Successful Physician-Hospital Integration – A Case Study

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Speaker bio

**Nick Fabrizio, PhD, FACMPE, FACHE** is a Principal Consultant with the MGMA Health Care Consulting Group. Dr. Fabrizio has over 20 years of practice management and health system experience in private physician and large medical group practices, for-profit and non-profit hospitals and health systems, academic medical centers, physician faculty practice plans, as well as ambulatory care networks. His primary expertise is in physician practice management and managing complex physician-hospital relationships and clinical enterprises in a broad range of environments. This includes helping align the interests of physicians and hospitals to optimize business and operational performance while achieving financial, quality, service, and market goals.

Dr. Fabrizio currently serves on the faculty at Cornell University in the Sloan Graduate Program in Health Administration where he teaches Management and Organizational Behavior and Human Resource Management. In addition, Dr. Fabrizio served on several boards including the New York State Medical Group Management Association, where he served as president, and was the Regent for the American College of Healthcare Executives serving the New York Empire Area. He is an author of numerous publications and frequent speaker at national conferences. He has published two books, *Goals into Gold: Strategic Planning for Healthcare Professionals*, published in 2008, and his latest book, *Integrated Delivery Systems: Ensuring Successful Physician-Hospital Partnerships*, published in 2009.

He has served a wide range of clients throughout the United States, including medical groups ranging from one to more than 800 physicians, community hospitals, and national hospital systems. He has also worked with several integrated delivery systems, faith-based systems, for-profit and not-for-profit foundation medical practices, and management services organizations.
Learning objectives

1. Examine the various components influencing integration movement

2. Review the key components guiding successful integration

3. Review the impact of strategy, governance, culture, and communication
Winds of change

Prepare for Industry Consolidation

✓ Strong, independent providers are now re-evaluating their ability to stand alone – high cost structures, compensation plans not sustainable, etc. Those most at risk are those in need of capital or intellectual capital.

✓ Many of the weaker providers and groups have been pushed over the edge and are now turning to divestiture as a survival strategy and a means to carry forward the organization’s mission.

✓ Some larger and stronger systems are looking at the economic downturn as a time to re-evaluate their portfolio of operations – pursuing opportunities to consolidate the market as well as divesting underperforming businesses (reallocation of cash and other resources).
Where we may be headed

Cumulative Percent Change Since 2001 for the Medicare Physician Payments, Not Hospital/IDS-Owned Multispecialty Group Operating Cost, and the Consumer Price Index

- 2012, 2013, 2014 median operating cost values are three year moving average projections of previous years’ data.
- July 2012 CPI reported value. The 2013 CPI figure is a three year moving average projection of previous years’ data
- Assumed reduction figure

Assumes a 30.0% reduction

Projected

- 59.2%
- 61.3%
- 61.5%

- 26.5%
- 27.6%

- 3.7%

- 30.0%

- 2.9%

- 2.9%

- 2.9%

- 3.9%

- 26.5%

- 27.6%

- -27.4%

Annual Medicare Update  CPI  Total Operating Cost per FTE Physician

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Why are we doing this?

<table>
<thead>
<tr>
<th>Stabilize Market</th>
<th>Gain Leverage-Growth</th>
<th>Transform Care</th>
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<tbody>
<tr>
<td>• Retain physicians who might leave</td>
<td>• Capitalize on key specialties (primary care, ortho, OB, etc.)</td>
<td>• Provide stronger incentives for physicians to use cost-effective treatments &amp; facilities</td>
</tr>
<tr>
<td>• Partner with physicians for care to underserved</td>
<td>• Weaken competitors</td>
<td>• Reward physicians for governance and quality</td>
</tr>
<tr>
<td>• Recruit physicians for gaps in care/for those who have left</td>
<td>• Recruit additional physicians to capture market share</td>
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### Who is your partner?

