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Optimal Alignment and Integration: Satisfying the Goals of Hospitals and Physicians Alike

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Introduction

To successfully manage the transition from a volume to a value based business model, in the future reformed healthcare environment, hospitals and healthcare systems (hereafter referred to simply as hospitals) will need to effectively align and integrate with their medical staffs. Unfortunately, the mechanism by which this is done is not well understood and many hospitals and physicians find themselves in a stalemate situation where they realize that moving forward in this arena is necessary but knowing how to do so without incurring intolerable risk is not well defined. This paper will outline a methodology that, if followed, will allow these groups to join together in a mutually beneficial fashion and successfully traverse the many challenges ahead.

I. Integration

One of the problems with analyzing hospital – physician relationships is the muddled nomenclature that is used to describe the ways that these two groups come together both functionally and structurally. The most popular term, used quite freely today, is ***integration*** or, more often, ***clinical integration***. This term describes a merging of the clinical and business models of the hospital with its affiliated physicians. Here, hospitals and physician staff work together within a common structure to accomplish mutually agreed upon goals particularly related to quality improvement and cost efficiency. Within this structure, which will be defined more clearly in later sections, the physicians and hospital staff often share in governance, planning, decision making and, most importantly, the delivery of health care services. The two entities also share in any of the risks of this enterprise, both upside and downside. Finally, while the organizational elements of integration are important, integration, as defined here, is more of a functional than a structural concept.

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The goals of integration are usually defined quite simply as those included in "The Triple Aim" first popularized by Berwick et al at the Institute for Healthcare Improvement. These goals of high quality clinical care for the individual patient, improved health for the population and lowered costs for the system as a whole can be further broken down and described functionally as those tasks in which hospitals join with physicians to do the following:

- Improve quality and patient safety
- Improve the patient experience
- Drive cost efficiency
- Grow market share
- Innovate and research new care delivery methodologies and technologies

It should also be emphasized that clinical integration is not the only type of integration required in a successful hospital / physician integration program. Indeed, as the adage goes, culture tends to trump strategy every time and cultural integration may be the most important element in any integration effort. Furthermore, some degree of ***legal and* economic integration** must occur for hospitals and physicians to truly integrate in a viable fashion.

As for the structure of an integrated hospital / physician entity, the landscape is literally littered with acronyms used to describe the various models used. The Patient Centered Medical Home or PCMH, the Accountable Care Organization or ACO, the Clinically Integrated Network or CIN and the Quality Collaborative or QC are all organizational structures within which integration can occur. While each of these have certain unique features, their commonalities, rather than their differences, should be emphasized. In fact, the differences in these bodies have more to do with their specialty makeup and association with certain organizations, such as CMS, whose shared saving's program is now fairly synonymous with the term accountable care organization.

The common purpose of all these entities can be described as driving higher ***value*** to the consumer of healthcare services, where value is defined as quality outcomes per dollar of cost. As has been highly publicized, the value of healthcare services delivered within the US is woefully behind most other developed countries, many of which rely on more state owned healthcare delivery systems. The reliance on free markets, private insurance companies and employer sponsored health plans in this country is unlikely to be replaced anytime soon by wholesale expansion of Medicare and Medicaid into a single payer, government directed system and in many respects this is a good thing. Nevertheless, reforms within the government run system are coming and will have significant ramifications for providers, payers and patients regardless of whether they participate in one of the federal or state supported programs.

These reforms will hopefully bring many benefits to patients such as access, quality and more coordination of care. Likewise providers should benefit with diminished responsibility for unfunded patients and a more satisfactory work environment. Finally, employers should see a much better cost / benefit ratio reflected in their premium payments.

Perhaps the most important and beneficial aspect of the integrated care delivery model is the enhanced coordination of care that will result. Providers now work in silos with staff performing separate duties and contracting for services in isolation. Meanwhile, quality improvement efforts have been focused mostly on hospitals and particularly the acute inpatient care arena where, even when present, the quality metrics are not uniform or significantly reliable and trustworthy.

Bringing hospitals and physicians together into integrated networks or care organizations will create a higher degree of interdependence and collaboration between providers. Once this happens, greater efforts can be directed toward the development of patient centered, clinical initiatives that provide a more satisfactory, high value coordinated care experience across the geographic, specialty, age and time continuum. This will result in more demand

for similar services and those systems that can meet this demand will be rewarded and able to fund further improvements in the currently far too fragmented, provider centric, unreliable and acute care focused system that exists today.

Creating such an integrated system will require those physicians and hospitals that undertake this challenge to develop many core competencies and key areas of expertise. The "right" leadership must be in place from both the hospital and physician side, i.e. those types of visionary, change agents who can embrace and learn new skills such as operations management, process improvement, risk management, quality improvement and measurement, care management, cost accounting and perhaps, most particularly, the use of new technology such as the electronic health record or EHR, health information exchange, smart phones and population health data and analytic systems.

