FEATURE STORY

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from acquisition to integration transforming a hospital into an ACO

Physician involvement in leadership and governance will be a critically important component of today's newly forming accountable care organizations.

AT A GLANCE

Five steps are essential to the process of hospitals acquiring physician groups to develop truly integrated delivery systems:

> Securing internal and external approvals
> Integrating physicians into leadership and governance
> Developing physician employment terms and compensation
> Exploiting reimbursement improvement opportunities
> Streamlining operations

The acquisition of medical groups by hospitals is back. But with today's acquisitions, unlike those of the 1990s, hospitals are looking to do more than just lock in a referral base. And their medical group acquisition targets are interested in more than just a steady paycheck and reduced administrative responsibilities.

Today, hospitals recognize the need for greater physician leadership within their organizations to achieve service line goals and prepare for a post-reform environment. This involvement of physician leadership is critical to helping hospitals prepare for a payment environment in which their financial imperatives are more closely tied to their ability to demonstrate high-quality clinical outcomes, coordinate care across multiple providers, and reduce the overall cost of care. For this reason, unlike in the 1990s, the focus of today's transactions is on integrating physicians into the organization rather than just acquiring them. The goal for each hospital is to develop, at last, a truly integrated delivery system capable of serving as an accountable care organization (ACO).

To achieve this end, integration planning must be a key component of a hospital's acquisition strategy. The medical group and hospital must work together before completing the transaction to develop a common vision for new consolidated ACO with an effective organizational structure and strong physician leadership poised to provide greater value to the community through improvements in care and efficiencies. The integration planning process, which should begin with this preliminary work and extend through the transaction and its implementation, requires proper execution of the following activities:

> Securing internal and external approvals
> Integrating physicians into leadership and governance

> Developing physician employment terms and compensation
> Pursuing reimbursement improvement opportunities
> Streamlining operations

Securing Internal and External Approvals

Just as every orchestra needs a conductor, an integration initiative needs a steering committee responsible for working through the activities and issues that arise during the approval process. The steering committee should comprise the senior executives from each party, external legal counsel, and a project facilitator. The steering committee should meet regularly to discuss key issues and topics identified prior to each meeting and to develop a mutually agreeable set of terms and definitive documents. These regular meetings will keep the steering committee focused on moving the initiative forward.

Although the steering committee should work through transactional issues as a group, the committee members also must obtain their constituents' approval of the transaction (e.g., physician shareholders, community members, parent boards, county health organizations). The timing and steps for approval within both organizations should be laid out in chronological order along with the documents required for members to approve the deal.

The timeline should identify any deliverables that must be provided to the members, the party responsible for the deliverable, as well as any related tasks that need to be completed for the deliverable. With a timeline in place and communicated to the steering committee, each party needs to finalize and distribute required documents, answer members' questions and concerns, and seek approval. The steering committee must actively manage this process if the transaction is to remain on track.

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With internal approvals secured, the steering committee should focus on ensuring that external organizations approve or are notified of the transaction. Certain federal and state organizations may have the power to block the transaction or suspend its progress until certain conditions are met. To address this concern, a work group should be assigned to identify and complete all of the necessary filings and notifications. This group's charge should be to identify all organizations that need to approve or be notified of the transaction, as well as timelines for approval where required. The exhibit below provides some examples of approvals and notifications that are often required.

EXAMPLES OF EXTERNAL APPROVALS NEEDED FOR TRANSACTIONS

External Approval	Regulatory Agency	Timeline Considerations
Hart-Scott-Rodino Act	Federal Trade Commission (FTC)	The FTC has 30 days after submission either to request more information or to approve the transaction.
Certificate of Need	State planning agency (not required in all states)	Some states require a formal review process of four to six months prior to approval.
Insurance Certification	State department of insurance (where required)	Certain state insurance approval boards require at least 60 days of formal review prior to approval.

Structuring a Physician Acquisition-Integration Project

A physician acquisition-integration project can be structured in a variety of ways depending on the size and perceived complexity of the integration. Regardless of the size, however, the project will require a steering committee, a central project coordinator (project management office [PMO]), and teams and individuals responsible for completing various tasks (work groups).

