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FOR HEALTH TECHNOLOGY

Structure and Payment Methods for Physician Organizations In the USA

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Overview

- Structures of physician organization
- Methods of physician payment
- Shifting care to lower-cost, lower-acuity settings

"You can't list your iPhone as your primary care physician"

Structures of Physician Organization

- The traditional structure of physician practice in the US, as in most other nations, has been the small or solo group practice, referred to as the ‘cottage industry’
- The alternative has been the multispecialty group practice, pioneered by the Mayo Clinic
- With the advent of managed care and novel payment methods (capitation, shared savings) a variety of new structures have emerged
- All are competing for affiliations by physicians

The Cottage Industry

- The traditional structure has been the solo or small single-specialty group, paid FFS by insurers, and referring patients based on informal personal ties
- It offers the advantage of simplicity and productivity (the doctors work for themselves) but the disadvantages of poor coordination
- Quality problems may result when a patient is referred or transferred among physicians that lack a common electronic medical record, culture of cooperation
- These small practices cannot hire the non-physician caregivers needed to manage chronic conditions (behavioral health, etc.)
- They cannot adopt a systems approach to identifying opportunities for performance improvement (quality, patient experience, economic efficiency)
- They are not compatible with physician work-life balance, a key concern now for younger physicians

Staff-Model Group Practice

- The most prominent alternative to the cottage industry is the multi-specialty physician group, often with a disproportionate membership of primary care physicians
- This is referred to as a staff-model medical group. Individual physicians are employees (also may be partners/owners)
- The group physicians take collective accountability for costs and outcomes (contrast with physicians in solo practice, who can only take accountability for their individual contribution, not the patient's entire course of care)
- Group may be paid capitation, bundled payment, shared savings, or fee-for-service, but individual physicians are paid a salary by the group practice
- Salary is based on specialty, seniority, volume of procedures, measures of process and outcome, patient satisfaction

Virtual Group Practice: The IPA

- Virtual or 'network' medical groups seek to combine the virtues of the staff-model group with the virtues of the solo practice
- These are referred to as Independent Practice Association
- Individual physicians remain owners of their solo and small group practices, but come together through the IPA for contracting with insurers
- The IPA can be owned by the physicians (or by a hospital) but the physicians are not employees (they are contractors)
- The IPA accepts capitation and shared savings payments from insurers on behalf of its member physicians, but pays them sub-capitation or FFS (not salary, as they are not employed)
- The IPA also conducts care management, quality improvement, patient education, and other functions traditionally performed by staff-model medical groups

Integrated Delivery Systems (IDS): Hospital Systems with Employed Physicians

- Hospitals have consolidated into chains in order to gain bargaining power against insurers
- These chains seek to evolve into IDS by aligning with their physicians, through employment or through partnerships
- Their goal is better discharge planning, cheaper supplies, less duplicative testing, fewer unnecessary treatments
- They also seek to increase revenues by expanding into ambulatory, post-acute care, and other non-traditional facilities. They demand and obtain higher payment rates from insurers as they dominate local markets
- Employers and insurers tend to view them negatively, as the costs of higher prices outweighs the benefits of improved coordination

Vertical Integration: Insurers with Exclusive Physician Groups or Networks

- Some health insurance plans own, or are owned by, a provider (hospital systems and/or physician organization)
- Kaiser Permanente, Intermountain, and Geisinger are traditional examples, but many hospitals now are launching their own insurance plans
- The insurer has the incentive to 'invest in' its own provider network, since improvements in cost and quality performance accrue internally.
- Contrast this with insurers who contract non-exclusively with providers (who also contract with competing insurers): they have no incentive to improve provider performance
- However, most insurers have not been able successfully to develop vertically integrated models

Challenges to Large Provider Organizations: Weak Governance

- Large and diversified provider organizations require sophisticated organizational governance
  - Strategic vision and ability to implement the strategy
  - Financial discipline
  - Inter-operable information technology
  - Professional management
  - Internal incentives for employees and sub-units, including physicians and other professionals
- With some exceptions, provider organizations often are not good at this, as the culture of professionalism promotes individual, not collective, accountability
- These ‘diseconomies of scale and scope’ explain the continued viability of small physician practices and independent medical groups

Challenges to Large Provider Organizations: Reduced Productivity

- IDS can weaken physician incentives for productivity (free-rider problem) as physicians move from self-employment to employment
- Contrast: the traditional solo practice is a for-profit firm where every dollar saved by the physician is a dollar earned for the physician
- Productivity problems grow as the practice grows, especially across multiple sites and specialties
- Many IDS employed physicians and moved them onto salary from FFS, then suffered productivity declines, then put them back on FFS, then suffered failures of coordination, so put them back on salary…
- Physician organizations tend to be more successful than hospital or insurer organizations in motivating and maintaining physician productivity

