

Hospital Physician Integration: The Next Wave



May 24, 2010

Issues Driving Change: Need to Bend the Cost Curve

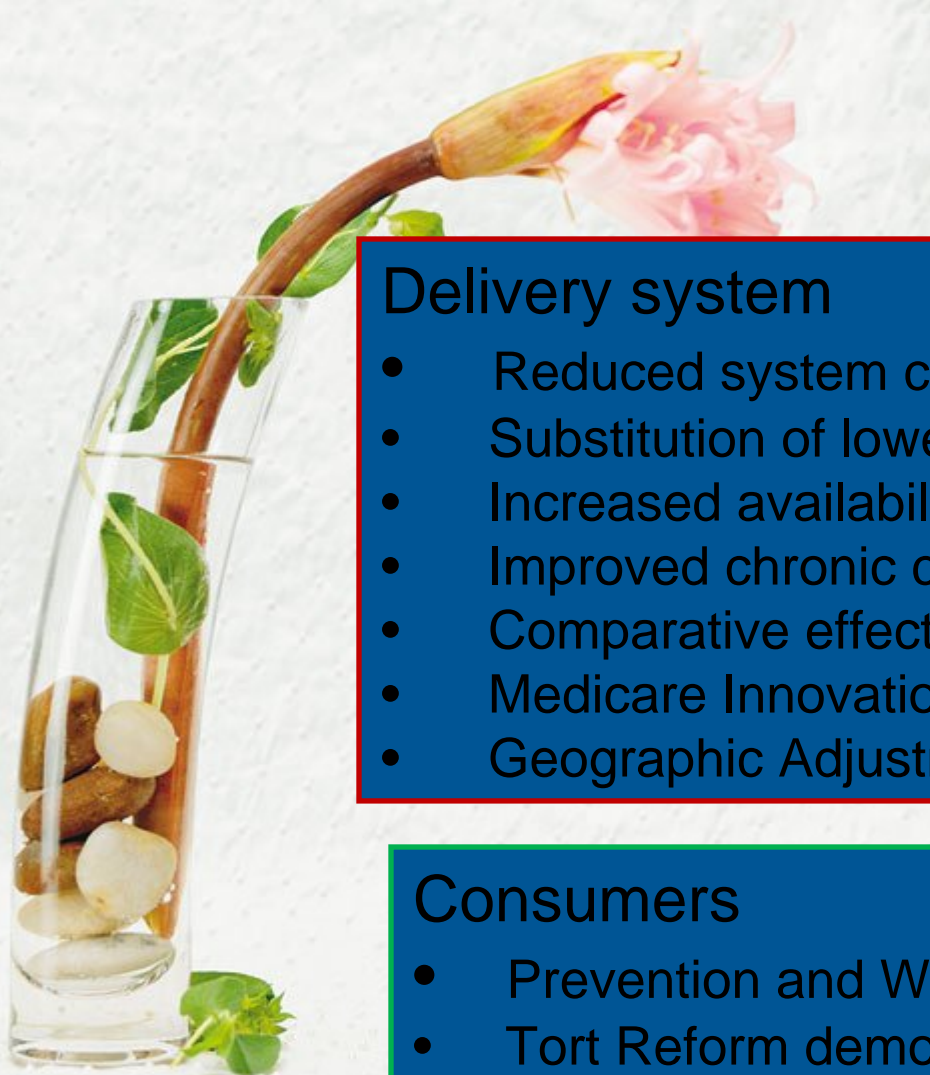
Competition between Health Plans

Delivery system

- Reduced system costs: duplication, competition
- Substitution of lower priced care inpatient , clinic, home
- Increased availability and use of primary care
- Improved chronic care (Medical home, ACO etc.)
- Comparative effectiveness research
- Medicare Innovations Center
- Geographic Adjustment

Consumers

- Prevention and Wellness
- Tort Reform demonstrations
- Consumer Directed Health Care



Issues Driving Change: Pressure on Reimbursement

Reimbursement



will be cut....

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Potential Winners and Losers

Almost Certain
Losers

Too Tough
to Call

Almost Certain
Winners



- Imaging
- Physician Owned Hospitals
- Brand name biologics

- Health Plans
- Specialty Physicians
- “Big Pharma”

- General Acute Hospitals
- Academic Medical Centers

- Nurses/ midlevel providers
- Rural Hospitals

- Primary Care Providers
- Health IT

Source: KPMG *Flashpoint on Healthcare Reform, Fall 2009*, from Interview with Blair Childs, Premier, Inc., in *Health Leaders Media*, July 27, 2009 “Who Will be the Winners and Losers in Health Reform?”



Successful Health Care Organizations Will Focus On:

- Payment reform will drive integration and alignment
- Care models will need to change; there is opportunity for health systems focused on quality, safety, and value
- Prudent strategic capital investment and effective operations will be essential
- Effective development and application of technology will be important
- Health systems will need to stay even closer to their missions and their communities
- Health care will always be personal – successful organizations will be highly responsive to patient's needs



Health Industry Outlook

“Consolidation activity is expected to increase as hospitals position themselves for survival in the current economic environment.”

“Hospitals and health care systems evaluating their partnership options *before* a declining financial position pins them in a corner will be best positioned for success.”

Source: Myers and Lineen, Healthcare Financial Management, November, 2009.