The steering committee should consist of senior executives from both organizations, their respective legal counsel, and a facilitator. The steering committee's primary role will be to negotiate the overall transaction structure and discuss and make decisions on the recommendations put forth by the work groups. The steering committee will also provide additional directives relative to the planning process, as needed. These decisions and directives will then be communicated back to the work groups and other interested parties by the PMO through standardized communication and decision-management tools.

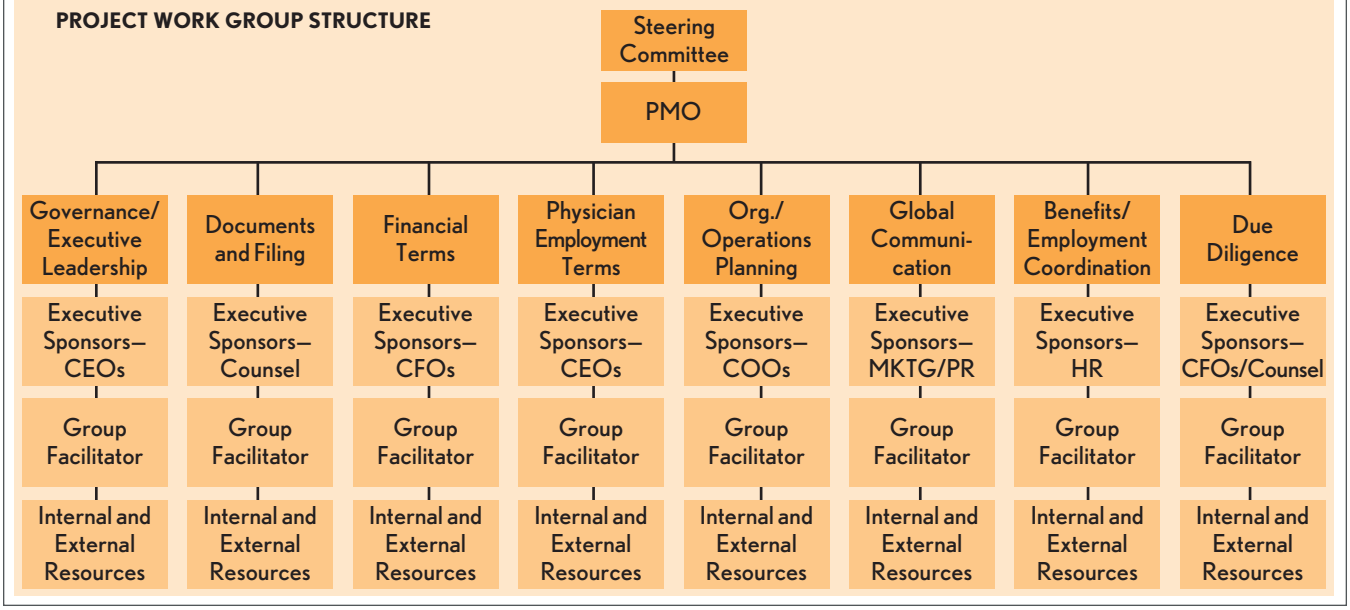
The PMO should oversee and manage the planning activities, including all work groups, and should be staffed with personnel experienced in healthcare transactions. The PMO is not intended to provide content expertise to the work groups; rather, it will coordinate the activities of the work groups, identify interdependencies among the various planning processes, and manage tasks and timelines throughout the entire process. The PMO will also serve as a communication conduit between the steering committee and the work groups by interacting routinely with the work group leaders and facilitators. In addition, the PMO will set the steering committee's agendas, prepare meeting packets, and document key decisions.

Finally, work groups should be identified based on certain functional areas and be responsible for developing recommendations for the steering committee on key decisions pertaining to the letter of intent, definitive agreements, and integration plans. To these ends, each work group must:

> Work with the PMO to identify decisions that should be addressed as part of the planning process, as well as the timing and interdependencies of those decisions
> Develop a work group project plan for the completion of tasks required for securing approvals, conducting due diligence, completing the transaction, and integrating the organizations
> Determine resource requirements necessary to complete planning activities within the defined timeline
> Generate data and supporting documentation relative to the work group's recommendations
> Develop recommendations regarding decisions that are required from the steering committee
> Provide input, as needed, on matters that overlap work groups

A sample work group structure is shown below.

