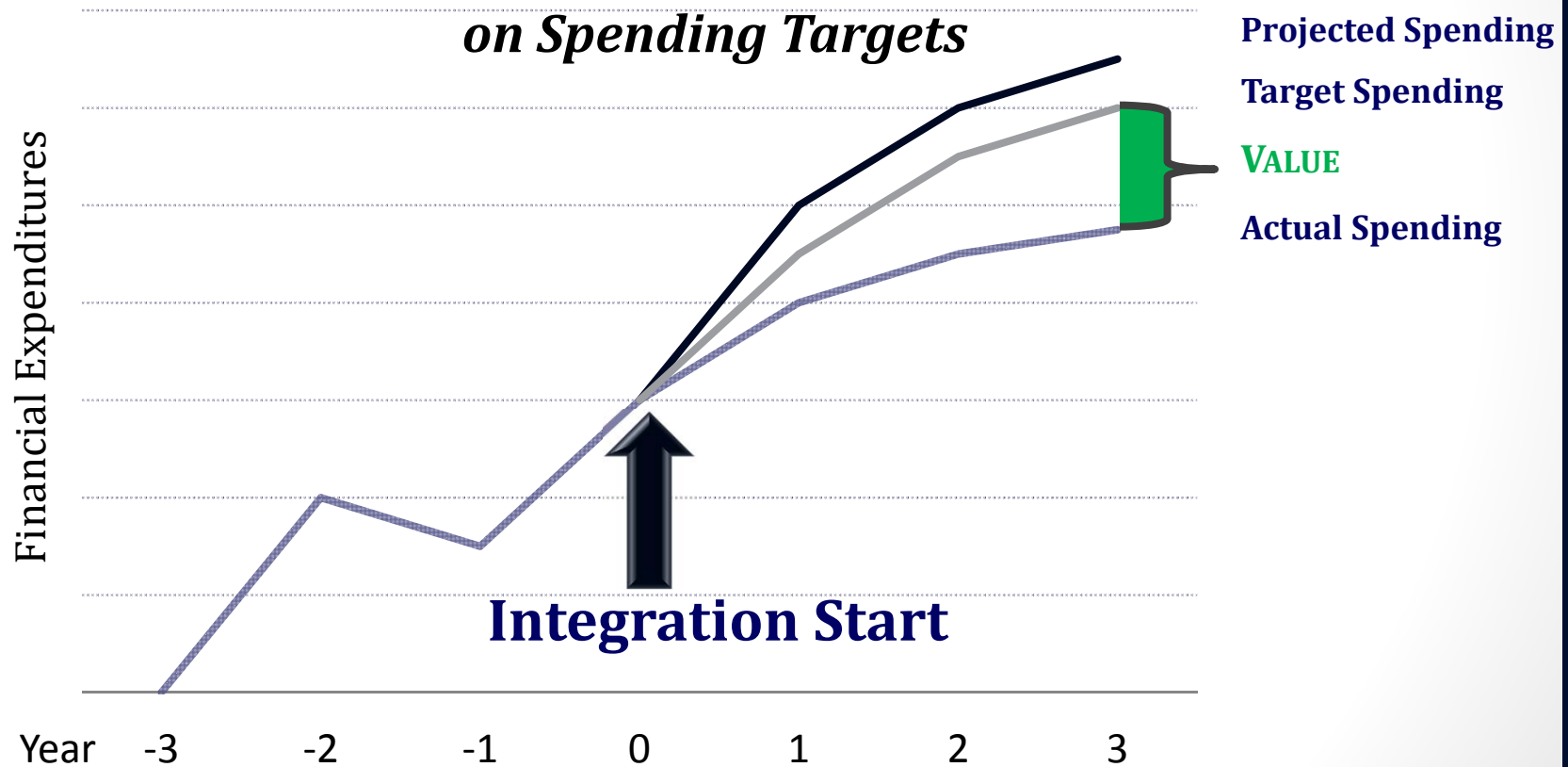
***Value, either to society or to providers, must be weighed against the prospective costs***

“Rising Healthcare costs may be Impervious to Courts, Regulators” By Philip Betbeze, HealthLeaders Media, July 1, 2011, <http://www.healthleadersmedia.com/print/LED-268129/Rising-Healthcare-Costs-May-be-Impervious-to-Courts-Regulators> (Accessed 7/1/2011).