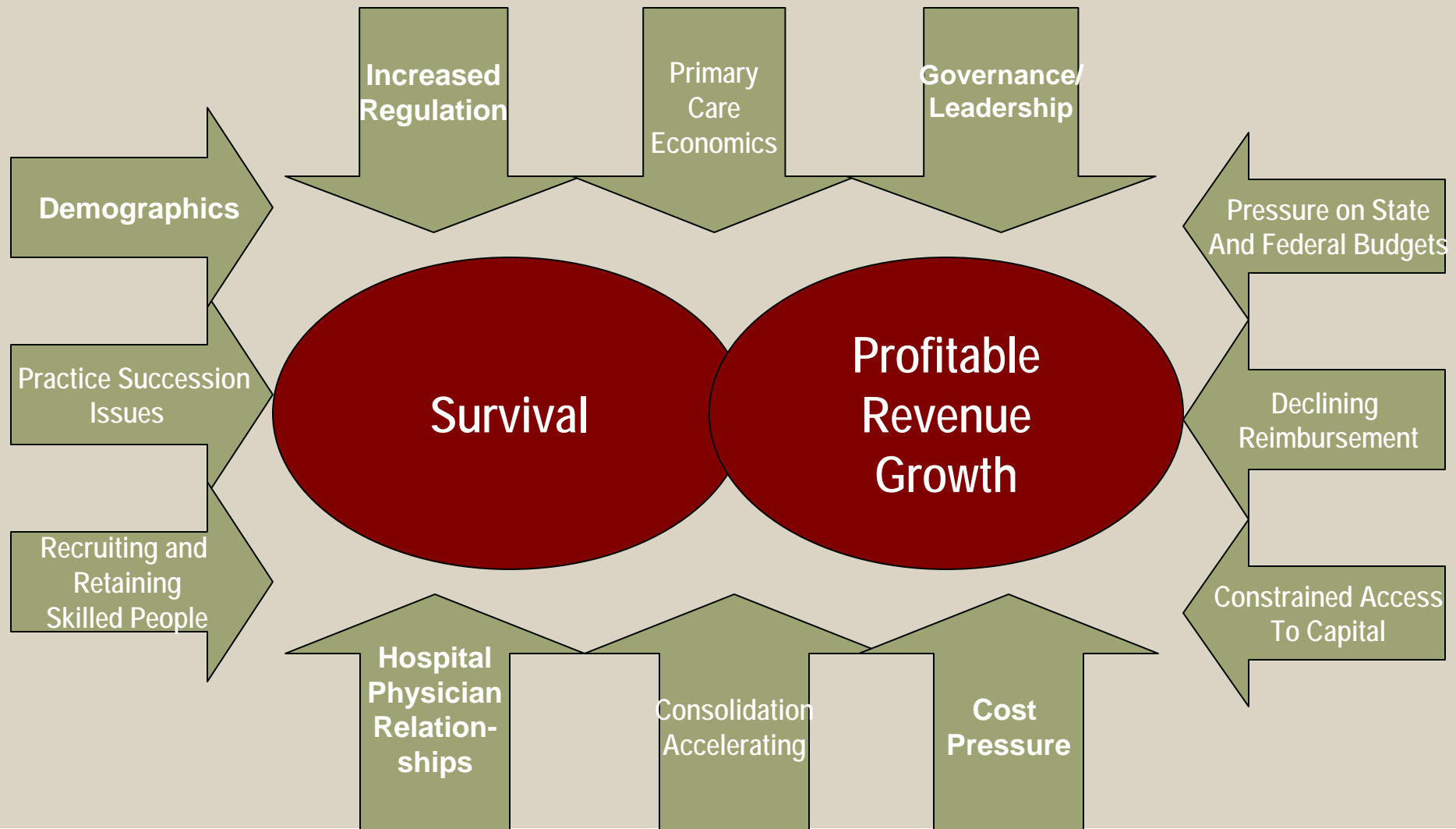


Physician Hospital Integration: The Next Wave

- Integration and affiliation is once again accelerating at all levels
 - Physician to physician
 - Physician to hospital
 - Small hospital to larger hospital or healthcare system
 - Do recent events such as the sale of Boston's Caritas Christi health system to Cerberus Capital Management and Detroit Medical Center's integration with Vanguard signal a new wave of provider acquisitions by for-profits?
- Affiliation is being driven primarily by reform on the horizon (federal and local/regional), the imperative to achieve cost savings and operating efficiencies, and to gain or maintain access to capital



What's Happening in Physician Groups and Hospitals Today?

