Changes in Practice Structure and Integration of Practices: Options for Practitioners in the Face of Declining Reimbursement

Raymond E. Dusman, MD, MBA, FACC

Presentation to the Indiana Chapter of the ACC 10.30.2010

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Why me?

- IM, Cardiology and EP at Indiana University
- 21st year at Fort Wayne Cardiology
- Executive committee role dating to 1995
- MBA (University of Notre Dame)
- Managing partner since 2007
- Chief Physician Executive for Parkview Health since 2009
- Vice Chairman, Parkview Health System Board of Directors

Coordinator of 24 cardiology “CEOs” that comprise our cardiology division

Living the integration process—and SURVIVING!

Fort Wayne Cardiology (by the Numbers)

- •Founded 1978
- •24 Physicians
- •3 NPs
- •196 staff members
- •Yearly office visits---46,000
- •Yearly hospital visits---38,200
- •Echo studies---20,000
- •Device patients followed---3450
- •Pacer/ICDs checks---12,500
- •Holter/event monitors---3600
- •Cath Lab procedures---2400
- •EP studies/ablations---240
- •Pacer/ICD implants---680

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What are the Drivers to Change Practice Structure?

The Headline Noise

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July 26, 2010
VOLUME 53 • NUMBER 14

American Medical News

www.amednews.com

Brief Medicare pay fix may mean showdown in lame-duck Congress

Lawmakers will wait until after the elections to tackle the Dec. 1 Medicare pay cut, observers predict.

CHRIS SILVA
AMNEWS STAFF

> The estimated 23% cut in Medicare physician payment that is scheduled for Dec. 1 will rise to nearly 30% on Jan. 1, 2011, if Congress doesn't take any action.

Washington For Leah McCormack, MD, the modest Medicare raise she started receiving in late June to replace a double-digit cut might be the last adjustment the government makes to her pay. After the first half of a particularly tumultuous year for Medicare physicians, she has decided to drop out of the program.

Dr. McCormack, who has operated a solo, private dermatology practice for 25 years in Forest Hills, N.Y., decided in July to terminate all of her contracts with Medicare and managed care companies as soon as she is able.

"The failure of the government to permanently fix the long-promised physician reimbursement rate factored greatly into this decision," she said.

Dr. McCormack, who also is president of the Medical Society of the State of New York, said she would continue trying to provide the best care she can to all of her patients. But the enactment on June 25 of yet another short-term payment patch — the fourth in the past six months — is the final straw for some physicians like her who say they are struggling to maintain a viable business under the Medicare sustainable growth rate formula.

The latest action gives physicians a 2.2% raise and undoes a 21% cut that went into effect June 1. But that's only through Nov. 30, after which the reduction comes back — this time at an estimated 23%.

"It is not a permanent fix for the SGR problem," Dr. McCormack said of the most recent pay patch. "It does not change the fact that doctors are subject to price-fixing by the government. The 2.2% increase is grossly inadequate, especially since the current fees are outdated by at least 10 years, and costs have increased dramatically during the same period."

On top of the fact that more lasting payment reform has been particularly elusive this year, the next deadline for Congress to prevent another cut

