

Hospital Review

BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

Primary Care Strategy: The Most Important Decisions Hospitals Can Make

By Molly Gamble of Becker's Healthcare

Only a few years ago, a hospital's physician-integration strategy was seen as the major determinant of a hospital's referrals and patient volume. Hospitals acquired physician practices like hungry hippos — quickly and aggressively — looking to boost patient volumes and get a leg up on contracting with health insurers. But, like many things under healthcare reform, that has since changed.

Physicians will still influence referrals — that capability is inherent. But the triple aim of healthcare reform — higher quality care, improved population health and reduced per-capita costs — has made primary care physicians a central component to any hospitals' long-term success. Patrick Easterling, president of Health Management Physician Network, based in Naples, Fla., cannot emphasize the role of PCP-alignment enough. "I believe that developing a strong primary care strategy with engaged physicians can be the single most important decision a hospital or health system can make," he says.

But it's not necessarily an easy one. Hospitals have a few things working against them in their pursuit of primary care physicians, such as a nationwide shortage of 25,000 PCPs — expected to be exacerbated by healthcare reform to 45,000 by 2020. There are also barriers in thought and culture, including tension in hospital-physician relationships, lack of innovation in alignment strategies and close-mindedness towards the

geographic settings of PCP practices. Numerous healthcare experts say the following key concepts can make or break a hospital's PCP-alignment strategy.

Employed primary care physicians — the critical link to accountable care

A 2010 survey conducted by PricewaterhouseCoopers¹ found 48 percent of PCPs were interested in hospital employment — 3 percent more than specialists. Employment was the most attractive alignment model for both PCPs and specialists, with 46 percent most interested in pursuing that model in the next two years. This alignment strategy is particularly attractive to younger physicians who seek financial security, work-life balance and the familiarity of a hospital setting after serving residencies there.

Hospitals can lose anywhere from \$150,000 to \$250,000 per year for the first three years they employ a PCP.² This is typically attributed to a change in productivity as physicians adapt to management changes or re-establish in new practice settings. Traditionally, hospitals stomached the six-figure loss for the long-term gain of influencing referrals back to the hospital and affiliated specialists, but experts say healthcare reform's broader need for PCPs has further reduced hospitals' concerns over initial monetary loss.

"Primary care in a value-based purchasing world should be measured on the ability to reduce costs and help population health," says Barbara Ladon, managing partner of Denver-based Newpoint Healthcare Advisors. "I don't think referrals are being ignored, but the difference is that a financial loss — that's really not where [hospitals are] looking at this point. They're looking at where the overall costs are in the system, and how PCPs can manage the system to reduce those costs," she says.

"Because the PCP is at the core of the value-based purchasing model, they're the link between hospital quality and the patient experience. Hospitals have to ask, 'How do we engage them? How do we make sure they're in the decision-making process and have a strategic voice in where the hospital is going?'" says Carol J. Geffner, PhD, president of Newpoint Healthcare Advisors. "[It's a] very different mindset from just trying to acquire PCPs to increase referrals."

Learning from mistakes

That was the mindset a couple of decades ago, however. The 1990s are characterized as years of turmoil between hospitals and physician groups. With high expectations for managed care growth and HMOs, hospitals aggressively acquired PCPs to boost leverage for contract negotiations with payors. By the end of the decade, most hospitals had divested themselves of the

practices due to financial losses. Those years left a bad taste in the mouths of hospital executives and physicians, exemplifying a history hospitals don't want to repeat.

"Hospitals acquired physicians due to capitation, thinking acquisitions were the route to financial security," says Clint MacKinney, MD, MS, assistant professor with the Department of Health Management and Policy at the University of Iowa. "Even though the concept of HMOs is exactly the right one, that is, health maintenance, the basic tenet was overshadowed in the 1990s by aggressive price negotiations with providers."