Challenges to Large Provider Organizations: Internal Politics

- Many physicians distrust government, insurers, hospitals, (and other physicians)
- Multi-specialty groups must mediate professional rivalries, plus the income and status concerns of primary care and specialist physicians
- This is especially a problem when medical group is linked to (owned by) a hospital or health insurance plan
- This can prompt an internal war of all against all
- It can consume energies and time that otherwise could and should be devoted to performance improvement
- But there are important examples of integrated organizations that do perform very well…

Physician Organization: Payment Methods

- Outside of health care, there are many ways in which producers are paid by consumers/purchasers
  - Fee-for-service (Starbucks)
  - Episode of service payments (vacation packages)
  - Annual fee for a package of services (university tuition)
- These offer incentive advantages in different contexts. Now health care is experimenting with novel payment methods for physicians
- The three layer cake: insurers pay physician organizations, which pay individual physicians

Bundled Payment for Service Episode

- A single price is paid for a bundle of related services
  - Example: Medicare DRG covers all services provided to a patient in the hospital, from date of admission to discharge (except for physician services, paid FFS)
  - The scope of the hospital service now is being extended to include 30 or 90 days post-discharge, to motivate the hospital to coordinate post-acute care
- The recipient of the bundled payment (e.g., hospital) distributes the payment among all the contributors
- This creates incentives for the contributors to cooperate in reducing cost and improving quality
- Service episodes are most easily defined for acute procedures such as orthopedic surgery, interventional cardiology, and maternity care, as these have a defined beginning and end

Bundled Payment for an Condition

- A single price is paid for all services related to a condition (typically a chronic condition)
  - Payment for services treating other conditions in same patient are reimbursed separately (by FFS)
  - Some (high-cost) components of care for the illness can be carved out and paid separately
- The illness episode, and hence payment, begins at diagnosis (or referral) and continues for a defined period of time (e.g., 6 months) or until a defined change occurs in care
  - The episode need not be centered around a salient procedure (e.g., surgery) or admission to a facility
- Example: bundled payment for cancer care. High cost specialty drugs are carved out.

Three-Part Payment: Shared Savings

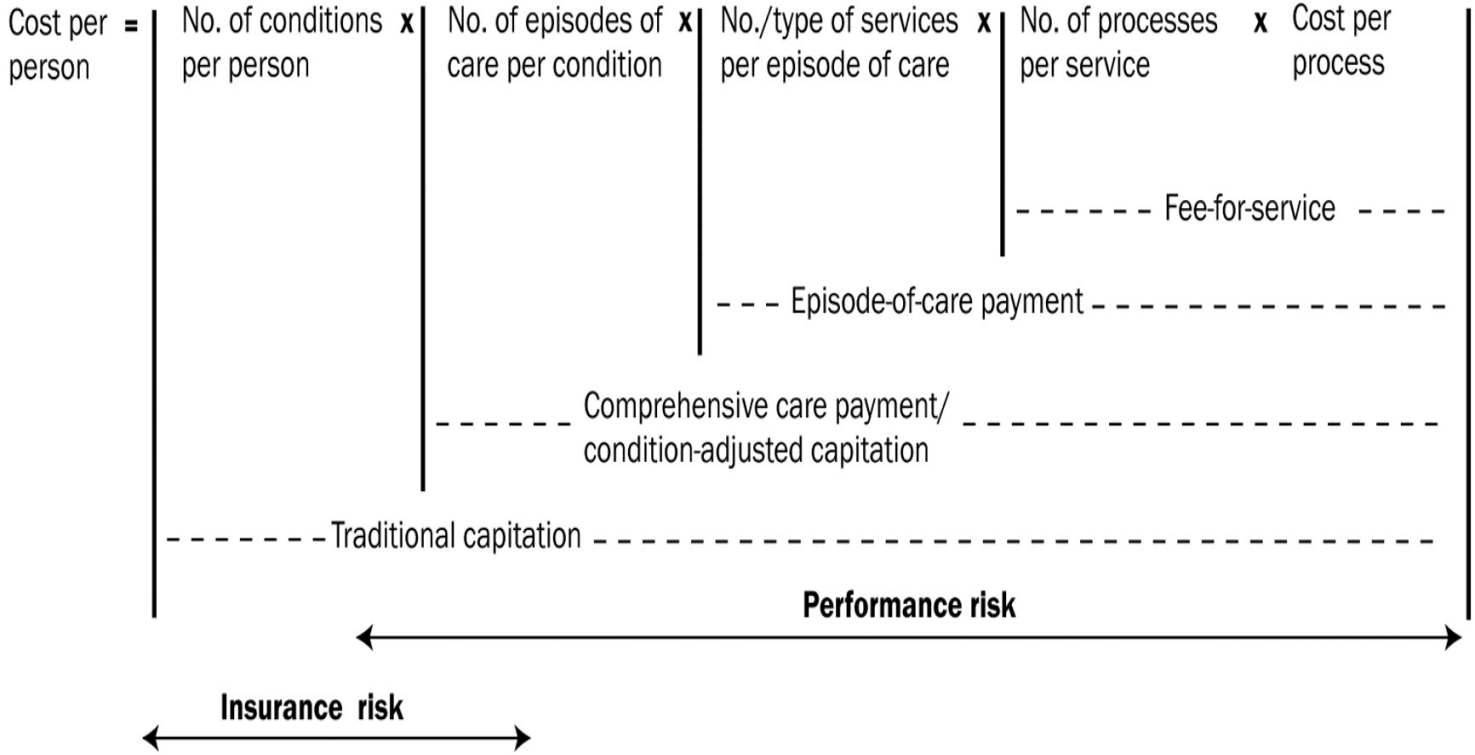
1. Physicians are paid FFS for each test and treatment, to encourage and reimburse physician time and expense
2. They are paid a monthly per-patient payment for care management (care planning, monitoring, non-physician visits, phone and online consultations, etc.)
3. They are eligible for annual bonus based on difference between the actual expenditures incurred per patient and the expected expenditures (savings are shared between physician and insurer, not hospital)
   - Expected expenditures are calculated based on past spending or on spending by peer practices
   - Physicians only share in savings if they also meet quality benchmarks, to guard against under-treatment

