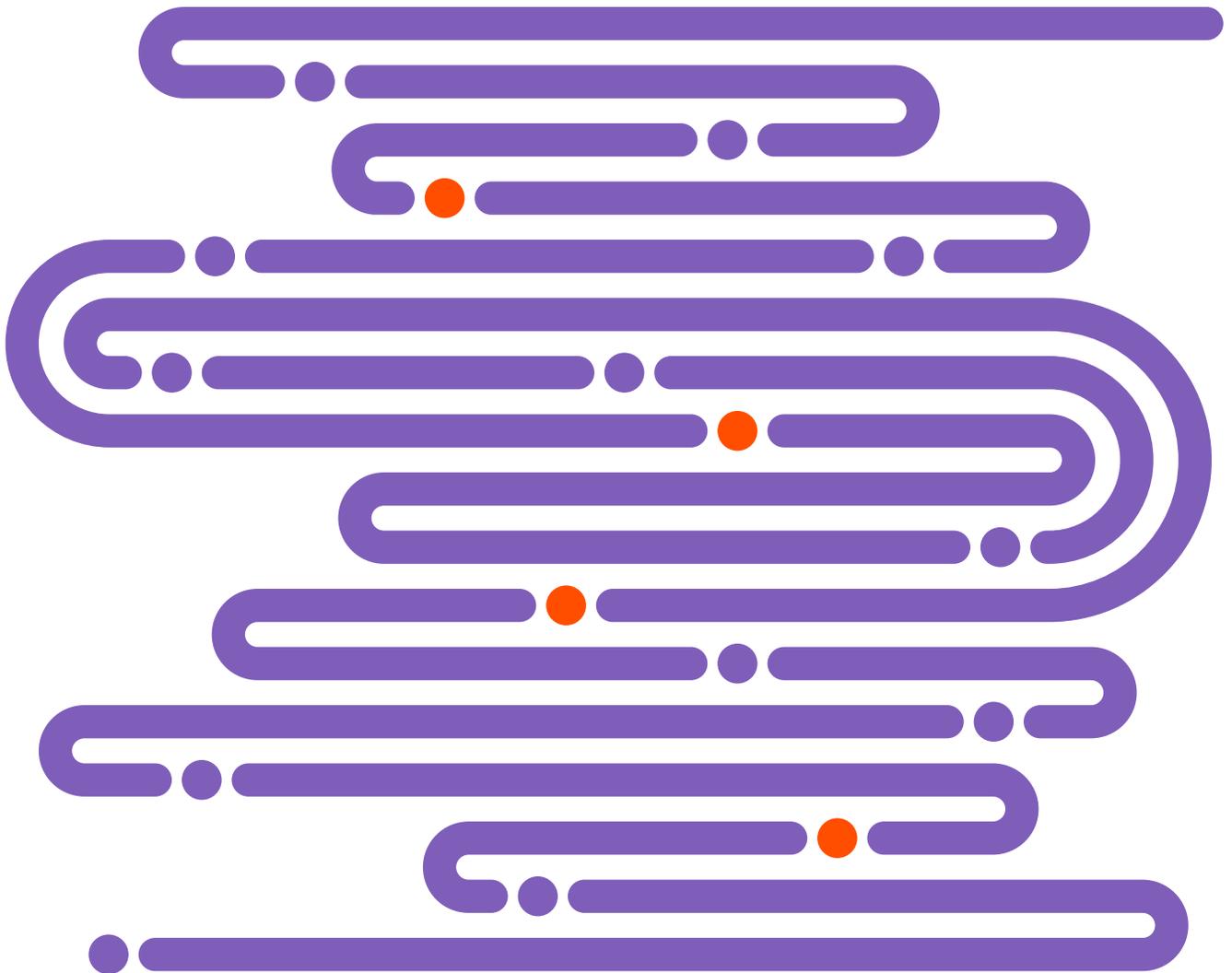


Physician alignment is a critical tool to enable a successful transition to value-based care





Executive summary

As payment reform moves toward value-based models of care delivery, health system executives are assessing their readiness to conduct business as usual even as new payment models evolve and change. Functioning in the tightening fee-for-service environment—while simultaneously navigating the transition to value-based care—has been likened to running treacherous rapids with each foot in a different canoe. But this river of change is not going to stop flowing; stasis is not an option.

Health care leaders find at least one element is foundational to success at virtually every stage on the payment reform continuum: alignment with physicians and other provider-partners.

Effective physician alignment speaks to health care leaders' top “pain points”

Payment reform is moving forward in its anticipated march from fee-for-service (FFS) toward 100 percent value-based care. The pace of change and adoption varies locally by health system and market; timing the change is extremely challenging for health system executives. Given these confounding factors, there is no single template for getting this right.