Continued on next page

Cardiology

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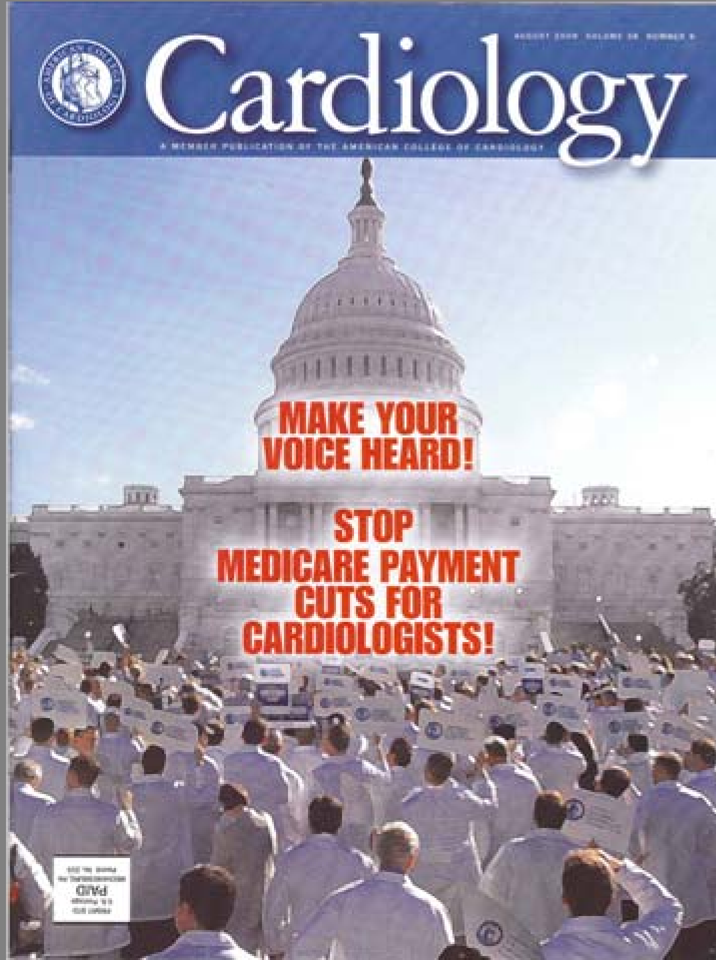
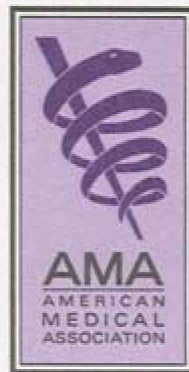


August 23, 2010
VOLUME 53 NUMBER 16



American Medical News

www.amednews.com

Medicare trustees' upbeat outlook relies on big pay cut for physicians

Cardiology

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HEALTH CARE&BENEFITS

Local experts discuss how health reform will play out at ground level. **16**

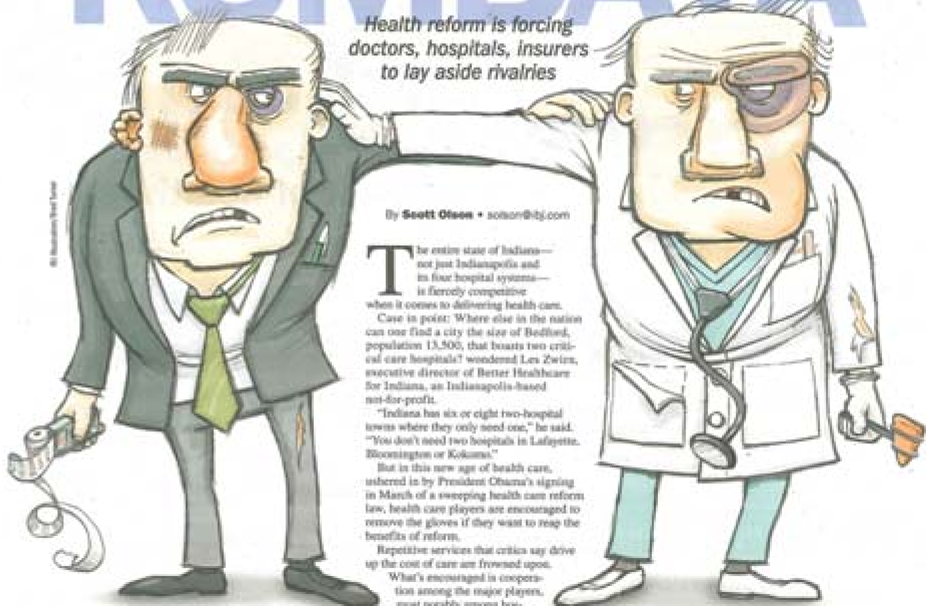
FOCUS

pages
15-32

HEALTH CARE & BENEFITS

KUMBAYA

Health reform is forcing doctors, hospitals, insurers to lay aside rivalries



By **Scott Olson** • solson@ibj.com

The entire state of Indiana—not just Indianapolis and its four hospital systems—is fiercely competitive when it comes to delivering health care.