Payment for a Population: Capitation

- Patients select a primary care physician and thereby a medical group, which is paid a fixed amount by insurers per patient per month for defined services
  - Capitation may be for primary care only, primary plus specialty physician services, or for physician plus hospital services
  - Some services can be excluded, and paid FFS
- Payments are adjusted for risk (age, health status) but this is always imperfect, creating problems with 'adverse selection'
- Payment level is decided prior to utilization (and hence is termed 'prospective payment')
- Capitation can be interpreted as bundled payment for all episodes that a population will experience over the year

EXHIBIT 1

Variables For Which The Provider Is At Risk Under Alternative Payment Systems

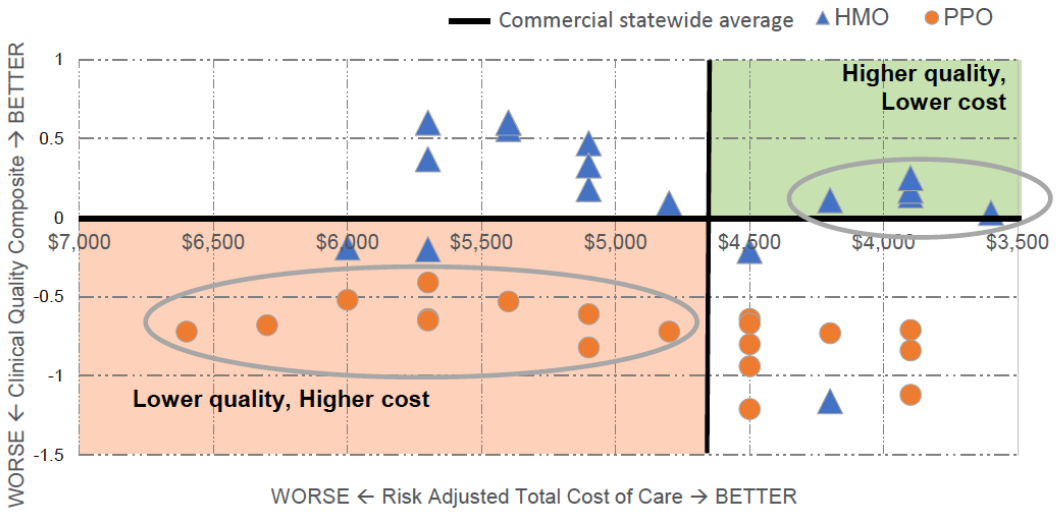


SOURCE: Author's analysis.

Harold D. Miller, From Volume To Value: Better Ways To Pay For Health Care, Health Affairs, Vol 28:1418.