The environment is both transformative and disruptive. Providers are sizing up one another as continuing—or potentially new—partners in a changing light. Payment reform “promises to accelerate physician-hospital integration, value-based population health and risk-based alternative payment arrangements.”¹

Regardless of where they sit on the spectrum between fee for service and value-based care today, hospital leaders surveyed by Vizient™ identify two top concerns for 2017: reducing clinical variation to improve cost and outcomes, and managing the shift from fee-for-service to value-based care.² Because alignment with physicians happens to be a linchpin to addressing both these concerns, health system leaders are keen to explore options to forge mutually beneficial relationships with select clinicians.

Fortunately, the currently available strategies for physician-hospital alignment are fairly well-defined. They have been vetted by health systems nationwide, whether in a fee-for-service environment or more fully integrated situations. These strategies can be implemented in a step-wise fashion, as regulatory and market needs dictate changing provider relationships. This whitepaper offers insights into the “how” and “why” of what’s working in these uncertain times.

Market factors to assess in planning transition to value-based care

- Current state of physician alignment
- Payer market complexity: single or dominant, multipayer
- Local market uptake of risk- or value-based products
- Current and predicted state of network utilization and spend
- Culture of citizenship and community outreach
- Correlation of physician panel to population health needs
- Systems to manage transitions across multiple locations of care
- Culture of and experience with care process redesign and evidence-based medicine
- Competing initiatives in the market (e.g. accountable care organizations)

The U.S. Congress has shown bipartisan support for value-based care initiatives because it aims to reduce costs of care, improve quality and enhance patient engagement and satisfaction. Over the past year, Vizient executives—from market strategy, supply chain, advisory and analytics— spoke with members individually and in groups. Vizient also conducted research on market imperatives and trends. From this, we know that hospital leaders need innovative and nimble partnerships to achieve the cost, quality and patient engagement goals. Our research tells us hospital leaders seek trusted expertise in some or all of these key areas:

- Identify optimal strategies to align physicians and other providers
- Design compensation models that incent physicians to support health system goals
- Create episode analytics to support mutual success

Let’s look closer at key expertise necessary for developing innovative partnerships.

Identify optimal partnership strategies

A key differentiator in value-based organizations is how they view partnerships with outside practices and organizations. On the journey to value-based care, hospitals and health systems will forge partnerships with a wide range of organizations, including community organizations, wellness and fitness centers, local businesses and other employers, schools and universities and senior living providers. Hospitals need to explore meaningful partnerships with other organizations that are

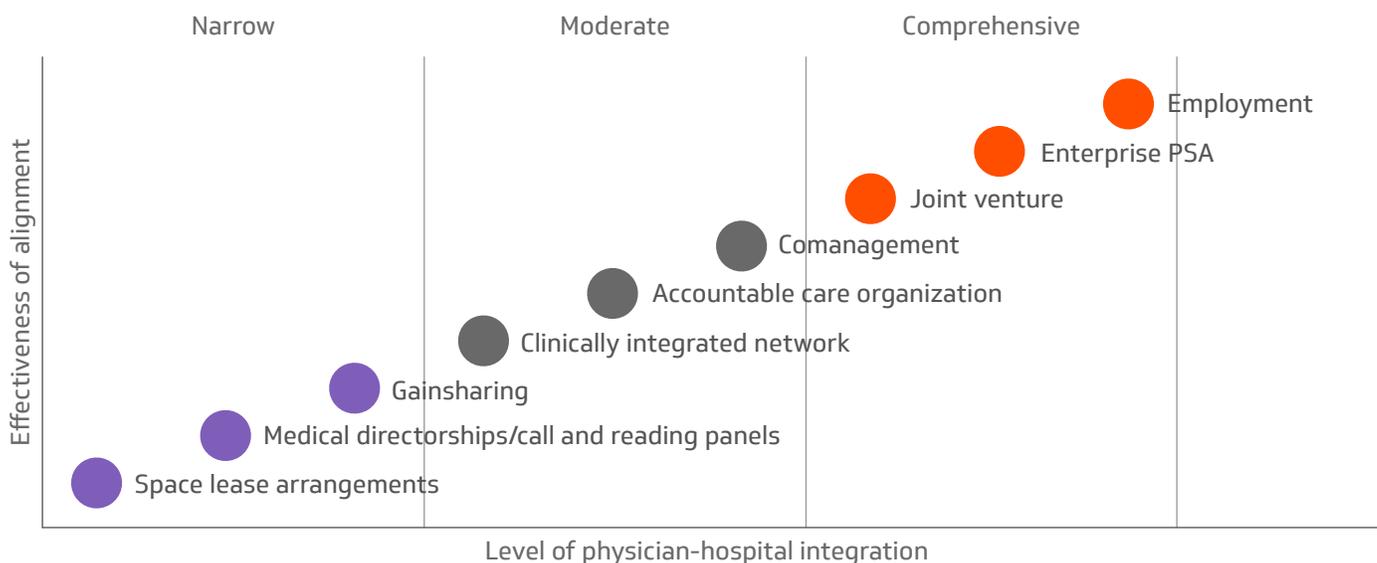
equally invested in making processes better and driving costs down. If incentives are not aligned due to internal dysfunction, then your organization is going to fall short.