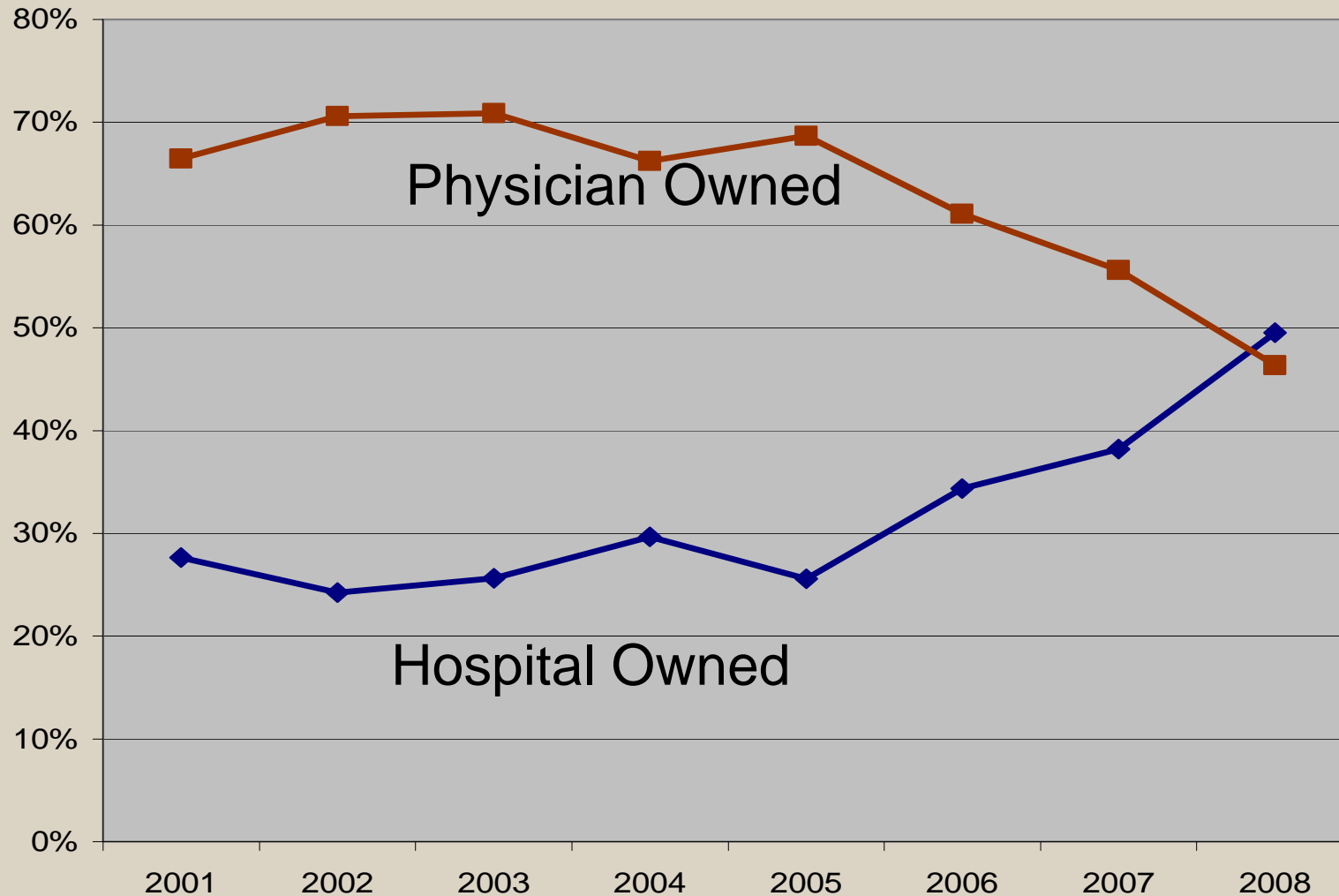


Physician Practice Trends

- Era of private practice is becoming less feasible
 - Private practice primary care tends to lead to consolidation
 - Specialty physician consolidation is now occurring rapidly in most markets
- Physician practice changes
 - Fewer hours worked by new generation of physicians (more feasible under integrated arrangements)
 - Primary care physicians (PCPs) in general with a narrowed scope of practice in urban areas either hospitalist or office based
 - Increased role of/reliance on mid-level practitioners
 - Need for capital for EMR and other technology initiatives



Changing Practice: Medical Practice Ownership in the U.S. Shifting to Hospital Ownership



Source: MGMA Physician Compensation and Productivity Survey Report, 2002-2009

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Key Trends Driving Physician Hospital Collaboration

- Declining physician incomes
- Lack of success recruiting new physicians
 - Short term income reductions related to recruitment of new physicians limits growth
- Limited access to key resources
 - Human
 - Capital
 - Technology
- Lack of managed care contracting leverage as freestanding practice
- Competition between physicians and hospitals for the same revenue streams
- Generational and multi-specialty internal group dynamics
- Fear of risks of ownership



Physicians Want....

- To maintain stable income
 - Fair market compensation
 - Access to patients
 - Access to ancillary revenue
 - Improvement in efficiency
 - Reduction in overhead cost
- Ability to “move the market” for primary care incomes
- Access to capital
- Contracting leverage
- Work life balance
- Input into decision-making
- Control of practice environment without the risks of ownership
- Scope of practice opportunities
- Positive peer professional relationships
- Market differentiation



Hospitals Want. . .

- Access to patients
- A stable committed medical staff
- Control over, or at least participation in, outpatient revenue streams
- Contracting leverage
- Alignment of financial incentives
- Avoidance of capital/service duplication
- Integrated electronic patient health records



Potential Benefits of Closer Affiliation

Physician

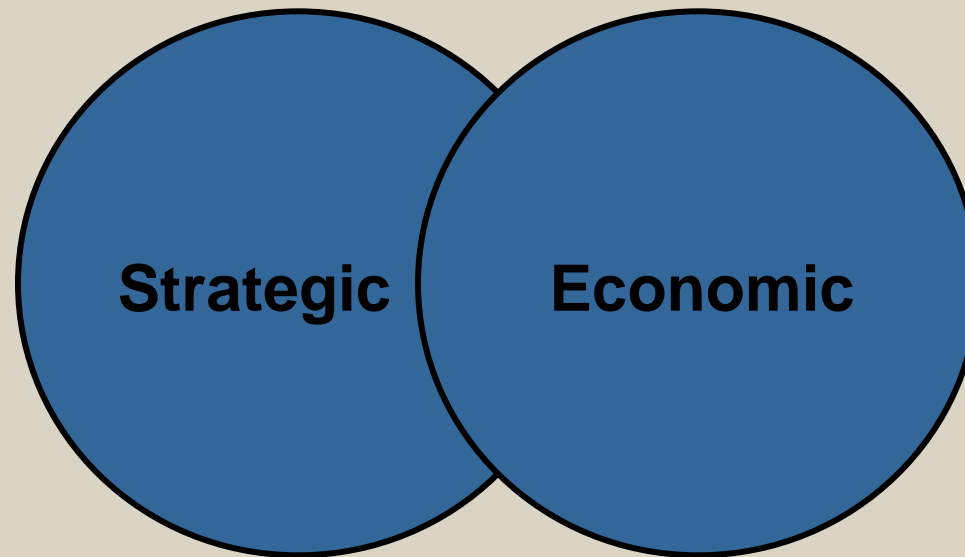
- Enhanced Security
- Greater Income
Predictability
- Improved Lifestyle
- Recruitment of additional colleagues
- Stabilized Referral Patterns
- Joint Marketing / Branding Strategy
- Economies of Scale
- Leverage With Payers
- Revitalization of Morale
- Group purchasing power