(High) Quality and (Low) Cost Performance for Patients Obtaining Care from Large Prepaid PO Compared to Patients Obtaining Care from Small Practices Paid Fee for Service: Working Age Patients

First Conclusion: Commercial HMOs can provide higher value



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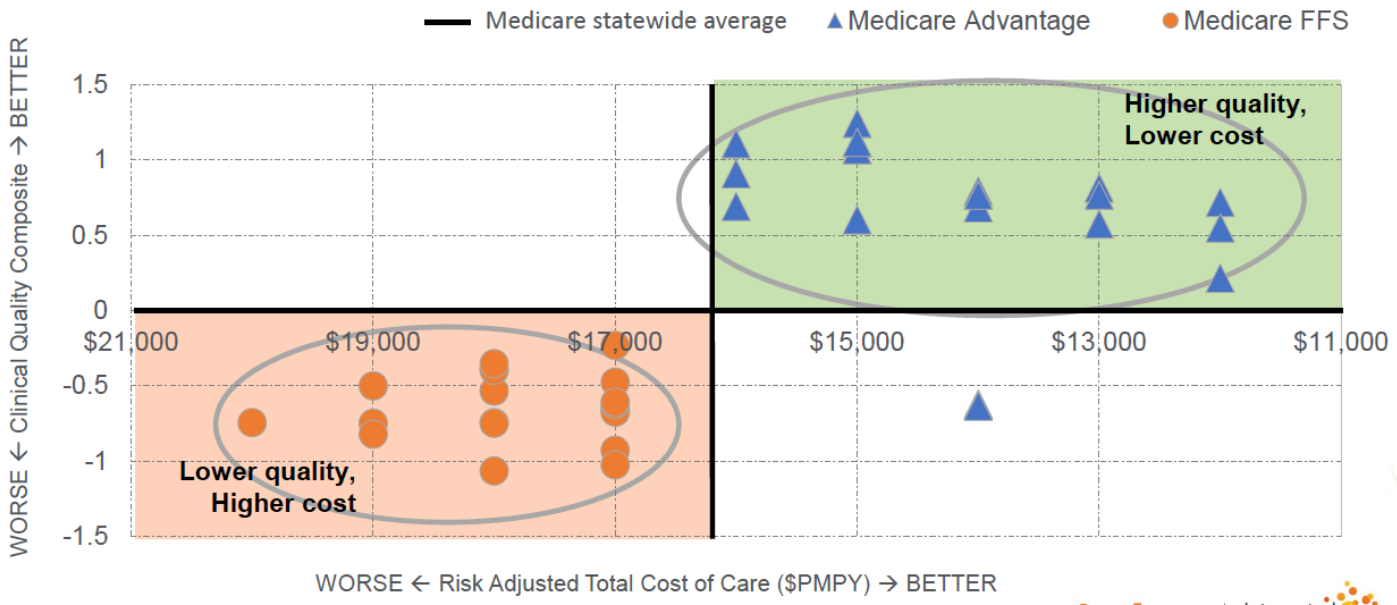
Atlas | Integrated Healthcare Association

(High) Quality and (Low) Cost Performance for Patients Obtaining Care from Large Prepaid PO Compared to Patients Obtaining Care from Small Practices Paid Fee for Service: Elderly Patients

Even Stronger Conclusion: more dramatic value for Medicare Advantage



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Moving to Lower-Acuity and Lower-Cost Sites of Care

- Historically, medical groups obtained the funds to expand scale and deepen their capabilities by reducing inpatient hospital utilization: admissions and LOS
- Today, the biggest targets for cost savings come from shift care within and across outpatient settings
- These shifts need to be based on clinical protocols that identify patients able to move, often the less severe cases
- Moving to less acute settings often will improve quality as well as reduce costs

Many Sites of Care

- There are many outpatient settings, and careful consideration is important for referring patients among them
- Cost reductions, clinical quality, and patient experience can be improved through movements from:
  - Same day procedures: from hospital outpatient department (HOPD) to ambulatory surgery center (ASC)
  - Minor procedures: from ASC to physician offices
  - Drug infusion: HOPD to physician office or patient's home
  - Kidney dialysis: from ambulatory centers to the patient's home
  - Palliative care: from subacute care facility to the home
- The economically most important is from HOPD to ASC
- ASC have much lower cost structure than HOPD as they are more focused, have higher throughput, have greater physician ownership and commitment, and excellent patient satisfaction