Strategies and models for physician alignment range from low to high integration (see Figure 1).

The spectrum of physician alignment models spans from loose constructs best-suited to traditional fee-for-service payment, such as medical directorships, to highly integrated ones capable of achieving goals under value-based care (e.g., enterprisewide professional services agreements, employment). In every case, however, successful models reflect parties’ priorities and a clear-eyed understanding of local marketplace complexities. A thorough assessment is the first step to clarify the motivations of the physicians and hospital, and frame the options relative to market needs.

Very often, hospitals and physician practices already have an idea in mind for how integration should look for them. The physicians may be getting burned out with the grind of running the practice. They may be looking for help and support under payment reform. Physicians know their future success includes being able to refer to hospitals that are high quality and low cost and have robust analytics to help them meet reporting requirements. For its part, the

Figure 1. Models range in their ability to provide true alignment



Source: Vizient

PSA = professional service agreement

hospital may be getting pressure from physicians for greater alignment, and has to evaluate whether to buy a particular practice, or structure a relationship with them other than employment that better supports the health system's strategy.

Where to start

In every case, organizations must start with a thorough assessment, incorporating quantitative and qualitative data, of the market and what's driving a desire for alignment. In addition, both physician and hospitals need to understand motivations and expectations. Based on this information, organizations can better understand and model the impact of maintaining the status quo, and compare it side-by-side with the modeled options for alignment. The parties can "test drive" the options and choose which route to take.

Often times, it's beneficial for organizations to work with an independent third party to assist them in building a strategy and to make it go-live. Independent third parties also act as program administrators to gather and analyze data for quality and cost metrics that are measured under the alignment agreement during the contract period.

The approach has proven equally effective for both low-to-high-integration models along the physician engagement spectrum— independent, affiliated and employed—and various reimbursement situations from fee for service to value-based care that take on varied levels of risk. Customizing compensation arrangements and bonus structures promotes beneficial behaviors and lay the foundation for deepening physician loyalty and collaboration going forward.

All of these factors and moving parts should be girded by strong governance. A solid governance structure is one that is more inclusive and allows all stakeholders an equal voice. Governance boards that are successful will understand that for change to occur, you have to make the current state uncomfortable. The partnership between physicians and the rest of the organization also needs to be more collaborative. Information technology platforms should be enterprisewide, not siloed, with the ability to exchange information and analytics.

The shift to value-based care presents incredible challenges to the health care industry and your organization. Take this holistic approach to break down silos and maintain quality

partnerships with a myriad of stakeholders to increase coordination and efficiencies as you map your journey forward. By doing this, you reduce care variations and costs, setting your organization up for success in a value-based care world.

Design physician compensation to align to health system goals and the transition to value

Whether physicians or the health system initiate the alignment conversation, outside expertise can help untangle the complexities of integration. A critical imperative for mutual success that is often overlooked is engaging an experienced third-party adviser.

Third-party expertise for aligning reimbursement models

An adviser expedites the process to identify the best alignment options relative to given market circumstances by providing an arms-length determination of fair market value for physician compensation, creating term sheets and facilitating negotiations in coordination with local legal counsel.

Further, you must structure alignment within existing legal and regulatory barriers, most enacted years ago to prevent fraud and abuse of the fee-for-service system and still in force today. Experienced advisers assist local counsel to navigate Stark Law, Civil Money Penalties Law, anti-kickback statutes, IRS rules and state constraints such as corporate practice of medicine laws.

It can also be helpful to have an adviser with a national perspective on what works for other, similarly situated health systems. "Every successful compensation model must be financially responsible, sustainable, include physician leadership requirements and reward physicians for achieving both clinical and nonclinical metrics," according to Andrew Mancuso, principal, Sg2 Consulting, a Vizient company. "The incentive models we implement are tailored to incent the behaviors that support each health system's business model, market strategy and appetite for risk under value-based care."