Hospital

- Support Mission
- Meet Growth Need
- Enhance Future Supply of Physicians/Improved Recruitment
- Eliminate competition/threat of competition for ancillaries
- Align Incentives
- Connect With Physicians at Different Points in Career
- Stabilize Primary Care network
- Increased downstream revenue
- Maintain local control of health care system



Overlapping Interests



- **Increase Market Share**
- **Expand Regional Presence**
- **More Value to Health Plans**
- **Expand Clinical Relationships**
- **Improve Physician Recruitment / Retention**

- **Stabilize Practice**
- **Capture Cost / Investment Synergies**



Success Metrics

Physician Group

- Impact on incomes
- Impact on work-life (control)
- Impact on personal balance sheet
- Recruitment / Retention

Hospital

- Market share
- Financial performance
- Recruitment / Retention



Key Questions Physicians Are/Should Be Asking Relative to Hospital Relationships

- Will we be able maintain our level of income (or within 20%) with anticipated reimbursement changes?
- Will we be able to recruit new physicians to our practice in the future?
- If financial support is required, what relationship models will allow us to accomplish our mutual goals?
- Do we, the physician group, share a common goal of local health care delivery with the hospital?
- Do we have a positive collaborative relationship with the hospital?
- Is the hospital susceptible to a “take over” by a larger system?



Key Questions Hospitals Are/Should Be Asking Relative to Physician Relationships

- Will we have enough physicians (breadth and depth) to support our community's needs and our market strategies?
- Are our key physician groups willing and able to grow organically or do they need financial assistance to do so?
- If financial support is required, what relationship models will allow us to accomplish our mutual goals?
- Do the hospital and our physician groups share a common goal of local health care delivery or are we vulnerable to “take over” by a larger system?
- Do we have positive/collaborative relationships with our physicians?
- Are our key physicians loyal to our hospital, or are they “splitters”, with services provided at competing hospitals as well?
- Are competing hospitals courting key physicians, either those loyal to our hospital or “splitters”?