<table>
<thead>
<tr>
<th>Hands Off School</th>
<th>Command &amp; Control School</th>
<th>New School</th>
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<tbody>
<tr>
<td>• Avoid medical staff confrontation</td>
<td>• Hospital interests always come first</td>
<td>• Operate with transparency</td>
</tr>
<tr>
<td>• Agree with all physicians with little progress</td>
<td>• Create bureaucratic policies and procedures</td>
<td>• Costs and revenue are known</td>
</tr>
<tr>
<td>• Talk about how and why we are different</td>
<td>• Decision making without physician involvement</td>
<td>• Physician leader is valued and respected</td>
</tr>
<tr>
<td></td>
<td>• Physician leader is thought of as hospital administrator</td>
<td>• Committees have physician representation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Joint standard setting</td>
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<td></td>
<td></td>
<td>• Respond to evidence, not panic</td>
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</table>
Relationships between hospitals & physicians are being tested

- Increasing competition between hospitals and private physicians (real and perceived)
- Demands for greater transparency
- Pay for performance reimbursement approaches
- Regulatory requirements are increasing
- Physicians are not as interested in an organized medical staff at the hospital (committee work for free)
- The rise of hospitalists
- Migration of physicians from inpatient to outpatient settings (loss of connection)
The Medical Group’s case for integration/alignment

- Need to recruit additional physicians places a risk on existing physicians
- Newer physicians want predictable hours and an income guarantee
- Declining reimbursement, higher malpractice costs, increased regulatory burdens, practice expense stress financial viability of independent practices
The Health System’s case for integration/alignment

- Large employers and Medicare are moving to bundled payments, single price contracting, and pay-for-performance
- Quality patient care
- Alignment of financial incentives
- Improve quality
- Solidify relationship with physicians
- Long-term success of the healthcare system
ACME Medical Clinic, P.C.

- **History**
  - Incorporated as PC in 1968
  - Started at county hospital

- **Facilities**
  - 5 clinic locations
  - 4 ancillary service locations
  - 2 business offices
Vital Statistics

- 73 physicians
  - 14 Overseas
- 20 mid-level providers
- 250 total employees
- 210,000 patient visits per year

Medical & Surgical Specialties

Family Practice
Hospitalist
Internal Medicine
  - Infectious Disease
Critical Care/Pulmonary
Public Health
Pediatrics
OB-GYN
General Surgery
Mission Statement: To be the leader in safe, high-quality, patient-centered, compassionate, health-related services

Takeaway: Know your mission statement and understand how it does and does not relate to your partner’s mission statement
ACME’s pre-integration level of integration/alignment

- Recruitment Assistance
- Physician Leadership
  - Board
  - Senior Leadership Team
  - Medical Directors (20)
- XYZ Care – Physician-Hospital Organization
- Exclusive Contracts Hospital-Based Services:
  - Emergency Services – Anesthesia
  - Hospitalists – Radiology
  - Intensivists – Pathology
- ACME Employed Physicians (10)
The Challenges

Physician Group
- Long-term financial success including compensation
- Recruiting challenges
- Maintaining mission, values, and culture
- Ensuring physician leadership

Health System
- Integrating a large physician practice
- Integrating a faith-based medical practice
- Allocation of resources – investment in integration
- Transition of health system leadership
Structure of legal entities and relationships
Approved February 2010

XYZ Regional Health System
501(c)(3)

Ownership & Reserve Powers

ACME Medical Clinic Physicians, Inc. (Non-Profit)

- Physicians
- Mid-Levels

XYZ Physician Care Network (Non-Profit)
- Physicians
- Mid-Levels

XYZ Medical Practices, Inc (For-Profit)

XYZ Health Partners (For-Profit)

XYZ Health Ventures (For-Profit)
Governance structures

XYZ Regional Health System

Board of Directors

(Same Persons on Both Committees)

XYZ Health Partners

Bd. Of Dirs. (Finance Comm)

ACME
Bd. of Dirs.

XYZ Medical Practices, Inc.
Bd. of Dirs.

XYZ PCN
Bd. of Dirs.

XYZ Health Ventures
Bd. of Dirs.
Management structure – ACME Medical Practice

Mr. Smith, FACMPE
VP ACME Physician Practices

Research Coordinator
ACME Physicians
Director Practice Operations
Senior Physician Practice Consultant
XYZ Physicians
Practice Managers
Benefits of integration/alignment

- Aligned incentives
- EHR
- Coordination of care/services
- Reduced costs
- Recruitment and retention of physicians
- Financial sustainability and long-term success
- Contracting leverage (critical mass)
- Adaptability
Benefits of integration/alignment

For patients

- Access to care
- Coordinated, quality care
- Prevention of excessive duplication of services
- Seamless access to records
- Care aggregation
Key challenges of integration/alignment