Figure 2: Alignment structures at a glance

Structure	Key constructs	Cost considerations to implement	Key pros/cons
Bundled payment	Payment for coordinated care and cost reduction for defined episode. Used in BCPI, CJR, EPM, MSSP, commercial bundles	<ul style="list-style-type: none"> • Low upfront cost • Analytics infrastructure needed to track outcomes and reconciliation 	<p>Pros: Gainsharing possible. Aligns cost and quality efforts. Can include private practice and/or employed clinicians.</p> <p>Cons: Risk of repayment if expenditures exceed target</p>
Gainsharing agreement	Physicians share results of efficient management of high-cost supplies such as physician preference items and other direct costs	<ul style="list-style-type: none"> • Low upfront cost • Analytics infrastructure needed to track outcomes and reconciliation 	<p>Pros: Gainsharing and clinical program reinvestment possible. Drives product standardization and cost reduction. For private practice and/or employed clinicians.</p> <p>Cons: Regulatory constraints</p>
Co-management and service line agreement	Hospital contracts with physicians to manage service line costs, quality and optimal efficiency	<ul style="list-style-type: none"> • Third-party FMV opinion of compensation to physicians 	<p>Pros: Remuneration only for work performed and results achieved. Scalable. Easy to unwind. For independent and employed physicians.</p> <p>Cons: Requires significant physician time and documentation</p>
Professional services agreement	Hospital engages physicians to provide professional services. Similar to employment except that physicians remain employees of practice.	<ul style="list-style-type: none"> • Lease of practice assets • Development of compensation model • Third-party FMV opinion of compensation to physicians 	<p>Pros: Physicians retain their practice (staff, assets). Easier to unwind than employment. Compensation stability.</p> <p>Cons: Complicated transaction and regulatory constraints</p>
Employment agreement	Physicians (independently or in a group) leave the practice setting and become employees of a hospital or health system	<ul style="list-style-type: none"> • Acquisition cost of practice assets • Development of compensation model • Third-party fair market value opinion of compensation to physicians 	<p>Pros: “Collaboration vs. competition” for hospital and physicians. Relief from running the physician practice. Compensation stability.</p> <p>Cons: Physicians sense loss of independence; hospital bears upfront capital costs; and possible ongoing subsidy.</p>

BCPI - Bundled Payments for Care Improvement; CJR - Comprehensive Care for Joint Replacement; EMP - episode payment model, FMV - fair market value; MMSP - Medicare and Medicaid Saving Program

Source: Sg2, a Vizient company

“With intensifying payment reform and population health management looming, we see more providers taking their next steps in alignment,” Mancuso continues. “In some cases, shared savings may be reaching a point of diminishing returns and the partners are ready for a new model of alignment. Others have seen success with their initial professional services agreements and are ready to go to the next level and include additional specialties.”

Andrew Mancuso
Principal
Sg2 Consulting

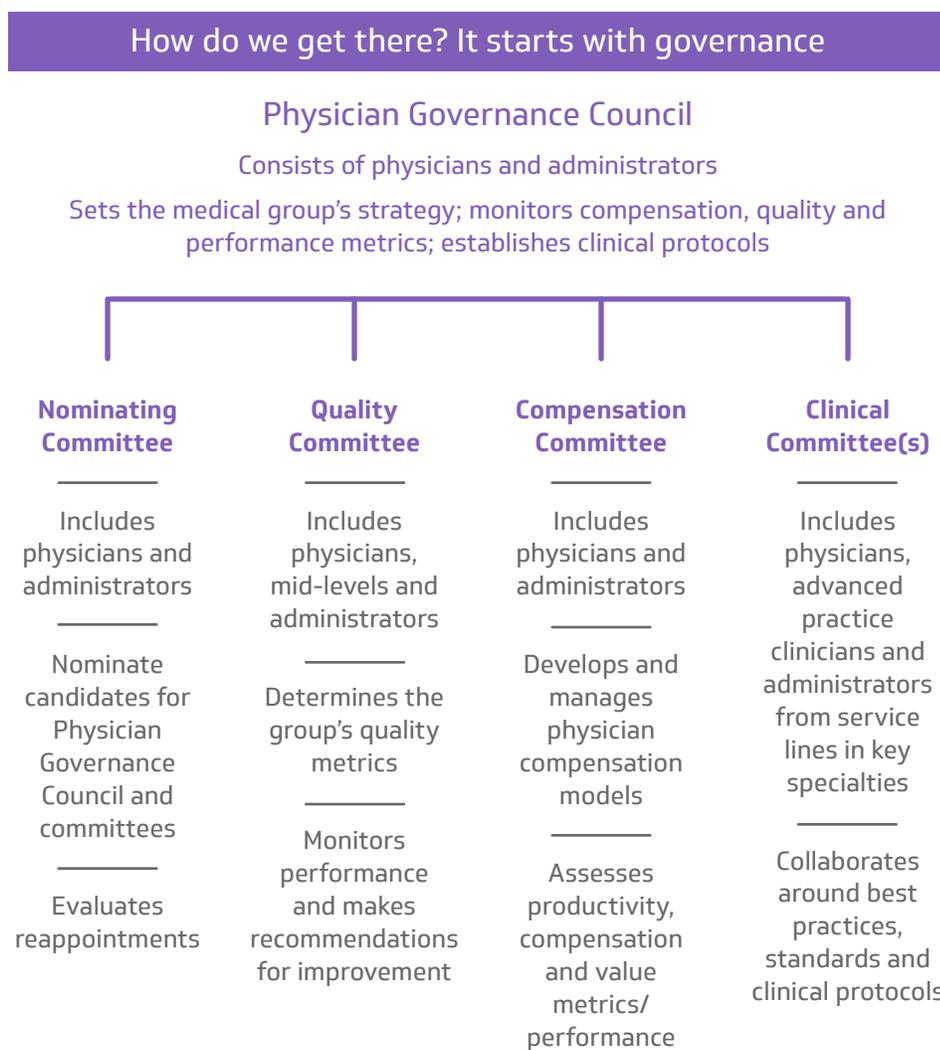
Further, programs employing physicians are rebalancing existing compensation models to reward quality, value and clinical leadership versus relative value units (RVUs), a measure of value used in the Medicare reimbursement formula for physician services and productivity. Although such change may be uncomfortable, physicians instinctively understand measures that drive toward improved patient care quality, safety and satisfaction, Mancuso says.