PROJECT WORK GROUP STRUCTURE



With the internal and external approvals in place, the steering committee can complete the transaction and begin the process of integrating physicians into leadership and governance.

Integrating Physicians into Leadership and Governance

All hospital leadership and governance structures should have integration as a goal. Physician leaders are best prepared to ensure quality and safety, coordinate care across the organization, achieve pay-for-performance goals, pursue service development opportunities, and foster relationships with employed physicians and independent medical staff members. Integrating physicians into hospital leadership will help hospitals succeed in a post-reform era that focuses on ACOs and restructures payments from a fee-for-service basis to one based on clinical performance. In addition to integration, the new leadership structure should achieve accountability, transparency, and efficiency.

To achieve these goals, many integrated organizations employ physician-led or dyad leadership models. Under a dyad leadership model, the COO and chief medical officer (CMO) provide joint oversight of all hospital operations. Each major service area of the hospital replicates the COO/CMO dyad, with an administrator and a physician leader responsible and accountable for achieving service area objectives.

Although the dyad structure adds complexity to reporting relationships, it creates a more effective line of communication among administrative, medical, and nursing staff. Moreover, the combination of a physician's clinical expertise and an administrator's business experience results in a leadership unit with a broad perspective.

Under the dyad model, each physician-executive team makes key operational, strategic, and financial decisions for the patient care departments within each service area of the hospital. Each team maintains bidirectional feedback from employees and manages services within a service area. This approach increases physician participation

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and leadership throughout the patient care areas. Moreover, as physicians participate in dyad leadership structures, their overall knowledge of and alignment with system goals also will increase. Because the approach also requires increased time commitments on the part of physicians, these leadership positions should be commensurately compensated.

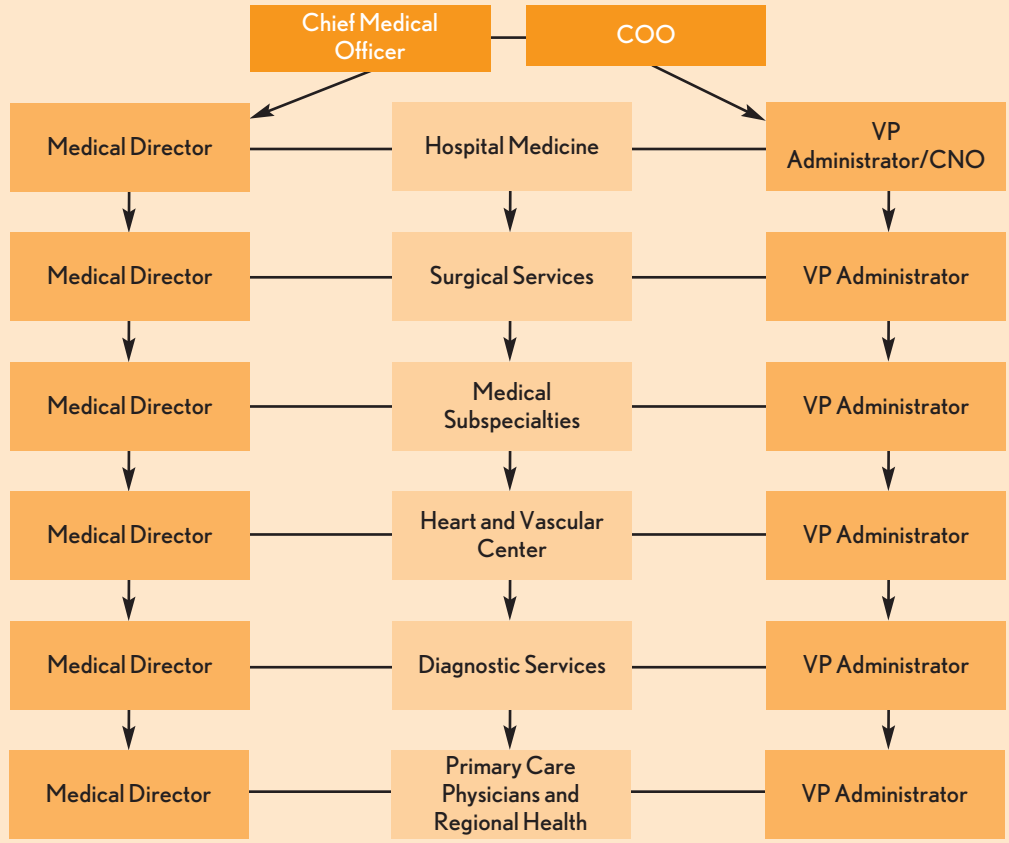
Developing Physician Employment Terms and Compensation

