What trends are driving hospital-MD alignment?

Hospitals have aggressive cost reduction goals coupled with more quality incentives.

“In the past, we would hear of goals in the millions of dollars,” says Lani Berman, MPH, MBA, senior vice president, performance services for VHA Inc. Today, she says goals are often in the hundreds of millions, especially for large health systems.

“To reach these aggressive numbers, you have to reach beyond pricing and standardization,” Berman says. Hospitals know they need support from physicians. An average-sized community hospital could lose more than $1.4 million annually starting in 2013 due to poor quality scores, notes a PricewaterhouseCoopers (PwC) report on hospital-physician partnerships.

At the same time, more than half (56%) of physicians PwC surveyed said they want to align more closely with hospitals to increase their income.

A megatrend
Physician employment “is a megatrend—in most cases, it’s going to be the model,” says Ken Mack, an independent consultant with long experience forging hospital-physician partnerships.

“We’ve seen a relatively quick evolution in reimbursement, and that dictates where physicians practice.”

A driving force is bundled payment, expected to become a common model in the next few years. Under this arrangement, hospitals, physicians, and other providers receive a single “bundled” payment for an episode of care, such as a total joint replacement. Medicare is conducting bundled payment demonstration projects. The aim is to encourage more collaboration among providers to deliver more efficient, coordinated care while maintaining or improving quality.

In the meantime, says Mack, depending on the local market, you can expect to see joint ventures, comanagement, and other types of physician partnerships.
Coming full circle
Where surgeons do surgery is coming full circle. Consider a urology practice, for example. Ten or 15 years ago, the urologists’ reimbursement came primarily from hospital-based procedures. Then they joined an ambulatory surgery center (ASC) where they could operate more efficiently and share in the profits.

As technology evolved and reimbursement policy changed, they began taking more procedures into their offices. Now, Mack says, many want to bring their procedures into a hospital-based ASC, where reimbursement is significantly higher.

Sharing in gains
Once surgeons are employed, Mack says, “There are lots of ways to participate in gain-sharing.”

A model he favors both for the short term and long term is comanagement where a physician or group takes a role with the hospital to jointly manage a service line such as orthopedic surgery.

These arrangements can be designed so physicians can earn a bonus for meeting targets, giving them an incentive to participate in projects to manage costs and improve care.

“Clinical comanagement works better than having medical directors,” Mack says. Unlike most directorships, comanagement contracts are formal and typically go year to year with specific, measurable goals. Generally, a third party sets the fair market value for the position to avoid any appearance of an illegal inducement for physician referrals.

Setting goals
This is how a comanagement bonus might work. The third party sets fair-market-value payment range, say $300 to $400 per hour for an orthopedic surgeon. The physician is paid the lower hourly rate but can earn the extra $100 as a bonus for setting defined goals, which might include:

• quality outcomes, such as length of stay or a lower SSI rate
• patient satisfaction
• assisting the OR to meet its budget.

“Under the law, you cannot pay physicians for savings, except under formal gain-sharing,” such as the Goodroe model, he says. But a bonus can be paid for meeting

Alignment models
A PricewaterhouseCoopers survey found 71% of physicians are currently aligned with hospitals on some level, from directorships to employment. Here’s a look at these arrangements.

Employment
Physicians are employed for medical services. In return, either a full-time or part-time salary is paid by a hospital, medical foundation, provider-based clinic, faculty practice plan, or group practice.

Joint venture
In a joint venture between physicians and a service line, such as an ambulatory surgery center, the venture owns the service line and bills third-party payers for patient services.

Comanagement
The hospital contracts with physicians to manage a service line either by direct contract or through a new-entity joint venture.

Directorships, stipends, and management contracts
Under a contractual relationship, a clinician leader provides leadership and administrative oversight.

Gainsharing
A structured arrangement between a hospital and physicians to share savings for a service without jeopardizing quality. The arrangement meets specific criteria set by the Health and Human Services Office of Inspector General.

Program reinvestment
A hospital and physicians collaborate to reach targets for cost and quality for a procedure or service line.

• The project extends beyond supply savings to include, for example, efficiencies, quality metrics, and length of stay.
• If targets are met, no cash payments are made to the physicians. Instead, the hospital shares savings by reinvesting into the service line. The reinvestment may be used for items such as capital equipment, additional personnel, and staff education to enhance the specialty.

the budget, which, of course, includes both cost and revenue.

Comanagement is flexible, in that it can be structured to contract with an individual physician or a group, Mack says.

**Looking to the long term**
He sees forward-thinking physicians starting to say, “I need to partner with a hospital for a long-term relationship.”

They see that if they partner with one health system, they are more likely to be able to influence the OR to become more efficient as well as to improve on their clinical measures than if they operate at multiple facilities.

The PwC report found orthopedics to be the specialty least interested in employment, at 25%.

But Mack says he’s hearing orthopedic surgeons—whom he says tend to be 2 to 3 years ahead of their peers on business matters—approaching hospitals about partnering in other ways.

**Benefits of partnering**
As physicians begin partnering with hospitals and working with OR leaders, they’re realizing they could see benefits. By collaborating on standardized protocols, they may find they can do an additional case because of improved throughput. The hospital might agree to hire an additional physician assistant to help manage orthopedic case flow. They might find ways to streamline the preop process so patients are cleared for surgery in a timelier manner.

Similarly, as surgeon partners begin to see the data on the hospital’s costs, they are more likely to be involved in managing those costs. They are also more apt, Mack says, to go back to their peers and say, “I’ve seen the data. We aren’t going to stock that implant anymore.”

“There is no question orthopedics is going to be bundled,” he says. With arrangements like comanagement, physicians and hospitals will have a way to transition from the current system of discounted fee for service to bundled payment.

“I really believe that with bundled pricing, if you start working now, by the time you need it, you will be true partners,” he says.

—Pat Patterson

**References**