Use physician leadership roles to generate stronger alignment

Avoid underestimating the importance of governance as an essential element of physician alignment design. Here again, knowing what works best in other, similarly situated health systems at a comparable stage of integration helps allay physicians’ fears, especially regarding loss of control.

Clearly defined physician leadership and management responsibilities are a key component of successful alignment models. Physicians are more apt to get on board with a transparent governance structure that puts them in control of clinical leadership as well as their performance metrics and compensation.

Figure 3. Physician governance roles



Source: Sg2, a Vizient company

Alignment is an ongoing culture shift; a health system with defined physician responsibilities and accountabilities is better positioned to respond to market changes.

Building in opportunities for physicians to gain leadership experience also helps physicians thrive and supports a culture of engagement. To become effective leaders and influencers, physicians may need access to formal training to acquire the skills demanded by a collaborative environment of value-based care. Physicians are not born with leadership skills any more than they are born with cardiac surgery skills; you have to develop them.³ Whether physicians are being engaged to achieve orthopedic implant cost savings or to manage population health, they need preparation to be effective team members.

The most successful physician leadership development programs spend time on the people aspect as well as on the business side.⁴ While business knowledge, including finance and human resources, remain important, physician leaders also need skills development in process improvement techniques, interpersonal and communications skills, use of information technology and conflict management. Physician “leadership academies” can be health-system based and local, in-person or online, and include co-participation by hospital executives when appropriate.

Factors that support physician alignment and network integration

Often, implementing or intensifying physician alignment takes place in the larger context of building out a robust, clinically integrated care network. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is likely to accelerate network integration and physician alignment.

MACRA legislates how physicians will be reimbursed for value, but it should not be pigeonholed as just a physician issue, according to Robert Dean, DO, MBA, senior vice president, performance management, Vizient. “MACRA will definitely impact how physicians refer patients to and work with hospitals, health systems and other providers”, Dean states. “Value-based care has for some years been developing as a worthy but somewhat amorphous goal for the health care system. Now, through MACRA, value-based care is no longer just a suggestion. It’s literally the law for most physicians and clinicians paid under Medicare Part B.”

This suggests opportunities for physician-hospital alignment because high-performing health systems can offer important partnership benefits and support to physicians. Meaningful data and analytics, care coordination and case management capabilities are required for success in MACRA. Practices and health systems that have these capabilities in place make for attractive alignment partners. Physicians who have used

some or all of these are ahead of the curve from a change management and performance standpoint. The basis for physician alignment, employment and compensation in the future may depend less on productivity and referral driven utilization and more on high value, low utilization care delivered to an attributed and capitated population. Even if this is not a near-term reality, health systems should have a roadmap of how they get to this future state.

In general MACRA will drive more physician practices to seek employment with health systems that can help them succeed with either the Merit-Based Incentive Payment System (MIPS) or the Advanced Payment Models (APM) path. Health systems not considering physician employment as a strategy have other options to support aligned physicians. The ability to assess practices for strategic and cultural fit will become ever more important for successful integration into a health system.

Episode analytics and cost-of care-analytics provide physicians with actionable insights to improve value-based care metrics

Data that is timely, transparent, benchmarked and “ready-to-eat” measures actual clinician behaviors against the agreed-upon goals and expectations. Providing aligned physicians with trustworthy data is essential to the success of any aligned compensation agreement.

Apply analytics across the value-based care continuum and within bundles

Payers and providers will increasingly leverage advanced analytics to model risk accurately and predict future resource needs. For example, population health ultimately means going at-risk with patients. Some are noncompliant with medications, or ignore other guidance on managing their own health choices, resulting in chronic illness. Clinicians can chafe at this, not least because they are accountable under value-based care for behaviors they cannot control. Data can predict where and what interventions and resources to develop, such as hiring care managers or deploying pharmacists to boost medication compliance. Better outcomes from patient engagement will in turn show up in the data. As value-based care increasingly rewards better outcomes, physicians will seek to align with health systems that support mutual success.