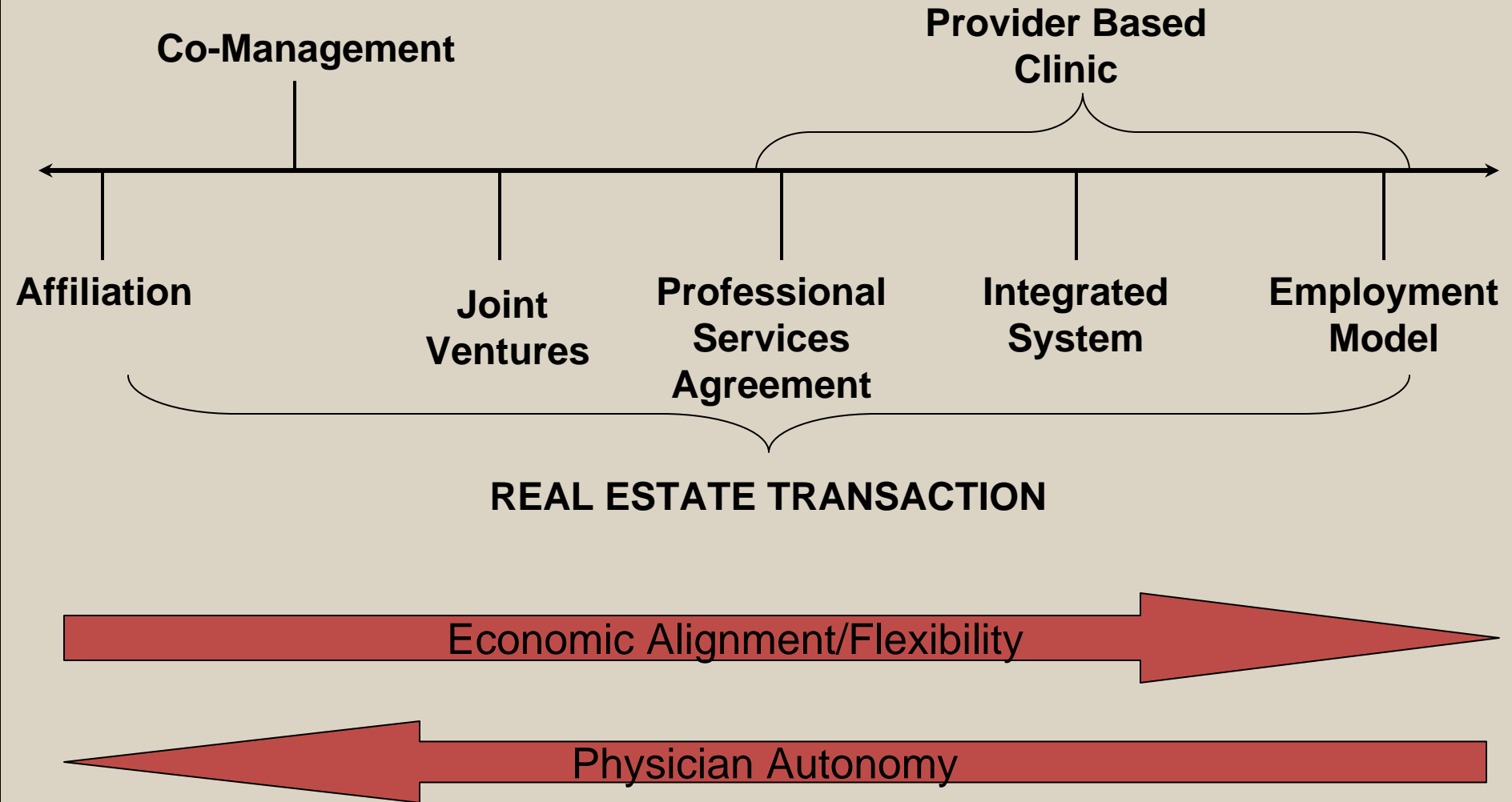


Is Merger/Acquisition the Only Way to Increase Alignment? . . .No. . .A Range of Options

- Hospital Relationships
 - Call Coverage
 - Medical Directorships
 - Affiliation Agreements
 - Co-Management Agreements
 - Joint Ventures
 - Partial Professional Service Agreements
 - Professional Service Agreements
 - Integrated System
 - Employment
- Medical Group Mergers – Multi-Specialty or Larger Single Specialty Groups



Relationship Spectrum: Hospital to Physician Group



Affiliation Agreements – What's Involved?

- Clinic not ready yet for full integration but desires closer ties with Hospital
- Often includes recruitment assistance, EMR, medical directorships, joint venture on ancillaries (e.g., imaging, ASCs), service-line co-management
- Clinic may sell right of first refusal/first negotiation
- Typically exclusive



Affiliation Agreements – Potential Uses and Risks

- First step toward future collaboration
- Clinic interested in financial support but not ready to merge with Hospital
- Clinic's stability is important to the Hospital
- Desire that the Clinic remain independent
- Stark and anti-kickback laws pose challenges (e.g., prohibition of physician ownership of certain designated health services)



Clinical Co-Management Agreements — What's Involved?

- The service is hospital owned in order to benefit from favorable hospital reimbursement
- The hospital contracts with a physician entity to provide management of the service, this can be clinical management, business management, or both
- Allows physicians to have significant involvement in and accountability for operations and outcomes
- Payment must be based upon fair market value