II. Alignment

The above definition and description of an integrated physician / hospital arrangement now needs to be contrasted with ***alignment*** between hospitals and physicians. In an alignment model, the physicians and hospitals work in parallel structures to achieve common goals and objectives. These parallel structures do not merge but, instead, align their efforts through transactional agreements that facilitate the two parties working towards common purposes.

The goals of alignment tends to be more tactical than strategic and revolve around hospitals and physicians avoiding ruinous competition, reducing or eliminating obstacles to joint success, recruiting for top talent and incentivizing desired behaviors.

Similar to integration there are also various types of alignment, however, their order of importance is reversed. While cultural integration and clinical integration are the higher

priority activities in an integrated model, legal and economic alignment take precedence in an alignment situation.

Alignment plays out through a variety of structural models ranging from simple medical staff membership to professional services agreement (PSA) or management services agreement (MSA) arrangements between hospitals and its affiliated physicians to full employment by hospitals of physician staff.

One of the most common structures through which alignment occurs involves professional service or management service agreements which some authors have labeled **"employment lite".** The purpose of these PSA or MSA agreements is to achieve some degree of alignment between hospitals and physicians without the hospital having to bear the risks inherent in a full employment model. This type of relationship allows for the hospital to contract for specific services, either directly or indirectly related to clinical care, with its affiliated physicians. These services may include call coverage, participation or oversight of quality improvement efforts and administrative or "medical director" services. Payments for direct clinical care are usually made on a top-line basis per wRVUs while payments for other wraparound services such as call pay; medical directorship services etc. may take other forms.

There are four possible ways of structuring an "employment lite" or PSA / MSA agreement. These different scenarios differ in how the professional services or management services are allocated between the two parties. In a traditional PSA model the hospital contracts with physicians for professional services and then employs the physician's office staff and "owns" their administrative or management services organization (MSO) structure. In a global payment PSA the hospital contracts with a physician practice who is paid a global payment for both professional and management services. In a practice management arrangement the physicians maintain ownership of the practice while becoming employees of the hospital, they then contract with the hospital for oversight and management of the office staff and office operations. The final option is what is known as a hybrid model where

the hospital employs the physicians and both entities jointly own a medical services organization or MSO who manages the practice.

All of the "employment lite" or PSA / MSA models outlined above bring advantages to the parties involved that include a flexible structure, the opportunities to increase and enhance the bottom lines of both participants, enhanced stability of the hospital – physician relationship, bonus opportunities for exceptional performance by the providers, opportunities to expand services together and a transitional structure from which it is easy to segue into a full employment model.

III. Optimal Alignment and Integration

The question then arises as to what is the optimal mix of integration and/or alignment, as outlined above, for a hospital system or physician group wishing to succeed in a reformed healthcare economy? This question has no single answer and will need to be customized according to the following considerations that are unique to each situation:

- How much of a shared vision exists between the two parties (i.e. the hospital and the physicians)?
- How much trust exists between both parties?
- How much tolerance for risk does each party bring to the relationship?
- How financially strong is each party?
- How much responsibility (command and control) is each party willing to share?
- How much resistance to change does each party possess?
- How much willingness is there to share profits and losses equitably?

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Within the alignment realm, things may get stymied by the hospital's fears of taking on a disproportionate share of the financial risk, their distrust of physicians, their lack of adequate capital to fund full employment or even "employment lite" and negative feelings towards certain physician groups that may have stemmed from past events such as failed primary care ventures, or competitive interactions in areas such as ambulatory surgery centers or GI labs. At the end of the day, hospitals may realize that their goals and objectives are simply too far apart from their physician affiliates to provide for successful alignment.

Similarly, on the physician side there may be resistance to alignment that stems from a fear of losing autonomy, distrust of the hospital, negative residual feelings from prior interactions such as employment, JV's or competition, lack of confidence in the hospital's management capabilities and a fear of becoming entangled in a large bureaucracy. Here again, the lack of a common compelling vision with the hospital may prevent trying to overcome these obstacles and points of resistance and alignment becomes impossible.

Many of the same obstacles, listed above, can also stand in the way of effective integration between hospitals and physicians. Residual distrust from past relationships, unwillingness to equitably share risks and rewards and lack of a common vision for the future can detail an integration effort before it even begins. Interestingly, failure to understand the distinctly different objectives of alignment and integration can also lead to failure in an integration model and therefore, the unique purposes of both alignment and integration need to be well understood by both parties.

Alignment efforts, particularly employment or "employment lite" arrangements, work well to facilitate a volume based, fee for service business model where incentivizing production is one of the primary goals. Integration efforts, on the other hand, are geared more towards a value based business model where the goals are to build systems that reliably produce high quality / highly efficient healthcare services that can then be reimbursed

under new payment models such as bundled payments, shared savings agreements or even capitation.