# Reimbursement/Financial Implications

Targets generally based on Industry Benchmarks

*Potential Savings Based on Spending Targets*



“ACO Model Principles,” The Accountable Care Organization Learning Network, <http://www.acolearningnetwork.org/why-we-exist/aco-model-principles> (Accessed 09/16/2011); ACO Toolkit, Accountable Care Organization Learning Network; “How to Create Accountable Care Organizations,” Howard D. Miller, Center for Healthcare Quality and Payment Reform, 2009.

# Regulatory Considerations

Regulation	Implication
Federal Anti-Kickback Statute	Current safe harbors to potentially shield from possible violations Direct employment Co-management arrangements Gainsharing
Federal Physician Self-Referral Law (Stark Law)	Current exceptions (e.g., physician practice) to potentially shield from possible violations. Waivers exist for ACO participants, “as may be necessary.”
Federal Civil Monetary Penalty	ACOs only - HHS has provided a waiver (Stark Law and the AKS waivers)
Federal Antitrust Law	Only an issue if one organization will obtain significant market power. ACOs have specific compliance criteria.
Federal Tax Law	Tax-exempt participants in Integrated Alignment models should be able to remain that way as long as organization furthers charitable purposes
State Regulations	State “ <i>Corporate Practice of Medicine</i> ” (CPOM) laws prohibit the practice of medicine or the employment of physicians by business corporations A variety of care models and structures for hospital-physician relationships have been developed to comply with state statutes, which may not fit easily with the structure or goals of an integrated model CPOM laws could prevent some organizations from hiring physicians to work directly with provider participants in managing and better coordinating the provision of health services

# Regulatory Considerations

## Federal AKS

### Definition

Prohibition against soliciting, receiving, or paying remuneration in exchange for the referral healthcare service billed to Medicare, Medicaid, or any other federal healthcare program

### Implication

All employment arrangements must be at FMV and commercially reasonable, so as not to be suspect.  
Current safe harbors to potentially shield from possible violations  
Direct employment  
Co-management arrangements  
Gainsharing

# Regulatory Considerations

## Federal Stark Law

### Definition

Prohibition against physician referrals to providers of Designated Health Services with whom the referring physician has a financial relationship

### Implication

All employment arrangements must be at FMV and commercially reasonable, so as not to be suspect.  
Current safe harbors to potentially shield from possible violations  
Compliance with the AKS and Stark may be waived for ACOs and Bundled Payment participants, "as may be necessary."

# Regulatory Considerations

## Federal Civil Monetary Penalties

### Definition

Civil penalties against hospital payments to physicians for

- Reducing length of stay
- Reducing readmission rates
- Other forms of fraud and abuse

### Implication

Hospitals and physicians must balance CMP with current value-based purchasing initiatives, and reimbursement changes that create disincentives for readmissions.

HHS has provided a waiver similar to those given for Stark Law and the AKS for ACOs.

# Regulatory Considerations

## Federal Tax Law

### Definition

Integration between providers coordinating care may cause nonprofit, tax exempt providers and for profit, taxable entities, to merge.

### Implication

Physicians going into a tax-exempt organization must adapt to charitable mission statements.

# Regulatory Considerations

## Federal Antitrust

### Definition

Sherman Act, Section 1 prohibits contracts, combinations and conspiracies that unreasonably restrain trade

- Applies to independent, competing providers
- Does not apply to:
  - Physicians all within the same group
  - A hospital and its full-time, employed physicians
  - A hospital and its controlled subsidiaries

### Implication

Only an issue if hospital gains significant market share.