While true population health management may seem a milestone that is inevitable but still distant, bundled payment initiatives are firmly in today’s landscape, espoused by public and private payers in markets across the country. Bundled payments are “population health ‘lite’”, covering comprehensive care over a specified time period for patients undergoing a specific procedure, such as lower extremity total joint replacement, or for other

medical encounter episodes such as maternity care. Participation in bundled payment initiatives allows a health system and aligned physicians to experiment with an alternative payment model contemporaneously with their ongoing fee-for-service business. Working within bundled payments also offers insights into population health management; in that bundles incent savings in institutional post-acute care, reductions in readmissions, lowered complications and improved patient engagement. Physicians share in the risk and reward of managing the episode of care, setting the stage for a high level of alignment. Many, perhaps most, clinicians understand intuitively that managing the patient care episode holistically is better for patients and therefore a valid model going forward.

A primary pillar of success in this payment model is the availability of timely, trustworthy data to manage outcomes and risk. The design, collection, analysis and reporting of relevant data are time- and resource-intensive processes, especially when the data reside in multiple systems inside and outside the health network. But if executives want physicians to lead – and share risk for – integration of patient care across a continuum of services, first-rate analytics are essential to track performance, justify compensation and validate that payments are made in compliance with existing legal constraints. Figure 4 depicts the compensation methodology for an internal cost savings gainsharing program between a health system and a physician practice partnering in a bundled episode arrangement for spine surgery. Payments reward performance regarding cost savings, but are reduced in the event of missed quality goals.

Figure 4. Ortho gainsharing—savings by procedure

Procedure	Volume	Baseline cost	Procedure average cost	Savings per case	Total gainshare savings
Total hip procedures	192	\$5,055	\$4,230	\$825	\$158,400
Partial hip procedures	86	\$3,272	\$3,207	\$450	\$38,700
Total knee procedures	504	\$5,015	\$4,165	\$850	\$478,800
Total	782	\$4,833	\$3,969	\$864	\$675,900

Figure 5. Example—Ortho gainsharing pro forma

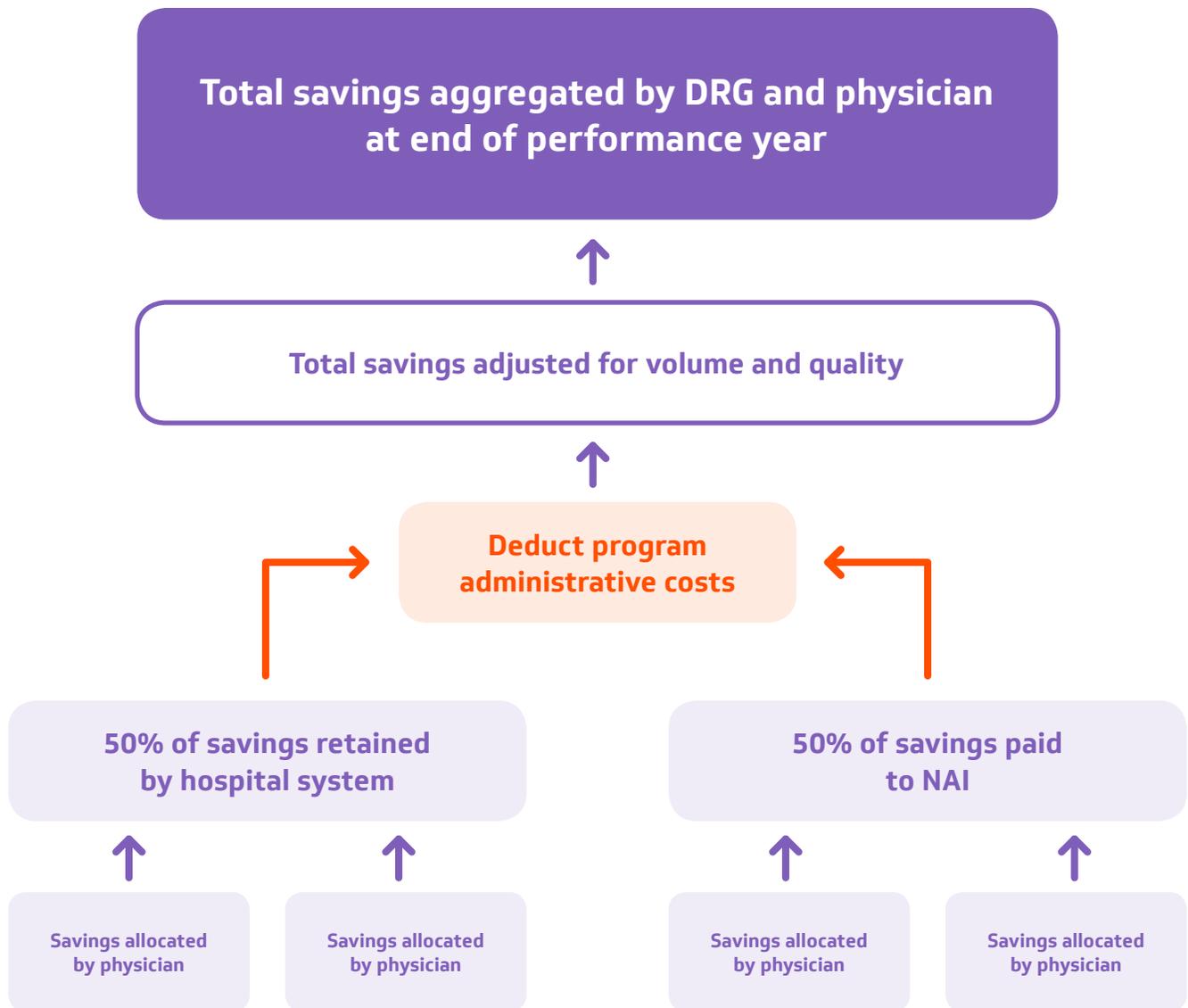
Gainsharing program impact	Partial hip	Total hip	Total knee	Total
Volume	86	192	504	782
Savings achieved	\$38,700	\$158,400	\$478,800	\$675,900
Savings after adjusting for volume cap	\$36,765	\$150,480	\$454,860	\$642,105
Savings after adjusting for quality impact*	\$34,927	\$142,956	\$432,117	\$610,000
Savings after adjusting for program expenses (\$64,000)				\$546,000
Gainsharing dollars retained by hospital (50%)				\$273,000
Gainsharing dollars paid to physicians (50%)				\$273,000