Case in point: Where else in the nation can one find a city the size of Bedford, population 13,500, that boasts two critical care hospitals? wondered Les Zwirn, executive director of Better Healthcare for Indiana, an Indianapolis-based not-for-profit.

"Indiana has six or eight two-hospital towns where they only need one," he said. "You don't need two hospitals in Lafayette, Bloomington or Kokomo."

But in this new age of health care, ushered in by President Obama's signing in March of a sweeping health care reform law, health care players are encouraged to remove the gloves if they want to reap the benefits of reform.

Repetitive services that critics say drive up the cost of care are frowned upon.

What's encouraged is cooperation among the major players, most notably among hospitals, doctors and insurers, enticed by numerous provisions and pots of money available to them if they indeed work together.

Paying hospitals and doctors as "accountable care organizations," and unveiling bundled-payment initiatives in which expenses would be packaged by Medicare to encourage collaboration, as well as pay-for-performance programs, are big parts of the new health law aimed at improving care.

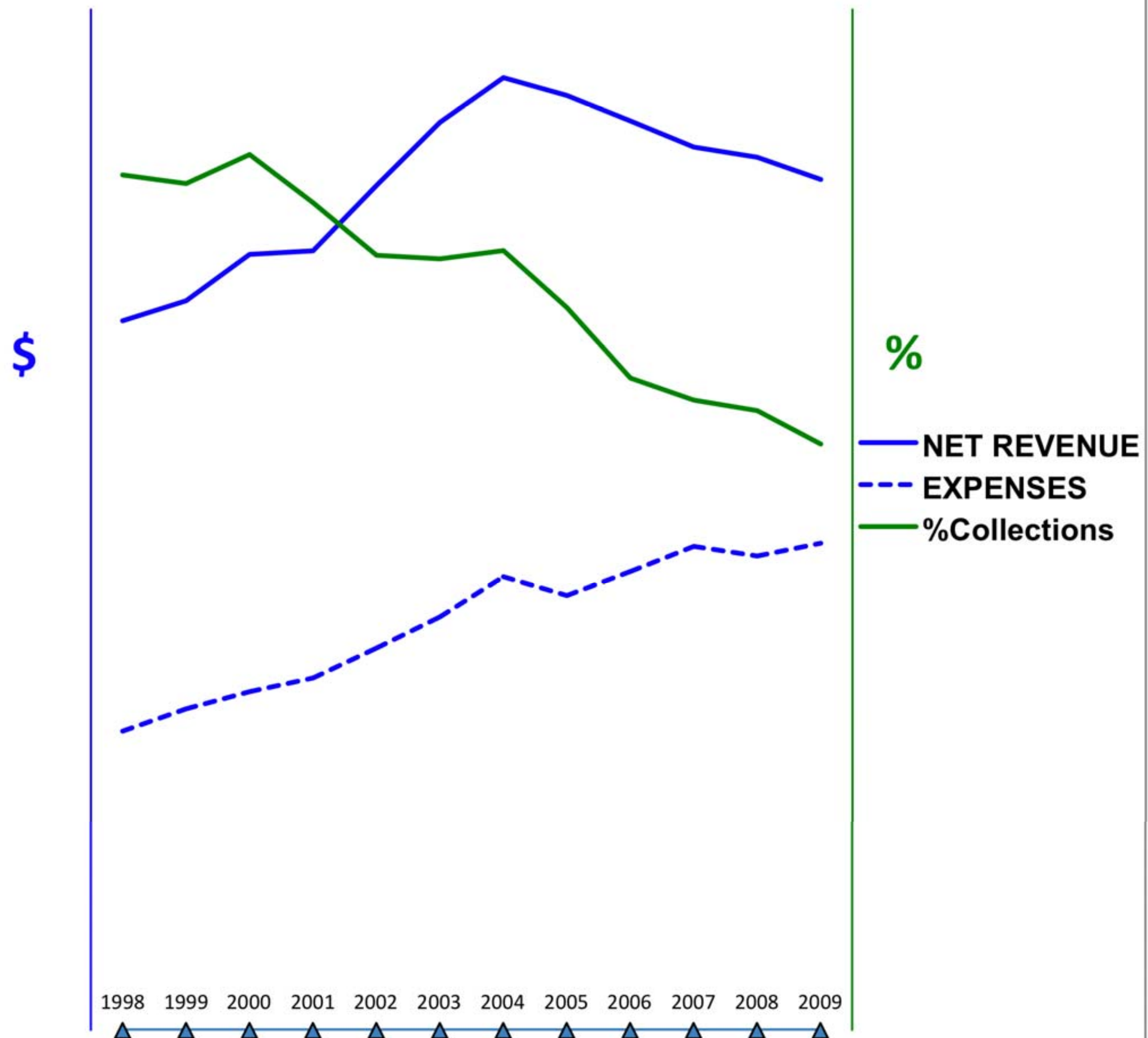
Time will tell whether the incentives are