Despite the evident lessons of the 1990s, relationships between hospitals and private practice physicians remain somewhat precarious. Private PCPs may be compelled to pursue hospital employment today for security, but they may remain wary of hospitals' motives when it comes to integration efforts. A physician who recently authored an op-ed for the *New York Times* said a health system acquiring local practices feels "like Wal-Mart coming into town." There is fear that corporate control could decimate the values of traditional primary care, and the idea of giving up autonomy and a time-honored private practice can leave physicians with notably low morale.

Each expert who contributed to this article overwhelmingly encouraged a common management strategy in PCP-alignment — physician participation in hospital governance and decision-making. Sturdy governance models let physicians retain the entrepreneurial spirit so many private practitioners value.

Max Reiboldt, president and CEO of Alpharetta, Ga.-based healthcare consulting firm Coker Group, says physician leadership was the missing key in the 1990s. "When hospitals failed in buying practices, one of the reasons is because they didn't give physicians any real feel that it was a partnership. You have to give physicians the ability to govern and

have a say in how the practice operates — not look down on them as, 'You're an employee; go do your job.'"

Mr. Easterling also said hospitals' rush to outmaneuver competition resulted in incohesive acquisitions. "Neither party really knew how to support each other's needs. Physicians were told by administrators to stay in their offices and see patients, while physicians would not relinquish any autonomy in their offices that badly needed sound business management."

Open attitudes to out-of-the-box alignment models

Many PCPs are moving toward hospital employment — the highest level of hospital-physician integration — but this isn't a uniform solution. Mr. Reiboldt suggests hospitals remain open to the numerous flavors of physician-alignment. He has seen some hospitals quickly rule out innovative alignment structures and attribute their resistance to concerns over the model's legality.

Really, the model may be perfectly legal, but hospitals only want one type of model and are quick to dismiss anything else, he says. Physicians may be un eager to affiliate with a hospital that insists on one model, as this can spark lingering skepticism of what this affiliation is really about.

"Often, hospitals will lean on the crutch of compliance. Compliance and structuring things within regulatory guidelines is absolutely essential, but many times hospitals — before they even consider a structure that may be slightly different than their in-the-box structure — before they consider it, they'll say it's illegal," says Mr. Reiboldt. "A lot of times it's nothing but a smoke screen for the fact that they don't want to do anything other than what they want. The hospitals that are amenable to at least considering these things while staying conservative — you don't have to go right up to the edge — I think these are

the ones to which medical groups are much more receptive."

Employment isn't taboo — in most PCP scenarios, it makes sense and is the most preferred option. But Mr. Reiboldt says hospitals should also be familiar with what he has coined "employment lite models." This reflects a closely aligned hospital-physician relationship that falls just short of "W-2" employment.

These arrangements are formalized and structured through Professional Services Agreements and commonly fall into one of four types: global payment PSA, practice management arrangement, traditional PSA or a hybrid arrangement. Here's a brief summary of what each of those employment lite arrangements looks like if full-on employment isn't the best strategy for a hospital or physicians.

- **Global payment PSA:** The hospital contracts with a physician practice for services in exchange for a global payment rate, which covers physician compensation, benefits and practice overhead costs. The practice, in turn, retains management responsibilities.
- **Practice management arrangement:** The hospital employs physicians, but the practice entity is maintained and still contracts with the hospital for management services. The practice's administrative staff is not employed by the hospital, since these services are provided through another management contract, for which the practice receives a corresponding fee.
- **Traditional PSA:** The hospital contracts with physicians for professional services, but the hospital employs practice staff and "owns" the administrative structure.
- **Hybrid arrangement:** The hospital either employs or contracts with physicians, and the practice entity is structured into a management service organization or information service organization.

Geographic placement of physicians

Once a hospital decides which model makes most sense for them, it then needs to determine where to locate PCPs. Historically, hospitals have lacked a retail mindset, according to Mr. Easterling. “[Hospitals] operate with the belief that if they build it next to the hospital, the patients will come,” he says. This is opposite of the traditional retail mindsets, which suggest providers identify markets and strategically place services, like primary care offices, either where patients live or where they prefer to receive care.