Purchasers are Focusing on Shifting Care from HOPD to ASC

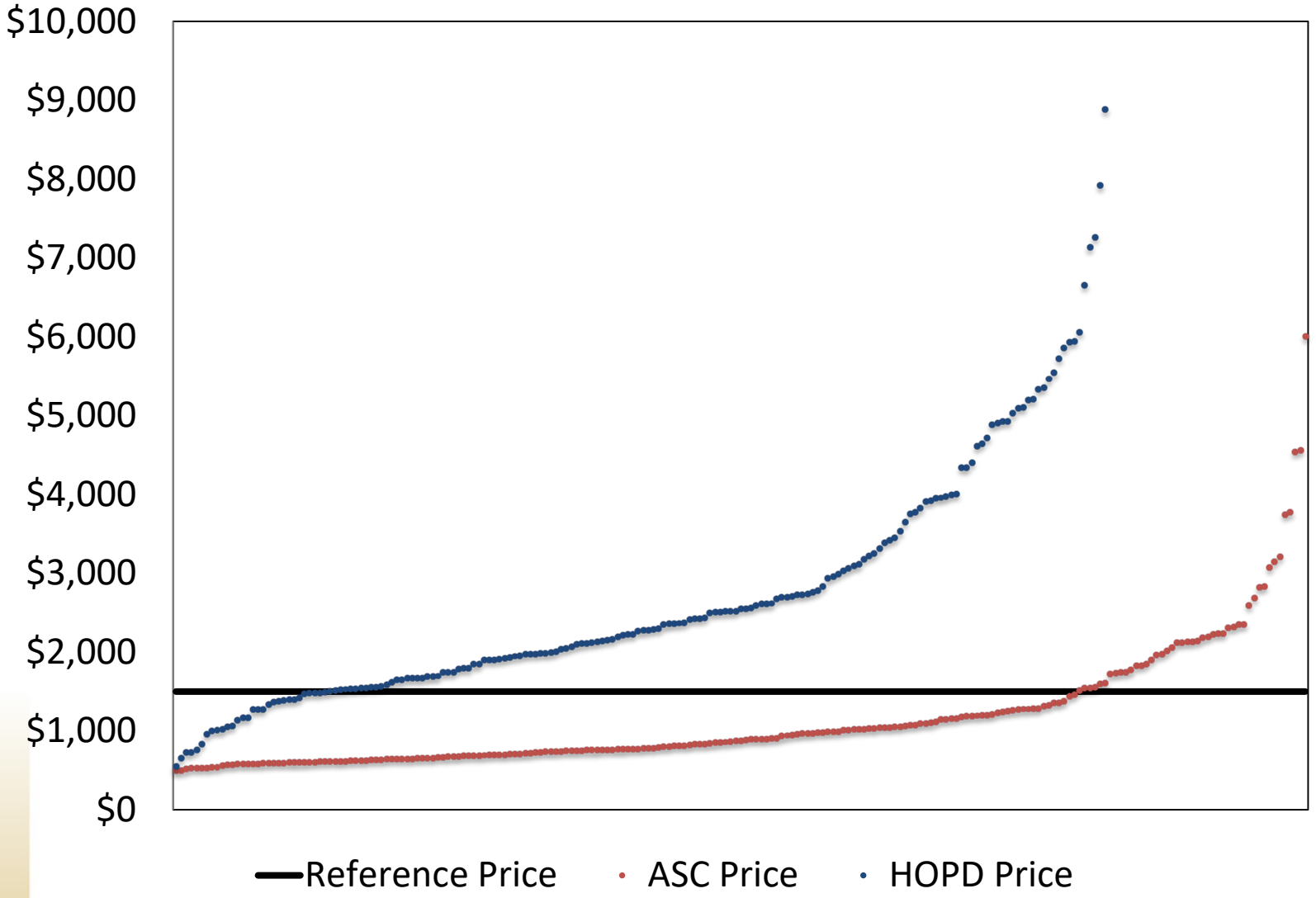
- Policymakers and purchasers recognize the imperative for clinical coordination, and that integrated provider organizations can do this best
- However, they want the value of these efficiencies to be passed to them, and are displeased to experience price increases ('monopoly power')
- When forced to choose, purchasers will channel their members/patients away from hospital-centered systems towards independent and physician-led ASC if this is the way to obtain lower prices
- Their insurance designs now reduce cost sharing for patients who use these freestanding facilities