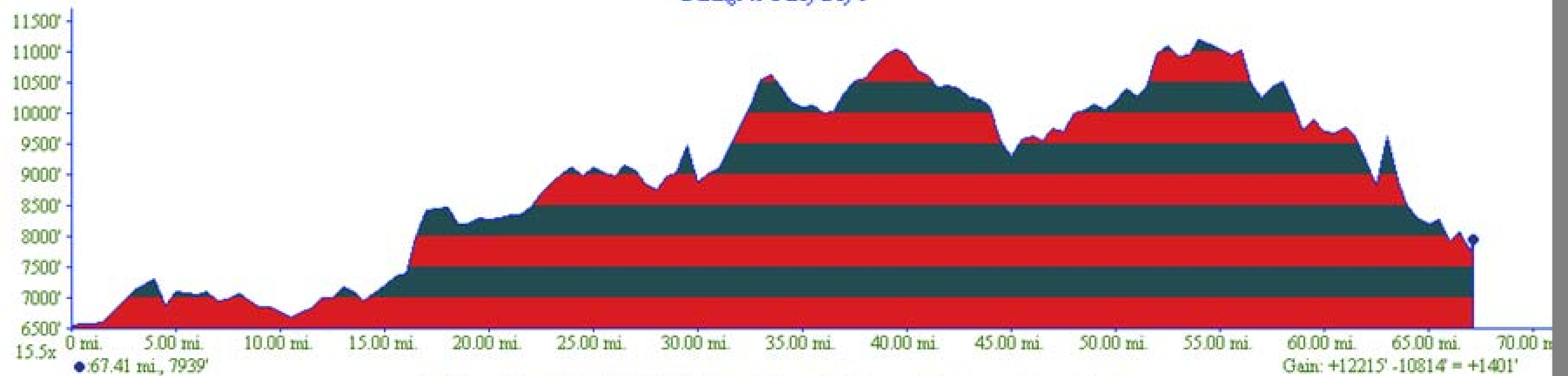
See **COOPERATION** page 21

What do we know for sure?

- Collaboration between hospitals and physicians will be critical (IDS)
- Focus on improving clinical outcomes
- Cost is a measure of quality
- Must add value
- Demand rather than supply driven
- Must be able to measure and enable change (Pinnacle)

Does this look familiar?

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Triple Aim

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce, or at least control, the per capita cost of care.