Guidelines for physician employment terms should be established early in the integration process to ensure that expectations can be met and verify the transaction's feasibility. Employment considerations include:

> Compensation formulas
> Duration of employment contracts
> Covenants to not compete
> Benefits structures
> Provisions for review and approval of compensation

The physician practice acquisitions of the 1990s were often accompanied by salary guarantees that provided little incentive for the physicians to maintain highly productive practices. Today's compensation arrangements encourage productivity, high-quality care, patient satisfaction, and good citizenship. Compensation formulas driven by

PROJECT WORK GROUP STRUCTURE



This exhibit presents a sample dyad model for a hospital that has identified six service areas under which to organize patient care activities.

these factors encourage integration by aligning incentives between the hospital and the physicians. Salary guarantees can also encourage integration by building trust and reducing barriers to completing the deal. But the guarantees should be limited. For example, compensation may be protected at historical levels for a limited period of time, provided that productivity does not decrease significantly.

Frequently, the employment of physicians is subject to regulatory requirements that do not apply to physicians operating within a for-profit medical group. Among these requirements is that all physicians' compensation levels must meet fair market value (FMV) standards. Therefore, to ensure that each physician can achieve compensation similar to historical levels for equivalent productivity, each physician's compensation should be benchmarked to determine whether it meets FMV standards. Because physicians typically operate with strong incentives for individual productivity, the primary means of gauging FMV is to determine whether physicians' earnings are commensurate with their productivity. An initial screen using ratios of compensation to productivity should be applied to identify any physicians whose compensation may be negatively affected by the transaction.

Pursuing Reimbursement Improvement Opportunities

After completing the transaction, the health system should investigate two areas to enhance its reimbursement position: opportunities from improved care management capabilities and potential for provider-based status for ambulatory clinics.

Opportunities from improved care management capabilities. A newly consolidated organization should pursue value-based payment methodologies that reward clinical integration and care

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coordination among multiple providers. It should also review major health plan contracts, looking for potential practice performance and care delivery improvements in preparation for negotiations, which will be required based on the change in ownership of the physician organization. Current reimbursement levels and structures should be benchmarked to establish rate thresholds for negotiations and identify opportunities for the combined organization. As part of this review, the health system should:

> Assess current contract language, with a focus on the terms that affect financial and operational performance
> Examine current administrative policies, with a focus on claims payment rules
> Analyze reimbursement levels, collections, and volume reports by plan
> Compare current health plan rate structures and levels with benchmarks
> Identify health plan historical performance for issues such as denials, inaccurate payment history, and undue administrative burdens
> Investigate rate leasing activity (silent PPOs) and other payer activity that may occur that negatively affects financial performance
> Define preferred payment levels and structures by service category for each health plan