Example: California Public Employees Retirement System

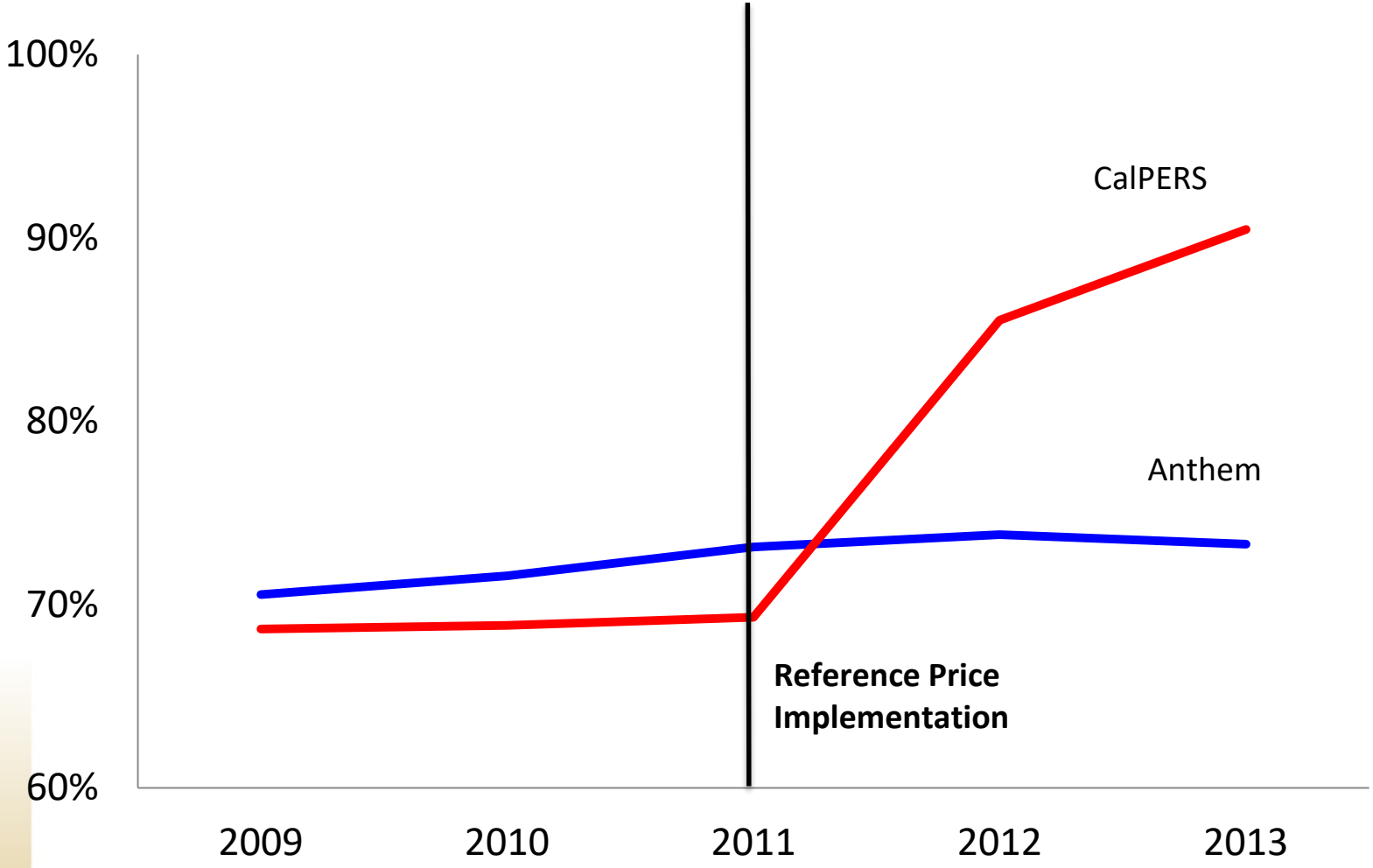
- CalPERS provides health insurance to 1.5 million employees and retirees of the state, cities, and other public entities
- It pioneered a benefit design for ambulatory procedures, with the intent to favor ambulatory surgery centers (ASC) over hospital outpatient departments (HOPD)
- CalPERS established payment maximum for each procedure, with the patient required to pay the difference if a more expensive site of care is used

  - For CalPERS, the payment limit was set for HOPDs at the average price charged by ASC
  - ASC were paid their full negotiated price (allowed charge)