	Physician A	Physician B	Physician C	Physician D	Physician E	Physician F
Gainshare % to physician	20%	20%	10%	15%	15%	20%
Gainshare \$ to physicians	\$54,600	\$54,600	\$27,300	\$40,950	\$40,950	\$40,950

*Volume and quality adjustments are performance based

Source: Sg2, a Vizient company

Figure 6. Compensation methodology



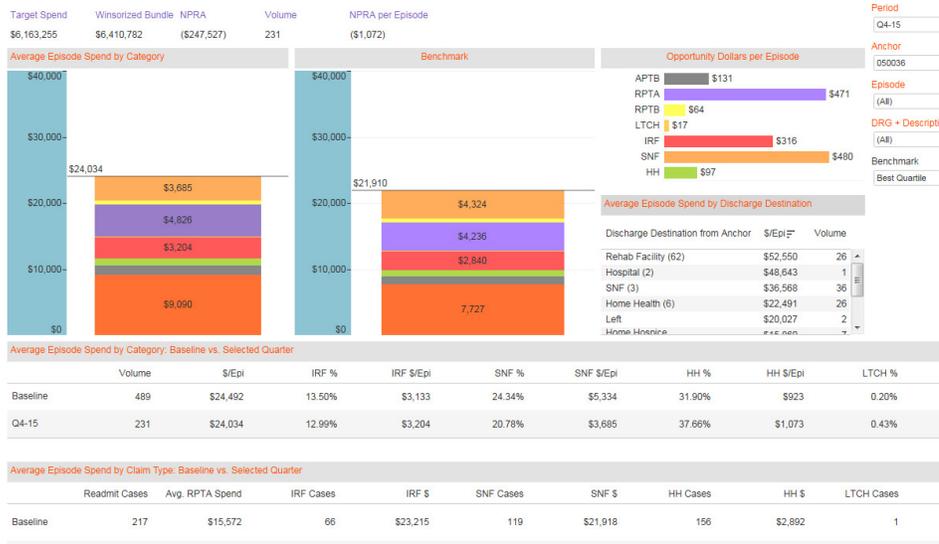
Episode analytics as the performance improvement catalyst

The right data can highlight that either processes or outcomes need to be improved, as well as suggest what the best tools for improvement should be. For example, a hospital shared data with its group of aligned radiologists that indicated slow throughput in the radiology department was impacting length of stay and therefore episode costs. The hospital proposed, and the radiologists supported, using a LEAN process to analyze the problem and implement solutions to improve on-time starts and patient scheduling in the department. In addition to reducing cost, the resulting changes improved physician and patient satisfaction. Further, the radiologists met incentive targets under their management agreement.

Providers in virtually any phase along the alignment spectrum look to metrics to measure their performance. At their most basic, metrics may relate to patient safety, complications, supply costs, throughput, cost of care and the like. MACRA and intensifying value-based care up the ante in terms of the “four Vs” of health care analytics: volume, variety, velocity and veracity.

High-performing systems implement a dashboard that aggregates relevant performance indicators. Episode analytics map spend, utilization and outcomes data for each patient’s journey through an entire episode of care over the specified time period.