Source: IHI

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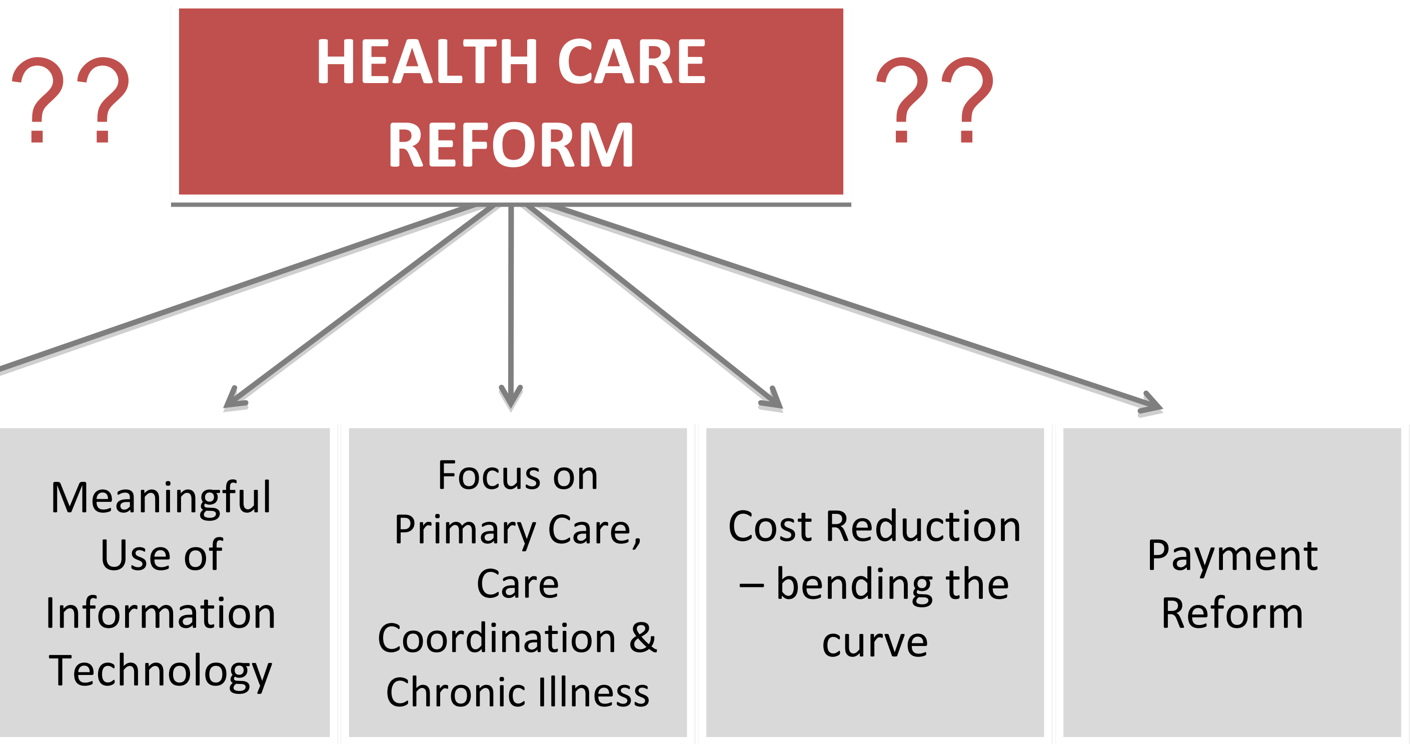
What are the patient and payor expectations?

- Collaboration and coordination between providers
- Eliminate ineffective care
- Physicians as the care champions and team leaders
- Payment tied to outcomes

