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Integration and/or Independence: Physician-Hospital Futures

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Of the 41,000 physicians in the 2013 MGMA *Physician Compensation and Production Survey*, 56 percent are employed by hospitals or health systems, compared with 42 percent in the 2010 survey. Conventional wisdom is that the remaining physicians will rapidly join the ranks of the employed. However, hospitals and physicians can explore many types of relationships in the long-term, and these approaches are likely to coexist with each other.

Hospitals will be under continual financial pressure. In many markets, being able to deliver high-quality care at a low total cost to the insurer will be a significant factor in securing market share. Within this context, options for physician-hospital relationships seem likely to include the following.

Health systems employ physicians, clinically integrate, and manage care effectively. There is still plenty of acquisition activity. If compensation is designed to reward physicians for managing population health and the overall cost of care, this approach can be an extremely effective way for providers to position themselves for a value-based market.

Physicians form strong independent groups, and may align with health plans. Some large physician groups may be able to continue their independence with the advent of healthcare reform and its payment innovations. Large multispecialty groups that include primary care may have the scale to form the cornerstone of an ACO, or to participate directly in shared savings or global risk arrangements with insurers.

In some markets, specialists have merged into large single-specialty groups. In addition to promoting their reputation for quality care, these groups may partner with insurers to manage episodes of care more cost-effectively.

Health systems spin off their employed physician networks into groups that are more economically independent, yet still closely tied to the health system. For some systems, employing physicians has been more expensive than expected. While performance can often be improved, the improvement may not be financially sufficient. In addition, physicians often bridle at hospital efforts to guide their practice operations.

It may be more effective to return some autonomy to physicians, thereby freeing the physicians to wholeheartedly pursue population health management retain the rewards for distribution as compensation. With pressure to deliver value in the overall cost of care, some of the wrestling over who should operate ancillary services may recede in importance.

Some hospitals have already mirrored this type of arrangement by giving their physicians significant autonomy in practice operations, with a compensation model based on practice revenues less overhead. The twist that may be coming is having those same physicians gain additional revenues through shared savings or other incentive arrangements with health plans based on quality and population cost management.

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Although physician groups can be spun off completely, it doesn't have to work that way. Physicians can remain part of the health system, self-govern on appropriate issues, and manage compensation as a group. There can be a separate legal entity that has an agreement with the health system, such as an ACO agreement or comanagement agreement for managing clinical services. The degree of alignment and independence remains to be refined and work

Article reprinted from the hfm Healthcare Finance Blog, September 2013.

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