

Physician-Hospital Consolidation

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Presentation to FTC/DOJ Health Care Competition Workshop
Washington D.C.
February 25 2015

Vertical Integration

Physician and Hospital Linkages

Input Markets



Output Markets



Topics to cover

- Types of consolidation
- Extent of consolidation
- Drivers of consolidation
- Impact on quality, cost, price, profitability, alignment
- Alternative forms of collaboration

Types of consolidation – Take 1

- Three types of “integration” often identified

non-economic integration

economic integration

clinical integration

Source: (Burns & Muller, 2008)

Non-Economic Integration

- Technology acquisition
- Facility upgrade & replacement
- Hospital branding
- Marketing of physician practices
- Physician-to-physician referral programs
- Increased number and skill-mix of nursing staff
- Convenience of scheduling tests and procedures
- Medical staff development plans
- Medical office buildings
- Clinical councils
- Physician liaisons and mediators
- Physician sales and outreach programs
- Physician surveys and focus groups
- Physician retreats
- Physician leadership development
- Hospital committees
- New technology and value analysis committees

Economic Integration

Physician Recruitment	Part-time Compensation	Shared Risks	Shared Gains	Leases	Participating Bond Transactions	Service Lines	Equity Joint Ventures	Employment	Outsourcing and Sale of Service
<ul style="list-style-type: none"> Location Assistance and Relocation Expense Start Up Support: e.g. Salary Guarantee Support for Group Practice Growth: Incubator Model, Temporary Employment Liability Coverage Assistance 	<ul style="list-style-type: none"> Medical Directorships Department and Program Chairs Management Contracts On-call Contracts Medical Executive Positions (CMO, VPMA) Professional Service Agreements Exclusive Coverage Contracts 	<ul style="list-style-type: none"> PHO/IPA Risk Contracts with Payers Bonus/ withhold Contracts with Employers Pay-for-Performance Contracts Payer “Guarantees” Physician Hospital Organization (PHO) Management Services Organizations (MSO) Independent Practitioner Association (IPA) 	<ul style="list-style-type: none"> Supply Chain Management Programs DRG – Specific Bundled Payments Hospital Provision of In-kind Services for Cost Savings 	<ul style="list-style-type: none"> Equipment Leases Time-share Leases Block Leases 	<ul style="list-style-type: none"> Subordinated Debt Issued to Physicians 	<ul style="list-style-type: none"> Centers of Excellence Clinical Institutes Patient Unit Model 	<ul style="list-style-type: none"> Ambulatory Surgery Centers Diagnostic Imaging Centers Hospital-in-a-Hospital Procedure Labs Medical Office Buildings Specialty Hospitals Retail Clinics Product Line Centers 	<ul style="list-style-type: none"> Practice Acquisition Salaried Employment Foundation Model Hospitalists Inter-entity Transfers and Funds Flow Model 	<ul style="list-style-type: none"> Syndicate Hospital Ownership and Management to Physicians

Clinical Integration

- Guidelines, pathways, protocols
 - a) development
 - b) implementation
- Physician & episode profiling
- Physician performance feedback
- Physician credentialing
- Common patient identifier
- Disease registry
- Case management
- Medical management committee
- Disease management
- Demand management
- Clinical information systems
- Patient self-management skills and education
- Clinically integrated networks (CINs)
- Quality improvement steering councils
- Continuous quality improvement
 - a) inpatient
 - b) outpatient
- Clinical service lines
 - a) inpatient
 - b) outpatient

Types of consolidation – Take 2

- Three types of relationship often identified

market ~ *buy* hospital medical staff

alliance ~ *ally* PHOs, MSOs, IPAs

hierarchy ~ *make* hospital employment

Extent of consolidation

- Alliance models (PHO, MSO, IPA)

dismal failures in 1990s

garnered few capitated lives from insurers

no impact on cost or quality

no impact on physician alignment

no infrastructure to manage risk

on the wane ever since

may make a comeback with PPACA

can serve as the chassis for an ACO

Extent of consolidation

- Hierarchy models (employment)
 - more hospitals now employ physicians
 - not entirely sure how many physicians are employed by hospitals
 - lots of WAGs
 - lots of group think
 - get out your BS detector

Extent of consolidation: Estimates

- Percent of Physicians Employed by Hospitals:

Credit Suisse (2013)	2/3 of physicians
WSJ (2014)	2/3 of physicians
SK&A (2012)	1/4 of physicians
AHA (2013)	1/7 of physicians
- Percent of Medical Groups Employed by Hospitals:

SK&A (2012)	14-18% of groups
MGMA (2012)	12-13% of groups
- Percentages vary a lot by specialty

Drivers of consolidation

Hospital Goals

- Increase MD incomes
- Improve care processes & quality
- Share cost of clinical IT with physicians
- Prepare for ACOs and Triple Aim
- Increase leverage over payers
- Increase physician loyalty/alignment
- Minimize volume splitting
- Increase hospital revenues
- Capture outpatient market
- Mitigate competition with physicians
- Develop regional service lines
- Create entry barriers for key clinical services
- Recruit physicians in specialties with shortages
- Address medical staff pathologies

Physician Goals

- Increase MD incomes
- Increase quality of service to patients
- Increase access to capital & technology
- Uncertainty over health reform
- Low leverage over payers
- Escape administrative hassles of private practice
- Escape pressures of managed care
- Exit strategy for group's founding physicians
- Increase predictability of case load & income
- Increase physician control
- Increase career satisfaction & lifestyle

Evidence Base on Physician-Hospital
Economic Integration

Literature on Hospital-Physician Integration :

Little Evidence for Efficiencies & Benefits

Evidence

Costs – No impact (early research), Positive impact (recent research)

Quality – Mixed impact

Prices – Mixed impact (early research), Positive impact (recent research)

Hospital profitability – Negative impact

IT linkages – Little impact

Clinical integration – Little impact

Physician alignment – Little impact

Bundled Payment

Seems to lower costs, improve quality

Overall, few consistent effects of integration

Impact seems to depend on specific form of integration

Most integration fails to align physician and hospital incentives

Most integration focused on financial, not clinical factors

Alternative Models of Collaboration

- Non-hospital firms that can integrate with and employ physicians
 - physicians themselves (group practice)
 - insurance companies
 - other equity-backed firms (PPM redux)
- Other types of vertical integration:
 - hospitals & ASCs
 - hospitals & LTC
 - hospitals & retail clinics
 - pharmacies & retail clinics
 - PBMs & pharmacies

Thank you for listening