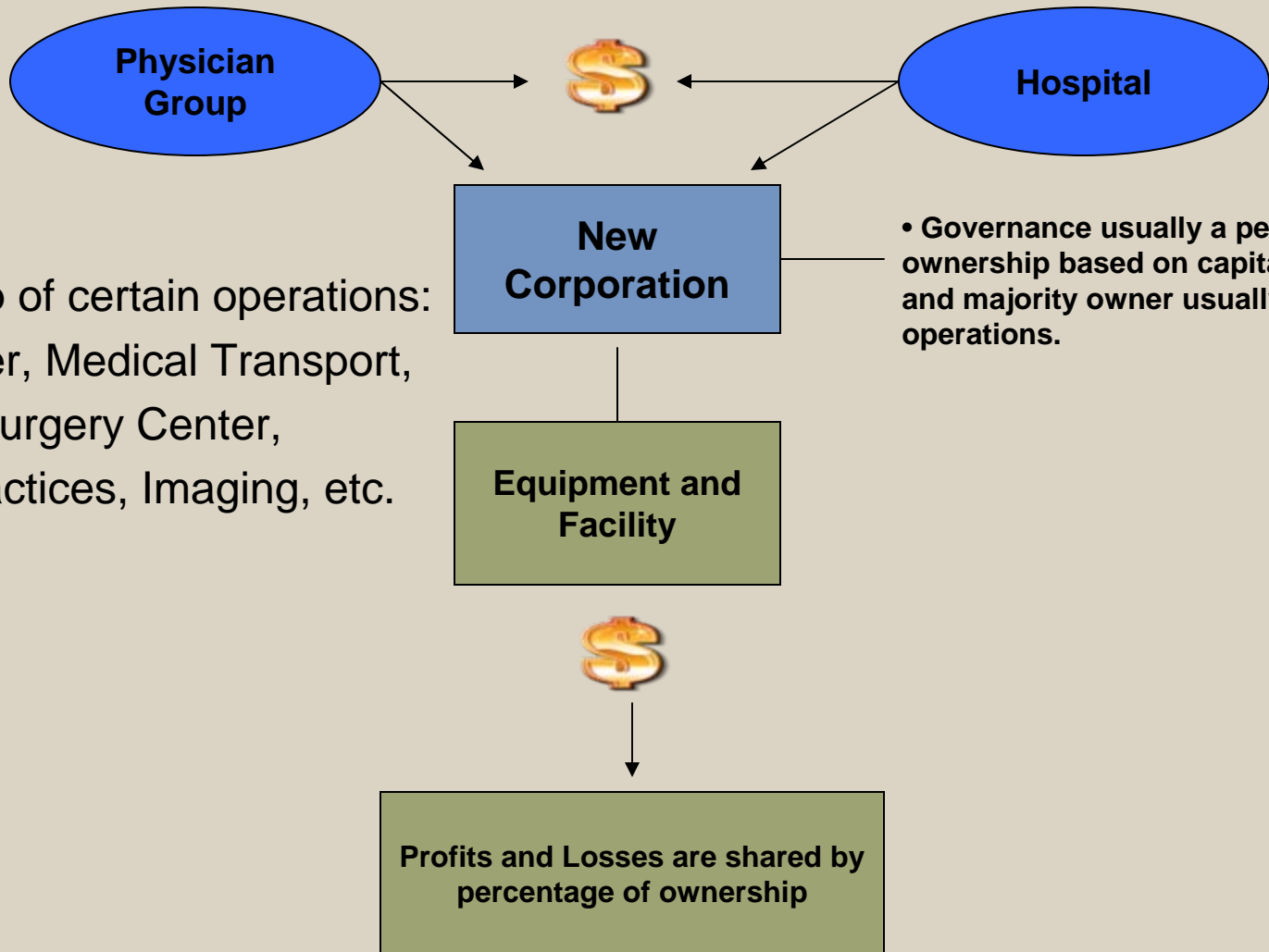


Clinical Co-Management Agreements — Potential Uses

- Co-management arrangements can be developed in:
 - Ambulatory surgery centers
 - Hospital service lines
 - Outpatient imaging centers
 - Radiation therapy centers
 - Infusion centers
 - Dialysis
 - Medical laboratories
 - Alcohol and chemical dependency centers



Joint Venture — What's Involved?



- Governance usually a percentage of ownership based on capital investment and majority owner usually supplies the operations.

Co-ownership of certain operations:
Cancer Center, Medical Transport,
Ambulatory Surgery Center,
Physician Practices, Imaging, etc.



Joint Venture — Potential Uses and Implications

- Co-ownership of certain operations: Cancer Center, Medical Transport, Ambulatory Surgery Center, Physician Practices, Mobile Imaging, etc.
- May or may not complement other clinical service relationships
- No governance integration, other than governance of JV
- Financial integration limited to scope of Joint Ventures



Professional Services Agreement – What's Involved?

- Clinic sells all of its operating assets to Hospital
- Clinic continues to employ physicians (may also include mid-levels)
- Clinic staff typically become employees of Hospital
- Hospital typically bills for all Clinic services as a provider-based clinic
- Hospital pays Clinic for its services, typically on a RVU basis plus benefits



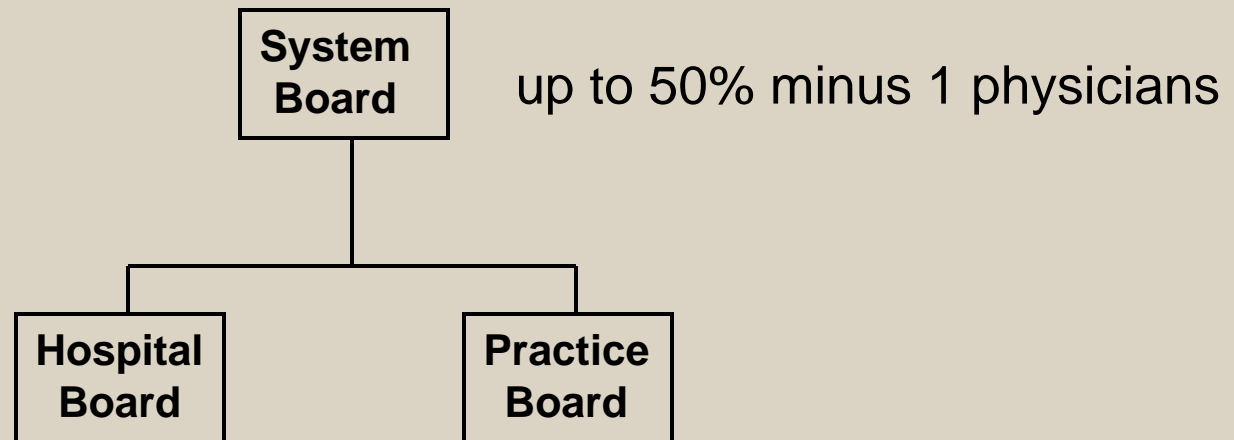
Professional Services Agreement – Potential Uses

- Clinic physicians not willing to commit to employment
 - Desire to maintain own benefits, internal compensation and shareholder decisions
- Open meeting laws and other public disclosure requirements discourage employment
- Clinic desires to avoid financial risk of payor contracts and overhead costs
- Hospital and Clinic desire increased revenue from Medicare provider-based billing
- Hospital seeks a closer (exclusive) relationship
- Renegotiation of compensation may pose challenges down the road
- Allows for potential to unwind relationship if unsuccessful



Integrated Delivery System — What's Involved?

- New system created with hospital division and physician division
- Typically involves significant governance change:



- Creates high level of fund flow flexibility, must meet market test
- Can be coupled with provider based clinics, creating Medicare reimbursement benefit
- Typically involves practice acquisition and physician owned real estate acquisition (if any)



Integrated Delivery System — Potential Uses

- Creates high level of fund flow flexibility, must meet market test
- Typically utilized when a larger physician group or groups desire to retain significant practice autonomy and has strong physician leadership willing to participate in governance



Employment Model — What's Involved?