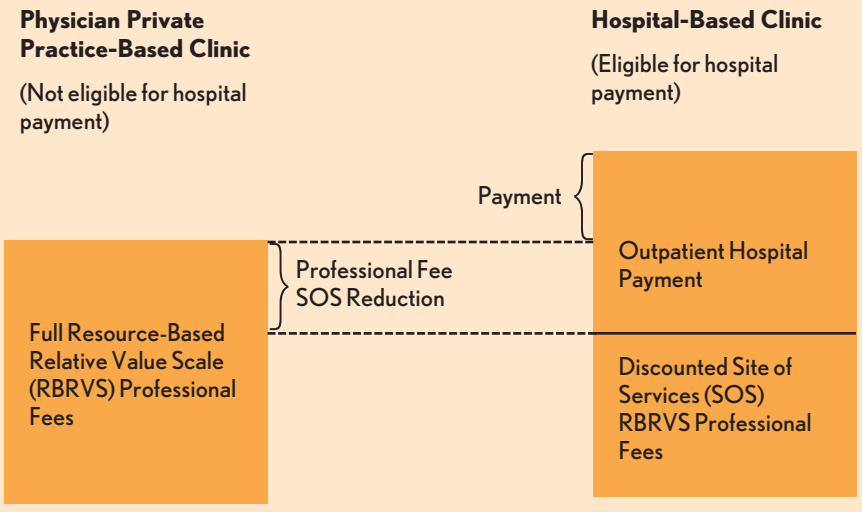
Potential for provider-based status. Provider-based status for ambulatory clinics offers a payment advantage, because Medicare and some commercial payers have authorized provider-based outpatient departments and facilities to charge "facility fees." As illustrated below, conversion of ambulatory clinics to provider-based status results in a payment increase, because the combination of the discounted professional fees and outpatient hospital reimbursement (facility fee) exceeds the global fee charged by a freestanding clinic.

To determine whether to convert clinics to provider-based status, the health system should evaluate both the payment impact of conversion and the potential additional expenses and infrastructure needs related to meeting hospital and regulatory requirements. The organization should

STEPS FOR A CONVERSION TO PROVIDER-BASED STATUS

> Compare freestanding reimbursement to provider-based payment on clinic location basis.
> Conduct a gap assessment of achieving provider-based status and the costs to convert clinics.
> Conduct a cost-benefit analysis to determine which, if any, clinics to convert to provider-based status.
> Charter revenue cycle, contracting, IT, finance, legal, and other work groups to identify conversion needs and processes.
> Collaborate with functional teams to implement changes and prepare for conversion.

REIMBURSEMENT OPPORTUNITY OF HOSPITAL-BASED CLINICS



Note: Not to scale.

assess the degree to which regulatory requirements are already being met or can be met within the clinics, and then clarify and quantify the organizational change and additional resources required for conversion to provider-based status.

Provider-based clinics should be operationally integrated with the hospital with regard to the following key functions:

> Human resources (e.g., employment of staff, training/competencies)
> Patient scheduling and registration processes
> Medical records
> Revenue cycle processes
> Financial accounting and reporting
> Quality assurance
> Facilities licensure
> Information systems

Streamlining Operations

Many organizations that call themselves integrated delivery systems or announce their intention to be an ACO are simply hospitals that happen to employ physicians. The physicians are often consolidated into a medical group, but little is done to coordinate care among them or among other members of the medical staff. Furthermore, their activities and priorities may have little in common with the strategic direction of the organization.

The integration of employed physicians within the operations of the hospital allows for not only consistent strategic priorities, but also streamlined operations that can result in reductions in costs. Hospitals that have no existing physician organization must design new financial, operational, and management reporting solutions. Well-designed solutions will allow for reduced costs by providing economies of scale, controlling major cost categories, and improving the coordination of efforts.

A shared services model to deliver administrative services throughout the ACO can provide efficiencies in human resources, finance, marketing, legal, IT, facilities management, procurement, and other administrative areas. The shared services model can be designed by defining the roles, processes, and technology involved in delivering future administrative services to the organization as a whole and then determining the appropriate allocation of costs for the services provided.

Among the reasons for failures in the 1990s was the conscious decision to have the physician practices maintain their autonomy from the hospital.

A New Opportunity

Many hospitals paid a dear price for their participation in the buying spree of physician practices in the 1990s. Among the many reasons for failures in the 1990s was the conscious decision to have the physician practices maintain their autonomy from the hospital and operate independently. The forces driving physician employment today should help hospitals avoid this same mistake. By truly integrating the physicians they employ, hospitals will be better positioned to improve clinical outcomes, coordinate care across multiple providers, and meet strategic and financial objectives. ●

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