Mr. Easterling says hospitals cannot continue this hospital-centric way of thinking, and that the focus needs to be on what is convenient for the patient. “Whether a physician works from a hospital, remotely or from a physician office, it just needs to be simple for the patient,” says Mr. Easterling. “This is why the retail-based clinics, although a small subset, are garnering market share. They are easy to access and the pricing is clear.”

As healthcare delivery becomes more patient-centered, hospitals’ physician-alignment strategies are following suit. There’s increased emphasis on where people want to receive care, especially baby boomers, given their significant healthcare spending. A hospital that factors community feedback into its strategic decisions on a practice’s location can benefit through increased referrals and higher patient satisfaction scores. Yet, despite the long-term gains of collaborative decisions, the geographic placement of physicians can still cause tension in the hospital C-suite.

“The way to do this is to ask the community,” says Dr. MacKinney. “Ask the people you’re serving which care setting is most convenient and comfortable for them. But it’s not always that simple, and I’m going to argue that this may make hospital CEOs uncomfort-

able. Sometimes the best place to deliver care is not in the hospital,” he says. Healthcare delivery is occurring in more non-traditional settings, such as clinics in churches, community centers and the home, as providers aim to fill gaps in the continuum of care and keep patients from growing so sick that they need to go to the hospital. It may be an uncomfortable finding for some hospital executives, particularly those who consider a hospital as the hub of community health. “History and tradition need to give way to new thinking,” says Dr. MacKinney. “CEOs often define themselves by [what they’ve brought to the hospital] — the new wing they purchased or how many PET scanners they bought. But that’s not the triple aim. It’s going to be hard when traditional egos or the traditional ways in which we value ourselves as leaders stand in the way of how we deliver care,” he says.

The availability of technology will have a huge affect on these decisions, but Ms. Ladon and Dr. Geffner also recommend hospital leaders keep an open mind and consider where PCPs may be most needed in a community. “One of the most important factors in determining which setting is optimal is the leadership’s ability, and the board’s ability, to really break with past-thinking,” says Dr. Geffner.

Forces working with and against hospitals’ physician-alignment strategies

Hospitals in certain markets may need to think in defensive terms when developing physician-integration strategies, especially for PCPs. The impending nationwide shortage paired with healthcare reform’s emphasis on the PCP has made them a desirable employee — not only for hospitals but large medical groups and health insurers. A 2011 survey based on 80 medical organizations found 74 percent planned to hire more or significantly more PCPs within the next year than they have in the past.

Payors are also making moves, either by employing PCPs directly or, in some states, not allowing any more PCPs in their panels. In September 2011, UnitedHealth Group announced its purchase of 2,300-physician Monarch Healthcare — the largest medical group in California’s Orange County. This was one of the most sizable acquisitions to date, but it reflects insurers’ growing interest in controlling costs and the providers who make healthcare decisions.

Despite these competitors, Mr. Easterling says there are far more forces working in favor of hospital-PCP alignment than any other time in history. Physicians are drawn to the access to capital to grow and expand, according to Mr. Easterling. They also want to partner with organizations that understand the shift to outcome-based reimbursement and are prepared for ACOs, bundled payments, patient-centered medical homes and other pilot programs. Robust health information technology is also another draw, as the installation of an electronic medical record can cost six figures and leave a severe dent in the bottom line of private practices.

“At no point in my career has my phone rung more from physician offices looking for a partner,” he says. “What’s more important is the size of the groups approaching hospitals or health systems. I am seeing the 25- to 50- to even 100-plus-physician groups approaching hospitals today. These were the groups that formed to build infrastructure and economies to ensure long-standing independence.” ■

1. *From Courtship to Marriage: A Two Part Series on Physician-Hospital Alignment.* PricewaterHouse Coopers, 2011.

2. *Hospitals’ Race to Employ Physicians — The Logic Behind a Money-Losing Proposition.* Robert Kocher, MD, and Nikhil R. Rabni, BS. *New England Journal of Medicine*, May 2012.