- Physicians become hospital employees or employees of hospital controlled subsidiary
- Can be coupled with provider based clinics, creating Medicare reimbursement benefit
- Typically involves hospital purchase of practice and real estate (if physician practice owned)
- Usually involves extension of the hospital's information systems, including electronic health records, into the physician practice



Employment Model — Potential Uses

- Creates highest level of fund flow flexibility, although physician income still must meet market test
- Generally the model of choice for small practices



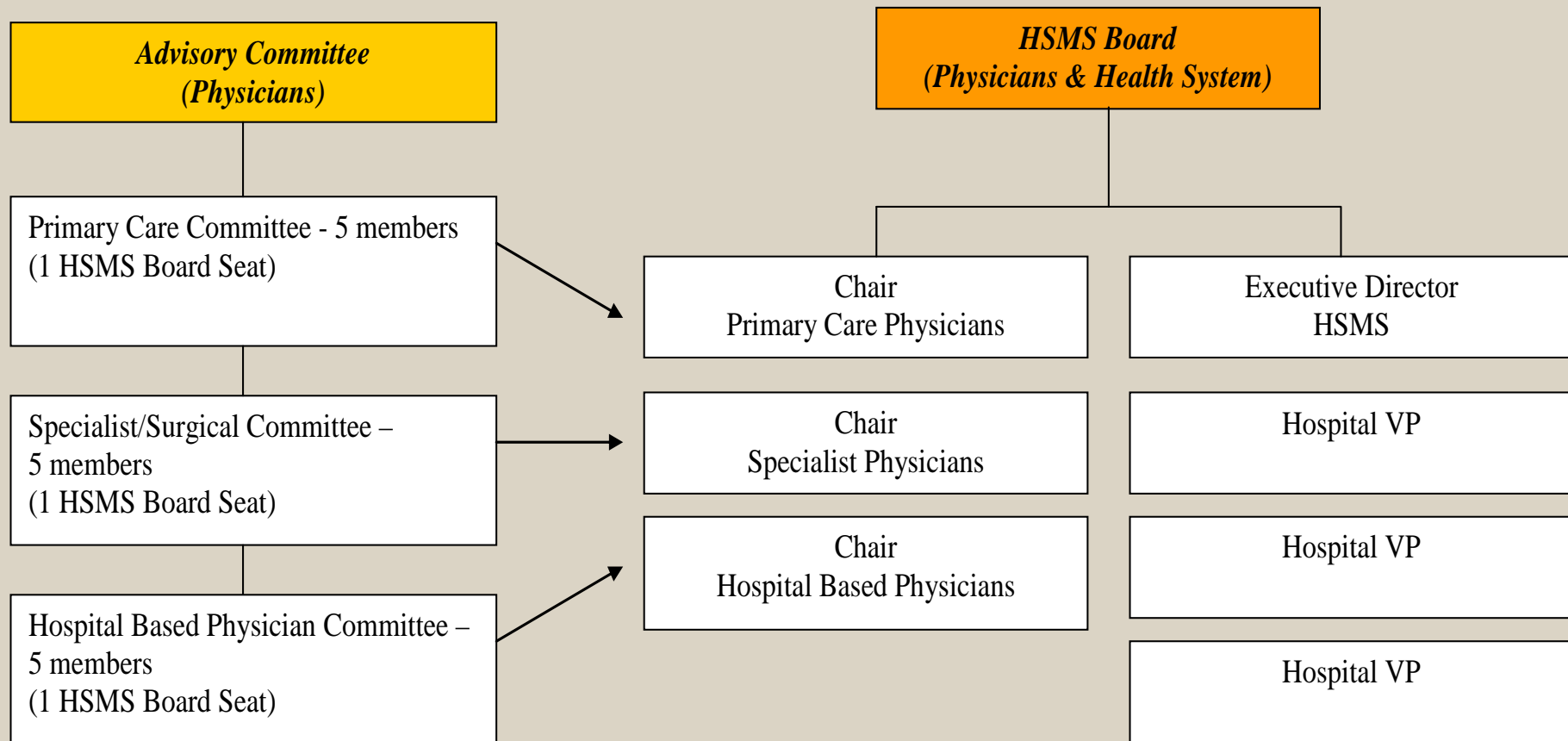
What's Being Paid for Practices Today?

- Under IRS CPE guidelines - the present value of post acquisition cash flow to the buyer after factoring new physician compensation (rarely are practices generating cash flow); alternatively they can be:
 - Tangible assets at their fair market value; and possibly (depending on facts and risk tolerance)
 - Identifiable intangible assets (patient charts/EMR, work force, telephone number, other miscellaneous intangibles)