Health Care Reform

Emphasizes Improved Access, Innovation and Cost Reduction



Physician Concerns

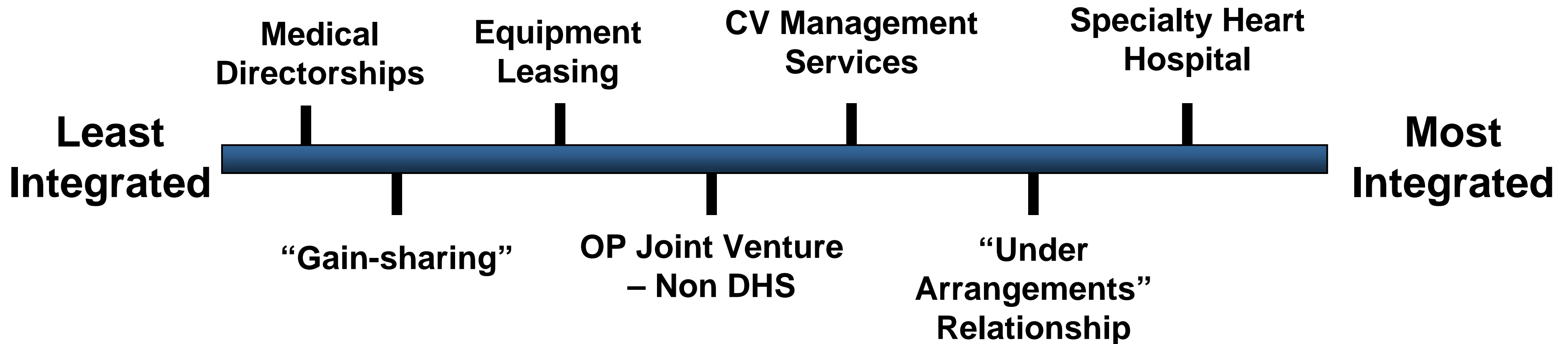
Partnership Rationale

"Why are you doing this?"

- ❑ Yesterday: Defensive - Threat of losing business
- ❑ Today: Offensive: Combining skills of physicians and hospital and aligning economic interests leads to:
  - Improved quality
  - Increased efficiencies/cost reduction
  - Increased services and access to community

TRG

Spectrum of Partnerships (historically)



TRG

General Models

- Contracting
- Leasing
- Employment

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Activity among Indiana practices …

18 practices have integrated into a hospital system

3 are in discussions about hospital integration

2 practices have merged with another practice

1 practices are in discussions about practice mergers

Helping Cardiovascular Professionals
Learn. Advance. Heal.

From ACC CV Practice Census, 9/2010

Alternatives to Merger

Independent Physicians' Association (IPA)

- Less integration
- More individual control of individual practices
- Various specialty and practice groups
- Need to satisfy FTC issues re: joint negotiation
- Need to create efficiencies that benefit consumers and competition

Clinical Integration programs

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From Sanders and Allen, Cardiology Jan-Feb, 2010

2009---

65% of established physicians and 49% of new physicians have joined hospital owned practices.

From MGMA, reported in Hospitals and Health Networks, 9/20/2010

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Reasons Behind Integration Development (MedAxiom)

- Belief that reimbursement trends favor a hospital centric model
- Wanting to improve reimbursement for diagnostic services
- More influence over the CV service line in the hospital/healthy system
- Protection by the hospital in an increasingly competitive market
- Hospital fears and strategies that enable the practice and hospitals to work together to reach common goals in practice style, income and lifestyle
- Capital for growth of CV service line
- Practice culture changes including younger physicians desiring a more balanced lifestyle that includes more vacation and family time
- Regulatory restraints
- Market pressure due to most groups aligning with a hospital
- Need for bundled payment
- Access to hospital employed primary care physicians.

From 2010 Hospital Integration Survey, MedAxiom

Why Physician Integration?

1. Focus is alignment with physicians around quality, outcomes, service, access, and cost
2. Ensure the community's access to physician services
3. Today's regulatory environment provides opportunities for economic incentives in an integrated (employment) model that are not available in other care delivery models
4. Tomorrow's reimbursement is increasing reliant on quality and outcomes measurements and the integrated delivery model significantly improves chances for success
5. Our operating environment is increasingly data dependent and common information technology will drive both quality and efficiency
6. Parkview recognizes that independent practice models are and will continue to be very important to our future

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Implications with Stark Statutes

If you have a financial relationship with an entity, then you cannot refer patients to that entity unless an exception is met………

Independent

- Director requires Personal Service Agreement and FMV
- Part-time employment, productivity and incentive compensation issues

Employed

- Director already has bona fide employment relationship
- Productivity and incentive compensation allowed; FMV
- Incidental benefits (recruitment, marketing, space and supply costs)
- Health system has acquired any referrals the physician might make to the hospital.