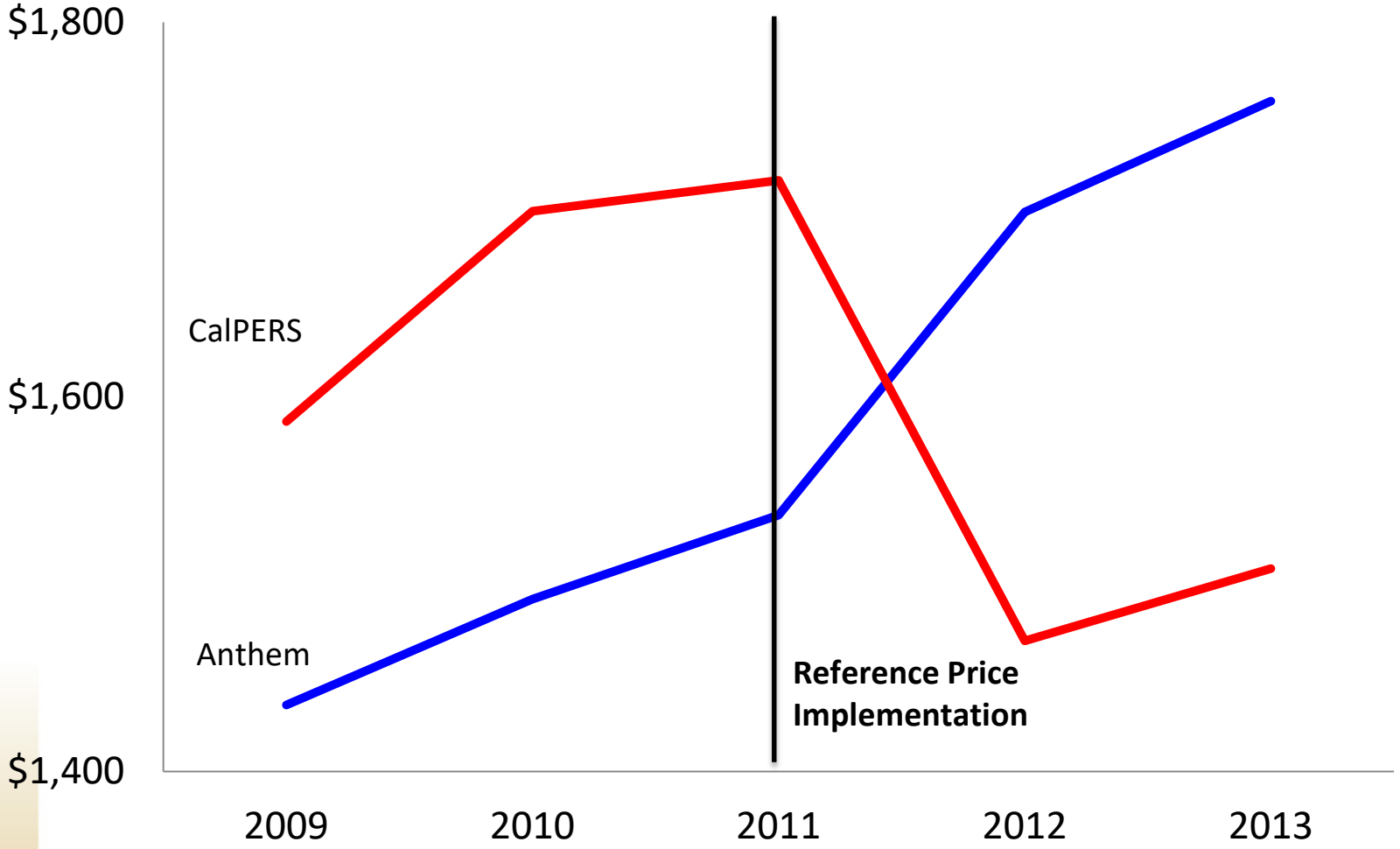
Prices Paid by CalPERS in HOPD and ASC Prior to Reference Pricing: Arthroscopy