Figure 7. Spend analysis for coronary artery bypass graph surgery

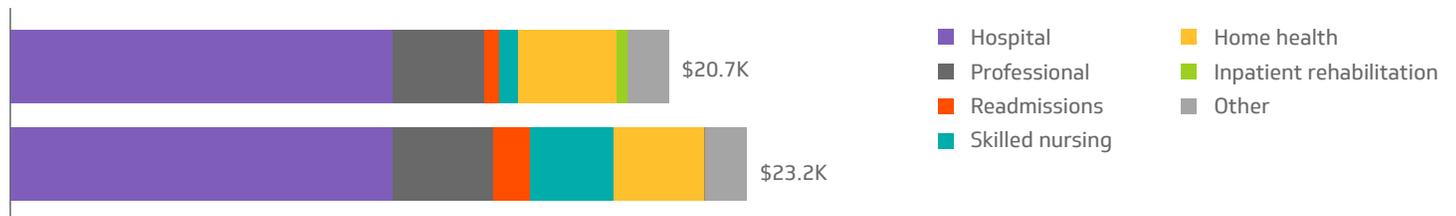


Source: Sg2, a Vizient company

Episode of care data dashboard features

- Measures of resource use and spend
- Claims data including readmissions
- Demographics
- Financial performance
- Quality scores including infection and complication
- Provider breakouts

Figure 8: Hospital system in the northern U.S. — average episode spend by category, MS DRG 470 elective



Target price \$21,300

Source: Sg2, a Vizient company

Good episode analytics are benchmarked against clinical and business best practice. To support meaningful discussion with clinicians, analytics must be physician- and specialty-specific and, ideally, provided quarterly or as often as claims data availability will allow.

A final note on analytics: well-structured episode analytics offer a direct and useful measure of physician adoption of alignment agreements. Data can pinpoint when physician referrals are sending patients outside the system for care, even if the necessary care is available within the network. This is often referred to as “leakage.” Leakage data enables health system leaders to have a conversation with an aligned physician to identify any barriers that are discouraging referrals within the network. Without credible analytics, it’s more difficult to approach a physician to discuss the situation; the goal is to improve the physician’s experience in accessing network services and strengthen the continuity of patient care. Data can directly create the platform to discuss performance metrics and incentives.

In fact, ongoing and open communication on every material aspect of implementation and monitoring is foundational to the success of physician alignment. Doctors have been hearing for some time that Armageddon is just around the corner and the message has gotten stale. It’s not a given that the business case for change or the rationale for increased integration is top-of-mind for physicians; hospital leaders have to communicate consistently. This requires following a formal communication plan that structures the frequency, content and medium of the message. In addition to the big picture, executives must address details about the “what’s in it for me” for physicians whose participation is desired. Finally, communication and incentives must be mutually reinforcing in order to get to the desired behaviors—it helps to convey that all of this is ultimately intended to improve patient care.

Conclusion: think beyond 2017

Barring a major retrenchment by the government, value-based care, prompted by MACRA legislation, is likely to continue to unfold, albeit at varying rates of uptake. Some take-aways to frame strategy this year and beyond are:

1. Physicians have long grasped that in most fee-for-service scenarios, the financial benefits of their exertions to improve outcomes accrue largely to the payer. Those same physicians understand that the right alignment strategy remunerates them for their efforts, and now can increase the likelihood of future success with MACRA and value-based care models. Health system leaders can take this opportunity to optimize physician alignment.
2. Choices made in this transitional time have strategic consequences that are perhaps more weighty than previously. Partners will continually update alignment models to support health system strategy as market conditions and the regulatory environment evolve and mature.
3. Analytics capabilities that support aggregation of data generated internally and externally (across the care continuum) position provider partners for success, provided the data are managed to provide actionable insights to clinicians and administrators.

Nothing points away from a continuing evolution toward value-based care, according to Dean, “Movement along the value-based payment system will be a continuum,” he believes. “The fundamentals are going to be the same... you’re going to need the same capabilities for success; risk stratification, care coordination, management across the continuum. Those will lead to success, (so) focus on building those core capabilities” for success in a value-based environment.”⁴

As the nation's largest member-driven health care performance improvement company, Vizient provides network-powered insights in the critical areas of clinical, operational, and supply chain performance and empowers members to deliver exceptional, cost-effective care.

- 1 Hospitals and Health Networks, HHN Mag 12/13/16. MACRA and the Giant Move into Value-Based Payment by Maggie Van Dyke. Accessed 4/28/2017 at <http://www.hhnmag.com/articles/7832-the-giant-move-into-value-based-payment-via-macra>
- 2 Vizient Post-Election Pulse Check Cross Tabulation accessed at <https://mail.google.com/mail/u/0/#search/rin/15b17d4fe3af3eda?projector=1>
- 3 The Traits of Today's Ideal Health Care CEO by Howard Larkin. Hospitals and Health Networks, June 9, 2015. Accessed April 28, 2017 at http://www.hhnmag.com/articles/3427?dcrPath=%2Ftemplatedata%2FHF_Common%2FNewsArticle%2Fdata%2FHNN%2FDaily%2F2015%2FJuly%2Ftexas-health-system-targets-seniors-blog-stempniak&page=1
- 4 Developing Physician Leaders by Lee Ann Jarouse, Hospitals & Health Networks, April 14, 2014. Accessed April 28, 2017 at <http://www.hhnmag.com/articles/2974-hospitals-find-health-it-help-in-their-own-backyards>



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