The different features and advantages of hospital – physician alignment and integration are outlined further in the following table:

IV. Implementing and Operationalizing Optimal Integration

The details of the separate alignment models, whether through PSA / MSA agreements or employment have been well outlined elsewhere. Some details regarding the separate integration structure however, warrants more discussion here.

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Funding for the startup of a separate integration structure can come from a variety of sources. Hospital or healthcare systems might fund the startup of this entity through a loan arrangement that is paid back over time as operational revenues into the integrated network begin to flow. Alternatively, both the physicians and hospital could put up seed money to get the integrated organization off the ground. Finally, a third party such as an insurer, a private equity firm or even a publically traded company could supply upfront investment dollars.

Whether the legal corporate structure is set up as an LLC, a 501 (c) (3) corporation or a wholly-owned subsidiary of a third party investor will depend on a number of factors unique to each situation. More important than its corporate structure, will be the legal underpinnings of the entity such as its governance and committee structures, its operating and participation agreements and its accountability / remediation system. Finally, it should be emphasized that any entity, wishing to jointly contract for a group of physicians who do not all share a common employer, is advised to seek legal counsel and advice from attorneys familiar with the formal and informal opinions rendered through the Federal Trade Commission and Department of Justice about these types of arrangements.

Once the startup funding is secured and the legal framework for the integration program is built then operations can begin. Critical to this stage of the organization's development will be setting up the financial operations, to include budgeting, accounting, contracting and bonus distribution, in a way that both parties perceive as fair and equitable. Next on the list of developmental priorities will be the creation of a strong IT infrastructure that can facilitate information flow, performance measurement and data analysis. Finally, most organizations will find that successful clinical integration and value driven care delivery will require an extensive case management infrastructure, to include disease management, health education, social work services and care navigation.

Once fully operational, an integration program's overarching goal will be to improve value production to benefit the healthcare consumer. Just to reiterate, value is defined as quality

outcomes per dollar of cost. While the following list is not all-inclusive, value production will depend on a number of activities to include:

- Monitoring of quality and efficiency metrics
- Care process design and clinical transformation
- Seamless coordination of care
- Population health management
- Elimination of waste and inefficiency
- Enhancing the patient experience
- Enhancing the provider experience
- Partnering with or acquiring payer / risk management capabilities
- Branding and marketing of the integrated entity
- Contracting for value enhanced services
- Innovation, research and development of new health care services and operations

V. Separation of Alignment and Integration

Traditionally, hospital – physician alignment and integration has played out in a sequential fashion in most organizations. The problem with this is that if obstacles arise that prevent effective alignment between a hospital and its physicians then integration efforts cannot go forward. Clear separation of alignment and integration activities and simultaneously proceeding with both can avoid the occurrence of this kind of stalemate situation. Keeping alignment activities, such as employment or contracting for professional services, totally separate from integration activities, such as formation of an ACO or PCMH, allows one to proceed independently from the other at a pace and in a fashion agreeable to all involved.

On the hospital side, the system will be allowed to pick and choose the alignment models it wants to use with particular physicians and mitigate the overall stress on its balance sheet by avoiding employment of large numbers of physicians. While fewer physicians may be

employed, physician engagement in value production will still be possible and, in fact, the hospital may find that it can more quickly bring an effective employed or clinically integrated physician network to scale in this fashion than through a more traditional sequence. This speed to market will also allow the hospital to more quickly respond to value based reimbursement models such as shared savings, bundled payments or capitation. In the end the hospital system that follows this approach will find itself clearly differentiated from other hospitals in the market and therefore at a distinct competitive advantage.

As for physicians, this model will allow those that wish to maintain their autonomy, to be able to do so while still leaving open the option of participating in joint hospital-physician activities, such as bundled payment contracts, internal referral networks, discounted pricing for IT and other group purchases and access to marketing dollars, that may be of benefit.. Finally, physicians who choose to integrate will be able to slow the seemingly never ending production treadmill and practice in a more satisfying environment that rewards value production and appeals to their original motivations for choosing a career in medicine in the first place.

VI. Solution and Conclusion

While hospitals and their affiliated physicians recognize the need for tighter relationships that facilitate physician's engagement in both the clinical and business enterprise of the system, there are often unresolvable differences between these two groups that prevent them from proceeding with either optimal alignment or integration.

A solution to this stalemate is to separate alignment from integration and allow each to occur independently of the other. This alternative to the traditional approach where alignment and integration are done together, should be strongly considered by hospitals and physician alike who are truly interested in joining forces to achieve success either in

the current predominantly fee for services, volume based, reimbursement model or in the future more value based, population health management, business model.

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