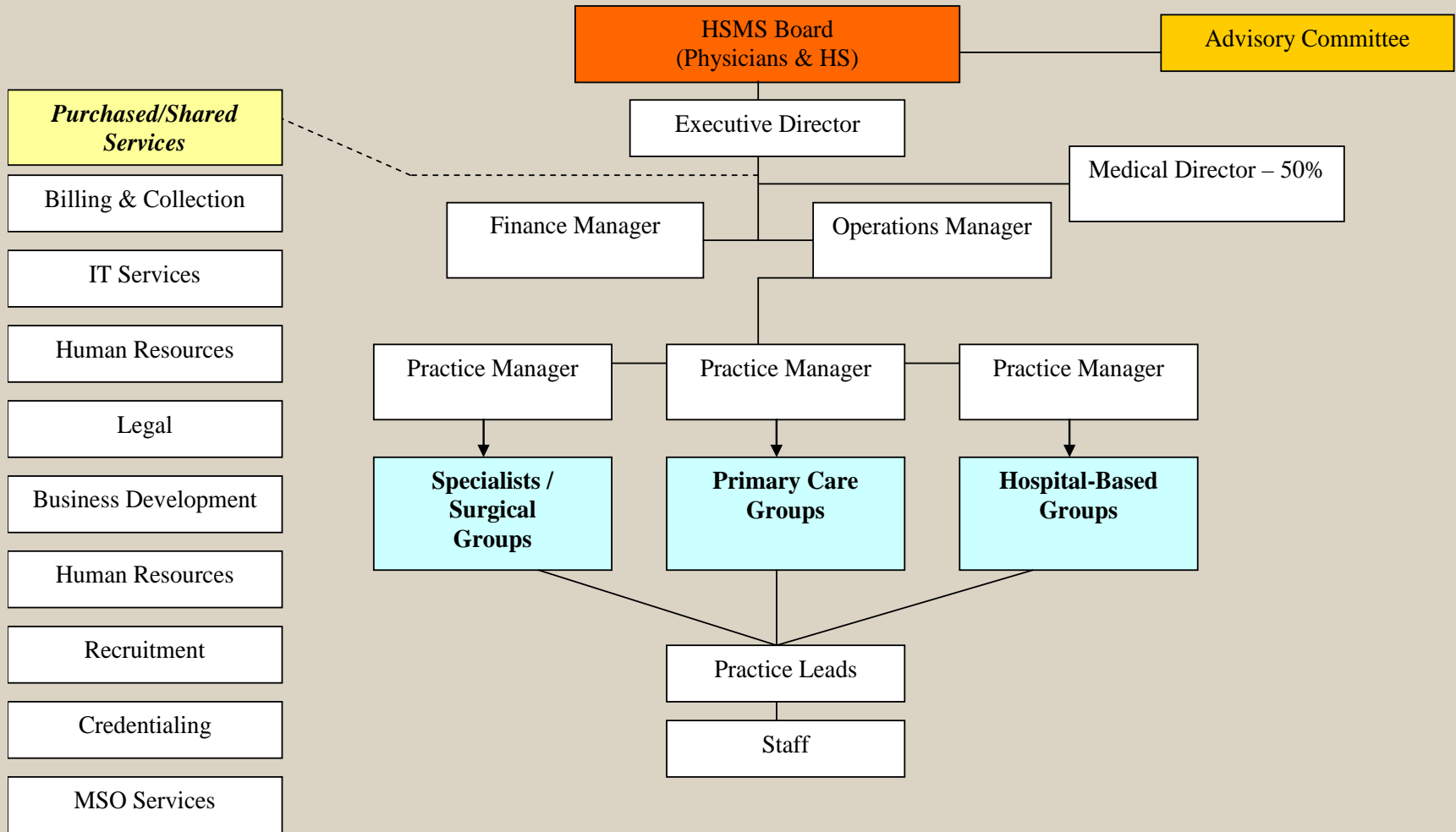
Governance Model

Health System Medical Services Advisory Committee and Board Design Details (Future)



Operations Model

Health System Medical Services (Future)



Medical Group Mergers - What's Happening?

- Full mergers increasingly popular among specialty groups, where groups merge and share a common bottom line
- Divisional mergers also popular, which allows groups to merge, with separate profit centers, followed by a full financial merger later
- Medical group mergers are occurring most frequently in specialties that are not facing severe Medicare reimbursement cuts



Medical Group Mergers (Cont'd)

- Management Services Organizations, that provide billing, collection, employee benefits and other services to clinic owners of the MSO have found limited success in some hospital-based specialty groups (e.g., ER, anesthesiology, radiology, pathology)
- Some medical communities exploring “community partnerships” where a new entity is formed to start discussions toward the “next generation” of payor contracting (e.g., allocation of payments for episodes of care)



Medical Group Mergers (Cont'd)

- For profit management companies also play an important role in some specialty groups (e.g., oncology, concierge care, pain management) by providing access to capital
- Failure of some of these ventures has caused some for-profit practice management companies to proceed cautiously with this approach



Legal Considerations

Law	What it Prohibits	Concern Behind the Law	Unintended Consequences
Antitrust (Sherman)	Provider joint negotiations without financial or clinical integration	Price fixing	Deters providers from pro-competitive innovative arrangements
Ethics in Patient Referral Act (Stark)	Medicare referrals by physicians to entities with which physician has an ownership interest	Physician incentives to refer patients for unnecessary services or choose based upon financial incentives rather than the patient's interest	Incentives for patient care improvements cannot be linked to quality and efficacy if they relate to volume of services
Anti-kickback	Payments to induce Medicare or Medicaid referrals	Physician incentives to refer patients for unnecessary services or choose based upon financial incentives rather than the patient's interest	Uncertainty in arrangements where physicians are rewarded for treating patients using evidence-based protocols
Civil Monetary Penalty	Hospital payments that induce physicians to reduce or limit services to Medicare or Medicaid patients	Physicians will reduce necessary services	Prohibits incentives that result in reduction of care. . .even if the result is an improvement in quality
IRS Tax Exempt Laws	Use of charitable assets for private benefit	Assets intended for public benefit are used to benefit an individual (e.g. a physician)	Can create a significant deterrent to clinical integration

Source: Adapted from AHA Trendwatch report “Clinical Integration—The Key to Real Reform.” at www.aha.org.



“No matter how innovative, equity-oriented, or financially beneficial the physician-health system relationship may be, they will fail in the absence of mutual trust and feelings of shared destiny that are engendered by the environment in which the relationships are forged. In institutions with strong physician-hospital relations, each party is confident that the other's decisions and actions are generally designed for the benefit of both.”

Holm, Craig E. and Brogadir, Stuart P. "Laying the Foundation for Successful Physician-Health System Partnerships," *Journal of Healthcare Management*. 45(1):

January/February, 2000.



Questions



Thank you!



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