Valuation

- Fair Market Value (FMV)
- Methodology
  - Income
  - Market
  - Asset
- Issue of timing

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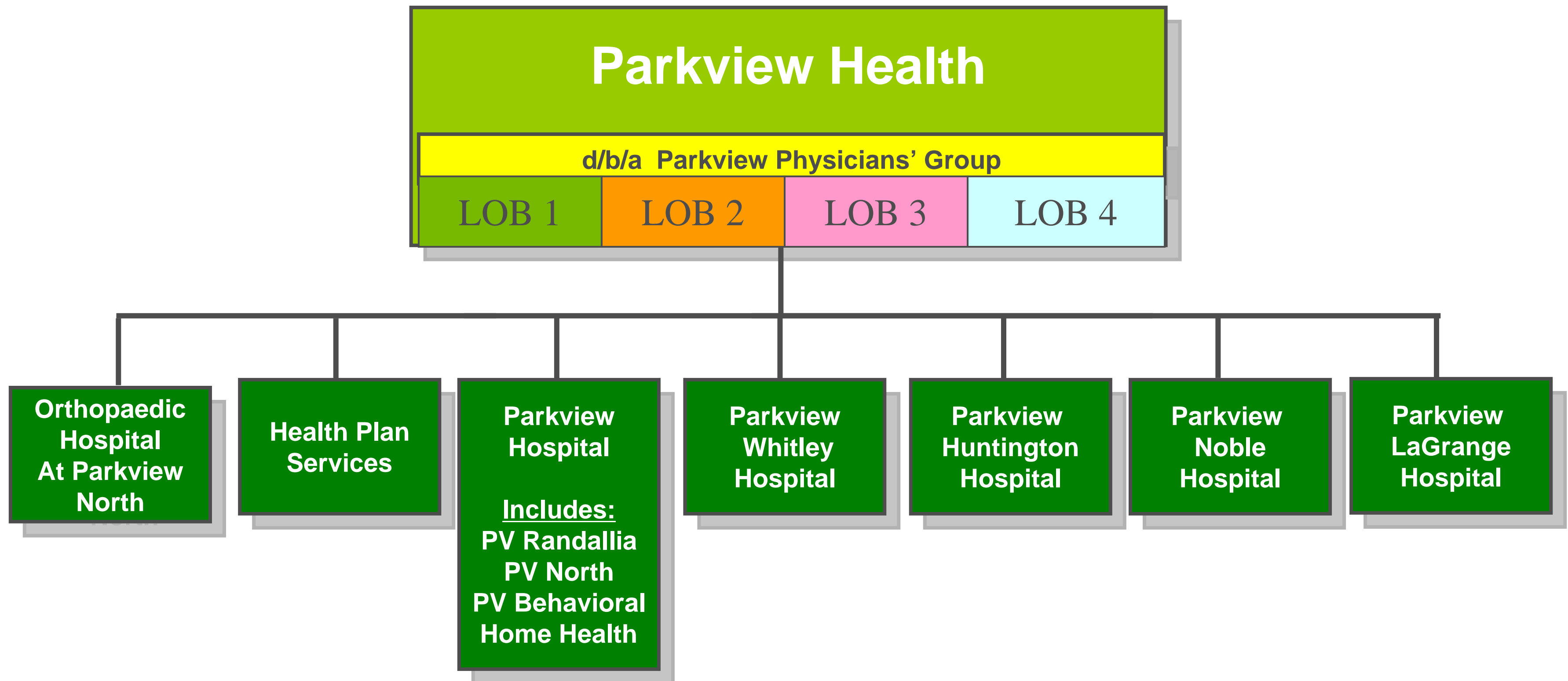
Corporate Organization