FTC and DOJ released proposed rules governing mandatory antitrust monitoring, based on the percentage of market share an ACO has for any specific service line



# Regulatory Implications

## State Law

- State “*Corporate Practice of Medicine*” (CPOM) laws prohibit the practice of medicine or the employment of physicians by business corporations
- A variety of care models and structures for hospital-physician relationships have been developed to comply with state statutes, which may not fit easily with the structure or goals of an integrated model
- CPOM laws could prevent some organizations from hiring physicians to work directly with provider participants in managing and better coordinating the provision of health services

“AAMC Statement on Legal Issues Related to Accountable Care Organizations (ACOs) and Healthcare Innovation Zones (HIZs),” Association of American Medical Colleges, October 5, 2010, [https://www.aamc.org/download/151426/data/aamc\\_comment\\_on\\_legal\\_issues\\_related\\_to\\_accountable\\_care\\_organizational.pdf](https://www.aamc.org/download/151426/data/aamc_comment_on_legal_issues_related_to_accountable_care_organizational.pdf) (Accessed 09/14/2011); “Toolkit”, Accountable Care Organization Learning Network, The Brookings Institute, 2010, <http://www.nachc.com/client/documents/ACOToolkitJanuary20111.pdf#page=6> (Accessed 9/14/2011); “Accountable Care Organizations in California: Programmatic and Legal Considerations” By: William S. Bernstein et al., California HealthCare Foundation, July 2011, <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/A/PDF%20ACOProgrammaticLegalConsiderations.pdf> (Accessed 09/14/2011)

# Regulatory Implications - Compliance

## Fair Market Value and Commercial Reasonableness

- Compensation arrangements for physician clinical and executive services (e.g. medical directorships) must be both at Fair Market Value (FMV) *and* commercially reasonable to avoid liability under the Stark Law, the Anti-Kickback Statute, and the FCA.
- The test for commercial reasonableness is a threshold which is distinct from that of the standard of Fair Market Value.
- While Fair Market Value looks to the reasonableness of the “*range of dollars*” paid for a product or service, the standard of commercial reasonableness looks to the “*reasonableness of the business arrangement generally.*”
- Because Fair Market Value under Stark Law does not “*necessarily comport with the usage of the term in standard valuation techniques and methodologies,*” a purely market-driven determination of Fair Market Value may not always be considered commercially reasonable for the purposes of federal fraud and abuse laws.

“All Eyes on Physician-Hospital Arrangements,” By Lewis Lefko, HealthLeaders Media, Jan. 24, 2008, [www.healthleadersmedia.com](http://www.healthleadersmedia.com) (Accessed 9/18/2008); “Tread Carefully When Setting Fair Market Value: Stark Law Must Be Considered,” Joyce Frieden, Nov. 1, 2003, available at [http://findarticles.com/p/articles/mi\\_m0CYD/is\\_/ai\\_110804605](http://findarticles.com/p/articles/mi_m0CYD/is_/ai_110804605) (Accessed 9/26/08); 66 Fed. Reg. 916, 944 (Jan. 4, 2001); 69 Fed. Reg. 16,093 (March 26, 2004); “Successful Medical Practice Valuation,” By Reed Tinsley, CPA, Physicians News Digest, July 2008, <http://www.physiciansnews.com/business/708tinsley.html> (Accessed 9/19/2008).

# Implications of Alignment Healthcare Reform Initiatives

- Demonstration projects formed under the ACA have not shown promise for lowering costs
  - Disease management and care coordination demonstration
  - Value-based purchasing demonstration
- Efficiencies achieved through care coordination may offer better outcomes
  - Best outcomes achieved when managers are in direct contact with physicians
- Physicians and Hospitals will need to work together to overcome initial setbacks

# The Future of Hospital-Physician Alignment

# Future of Hospital-Physician Alignment

- Healthcare reform is already driving changes in both the operational and financial aspects of healthcare enterprises
- New healthcare delivery models and payment reforms induced by the ACA necessitate hospital-physician alignment and will demand a level of cooperation never before expected of healthcare providers
- The once well-defined, relatively stable business landscape of U.S. healthcare delivery now presents an unpredictable milieu of new provider configurations, strategies, and tactics
- Advisors should keep abreast of *The Four Pillars* in order to assist individuals and businesses in navigating the unique complexities of an increasingly volatile healthcare marketplace

*“Love everyone, trust no one, and  
paddle your own canoe.”*