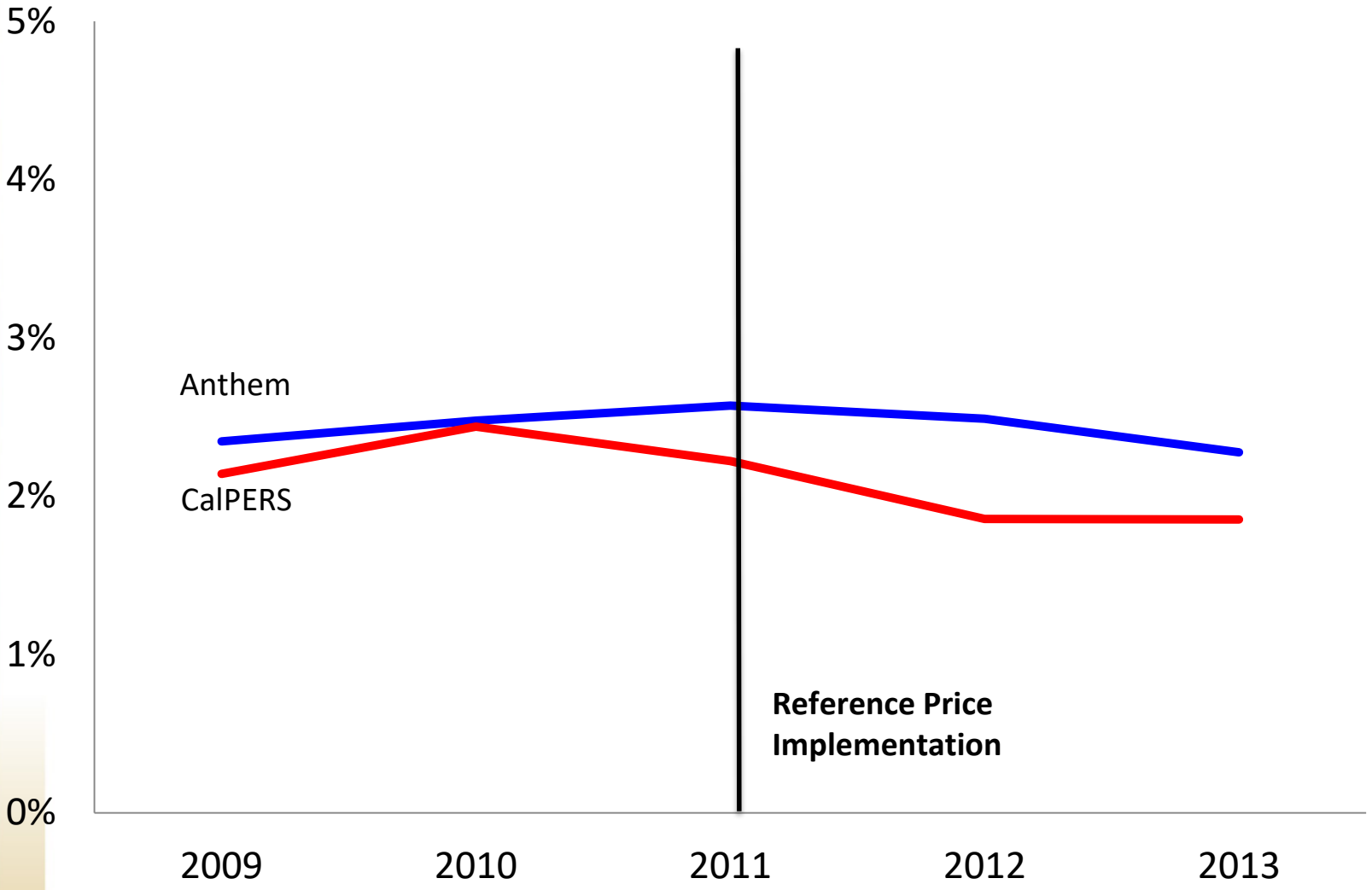
Patients Selecting Ambulatory Surgery Centers (ASC) Before and After Reference Pricing: Arthroscopy



Prices Paid by CalPERS Before and After Implementation: Arthroscopy



Surgical Complications Before And After Implementation: Arthroscopy



CalPERS is Expanding Reference Pricing for Diagnostic and Surgical Procedures

It is focusing on moving drug infusion (biologics) to non-HOPD sites (physician office, community infusion clinic, patient's home)

Reference Pricing for Twelve Procedures Compared to Costs for Ambulatory Surgery Centers and Outpatient Hospital Facilities

	Upper GI Endoscopy with Biopsy	Laparoscopic Gall Bladder Removal	Upper GI Endoscopy	Esophag-oscopy	Sigmoid-oscopy	Hysteroscopy Uterine Tissue Sample (with Biopsy, with	Nasal/Sinus - Submucous Resection Inferior Turbinate	Tonsillectomy and/or Adenoidectomy, Under Age 12	Nasal/Sinus - Corrective Surgery - Septoplasty	Lithotripsy - Fragmenting of Kidney Stones	Hernia Inguinal Repair (Age 5+, Non-Laparoscopic)	Repair of Laparoscopic Inguinal Hernia
Ambulatory Surgery Center												
Highest Cost	$5,846	$15,586	$4,131	$4,247	$3,766	$7,277	$7,623	$7,638	$12,069	$14,267	$10,491	$13,557
Lowest Cost	$721	$2,661	$530	$1,079	$403	$1,398	$1,564	$1,550	$2,123	$3,916	$2,311	$1,942
Outpatient Hospital Facility												
Highest Cost	$18,589	$78,822	$9,652	$9,030	$9,907	$60,818	$22,695	$20,990	$22,014	$25,759	$20,129	$43,612
Lowest Cost	$786	$3,082	$703	$1,786	$449	$1,601	$4,591	$1,934	$4,950	$3,734	$2,152	$3,924
Recommended Reference Price	**$2,000**	**$5,000**	**$1,500**	**$2,000**	**$1,000**	**$3,500**	**$3,000**	**$3,000**	**$3,500**	**$7,000**	**$4,000**	**$5,500**
CalPERS Annual Projected Savings Per Procedure	$608,102	$560,857	$109,775	$21,137	$24,683	$112,468	$108,900	$94,505	$125,637	$96,731	$99,711	$76,737
TOTAL ANNUAL PROJECTED SAVINGS												$2,039,242

Assumes 10% increase in ASC use

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