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Parkview Physician Integration Goals

1. Growth of primary care and key specialties
2. Retain entrepreneurial spirit of independent practices
3. Physician led governance
4. Leverage on positive aspects of each practice
5. Create opportunity for physician participation in economic success through alignment of goals and outcomes
6. Provide compensation models that support the unique aspects of each specialty
7. Provide compensation models that encourage hospital coverage and outreach
8. Leverage back-office and information systems capabilities
9. Leverage managed care opportunities
10. Provide opportunities for physician investment (real estate)
11. Utilize Parkview capital to grow physician practices and build infrastructure systems that improve quality, service, outcomes, and cost

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Parkview Physician's Group Board of Managers - 15 (11 Physicians, 4 Administrators)												
Exec Comm	Exec Comm	Exec Comm	Exec Comm	Exec Comm	Exec Comm	Exec Comm	Exec Comm	Exec Comm	Exec Comm	Exec Comm	Exec Comm	Exec Comm
Primary Care Clinical Quality Committee				Specialist Clinical Quality Committee								
Electronic Medical Record Committee												
Parkview First Care (Allen County)	Parkview First Care (Communities)	ParkviewSpecialty Phys-Inpatient	ParkviewSpecialty Physicians-Pysch	ParkviewSpecialty Physicians-Comm	Northeast OB/GYN	FWCVS	NEICRS	FWC	FW URO	Rheumatology Associates	Parkview Gastroenterology	Parkview Pulmonary
Billing and Collections												
Information Systems and Desktop Support												
Administrative Support												

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Growth - PPG

PPG by the Numbers

- 2007 – 45 physicians
  - 39 primary care, 7 specialists, 4 NPP
- 2008 – 60 physicians
  - 53 primary care, 7 specialists, 5 NPP
- 2009 – 120 physicians
  - 80 primary care, 40 specialists, 10 NPP
- 2010 – 192 physicians
  - 100 primary care, 92 specialists, 25 NPP

Leverage by Hospital System Employer

- Importance of employed PCPs to specialty partners
- Resources directed preferentially to employed MDs
- Privileges with employment under Stark
- Market position
- Capital support to employed MD group
  - Less legally complex
  - Less expensive to support operational and strategic management activities
  - Greater degree of long term organizational commitment

From Healthcare Advisory Board, 2010

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Critical Integration Success Factors

1. **Development of formal physician leadership.** Systems require strong top-level physician leadership, where the physicians are part of the leadership team and are included in decision making.

2. **Creation of a shared vision & culture.** Physicians see their role as practitioners in relationship to the organization as a whole, widespread mutual respect exists between physicians and administrators.

3. **Collaboration between PCPs and Specialists.** Essential to maximize geographic reach and referral capture.

4. **Commitment to information sharing & process improvement.** Access to advanced clinical information systems and implementation of quality initiatives provides opportunities to produce best clinical outcomes, and reward improvements in services, quality, and efficiency.

Barriers to Success

What are potential barriers to the success of our strategy?

- Lack of physician engagement in improvement
- Poor communication
- Timid leadership
- Physician mistrust of leaders and resentment of change initiatives
- Hospital – physician cultural differences
- Under-investment in clinical staff and employees
- Under-investment in clinical technology
- Under-estimation of intensity of change process
- Inability to sense and adapt to market changes
- Competitive response in the marketplace
- Political landscape

Parkview Health Priorities

1. Develop and implement clinical care models that align Parkview Health and PPG service lines and priorities
2. Provide for ease of navigation and access among all care delivery sites
3. Engage both employed and otherwise aligned physicians on the business side of health care delivery
4. Align, coordinate and manage the connections among all the clinical divisions of Parkview Health

PPG Measures of Success

The work continues----

- Governance
- Leadership
- Practice Experience
- Clinical Delivery

PPG is a new entity and must be different than its parts.

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