- Maintain faith-based values in a secular non-profit health system
- New identity for group Board of Directors
- New management structure – reporting relationships
- Decision making in a larger organizational structure
- Managing expectations – physicians, medical group staff, hospital administrators
Merger and acquisition phases

1-3 months
- Pre-Merger Planning

3-6 months
- Due diligence

6-10 months
- Merger Planning – legal, financial, operational and strategic planning. Physician compensation and contracting

1-2 years
- Implementation and course correction strategies
Pre-merger cultural assessment

- Expectations
  - Decision-making styles
    - Incentives/disincentives
- Beliefs
  - Administrative & Physician Leadership
    - Financial indicators
- Core values
  - Communication styles
    - Tangible & intangible assets
Key challenges of integration/alignment

- Valuation
- Compensation
  - Hospital
  - Medical Group
- Governance
- Relationship to other employed doctors/groups
- Exit clause
- Negotiating the deal
Legal and Business

- Identify legal and operational structures that are acceptable to each side
- Present the pros and cons to various models
- Educating hospital and medical group boards
- Educate the health system board – “Physician-Hospital Integration 101”
  - One-on-one discussions with board
  - Board meeting
- Educate the physicians – Hospital Administration 101
  - Budgeting, HR, equipment purchases, etc.
- Other options for physicians and hospital?
The consultants’ role

- Communication
  - Establish a joint planning committee (medical group and health system administration – must be decision makers)
  - Establish forums to communicate decision items back to larger constituents
    - Compensation, contractual terms, deal breakers and non-negotiables, reason for the relationship
  - Continue to discuss mission, vision, goals, short- and long-term goals and benefits of integration
The consultants’ role

- Facilitation/Negotiation/Mediation
  - Planning committee meets every 4-6 weeks to review homework assignments
  - Mediate non-negotiables (compensation, terms, valuation)

- Compensation
  - Short- and long-term goals
  - Methodology
  - Designing a compliant compensation plan
  - Fair market value
  - Match desires to goals

- Keeping momentum – closing the deal!
Timeline & key milestones

**Due Diligence, Business and Legal Preparation**

**March 2010**

- Proposal
  - Jan 2010

- Project Begins
  - March 2010

- BOD Meeting
  - May 2010

- Mediation
  - August 2010

- MOU
  - November 2010

- Implementation
  - January 2011
Governance stages of maturation – integration

Integrated billing, collections, recruitment, quality, system revenue

Operations

Budgeting, Operations & Strategic Planning

Physician Recruitment & Termination

Individual Group Management (me for me)

Quality is group specific

Mature

Emerging
Keys to success

- All integration is local
- Trust
- Shared values
- Open, transparent communication
- Vision for the future
- Willingness to change
- Physician engagement in leadership
**Planning process for Phases I, II & III**

**Key Tasks**

- Establish routine meetings;
- Give homework to all;
- Determine how costs are to be allocated;
- Active participation of all physicians;
- Report outcomes as needed;
- Identify key issues to enable the respective parties to make a “go/no-go” decision about moving forward;
- Participative process with focus on designing the right model – no pre-determined outcomes. The model that worked for your friend may not work here!
Planning process for Phases I-IV

**Phase I**
- Select planning committee members
- Develop list of deal-breakers
- Determine why you want/need this
- Identify key issues moving forward

**GO**

**Phase II**
- Model education
- Practice valuations
- Compensation methodology
- Financial modeling
- Review deal-breakers list
- Next steps

**NO-GO**

**Phase III**
- Agreement in principle
- Employment agreements
- Finalize compensation plan
- IT/Operational integration
- Binding commitments

**Phase IV (post integration)**
- Refine compensation plan
- Update framework for additional physicians
- IT issues
- Governance
- Tools
- Structural

9 – 12 months

1 – 12 months...
Where are they today – post integration?

- Integration has not stopped with this arrangement (additional practices integrated)
- Legal structure(s) continues to evolve
  - current practice, new practices coming in, board seats, governance structure
- Diversity in compensation plans (standardize compensation, benefits, etc.)
- Physician survey
- Still learning how health system operates (budget process, strategic planning, etc.)
- Productivity increased 9.5% (above MGMA median)
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