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AOA Critical Issues

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The health-care delivery environment continues to evolve. Changes are continuously occurring, making it difficult for the practicing orthopaedic surgeon to remain current with new opportunities and options. While there may never be complete loss of traditional private practice and academic practices, there will be many new practice variations driven by multiple entities, including employers, insurers, the government, and hospitals. It is imperative that orthopaedic surgeons remain integral participants in the development of these new models.

On June 28, 2012, the American Orthopaedic Association (AOA) presented a symposium at its 125th Annual Meeting in Washington, D.C., the intent of which was to identify these current trends and issues in the evolving U.S. health-care marketplace. The symposium presented a range of perspectives that were designed to assist orthopaedic leadership in managing these changes, including the perspectives, key goals, and results to date of a successful academic medical center's consolidation efforts; the trends, some key components, and preferred physician models for integration; and best practices in negotiating an integration deal that included "lessons learned" and key issues to consider before, during, and after the deal is executed.

The inevitability of change was recognized by the audience at the symposium in Washington, D.C. Through the use of the audience response system, the audience (88%) responded that fee-for-service may continue in some form but be reduced or merged into a hybrid model of reimbursement. Additionally, 95% of the audience believed that the number of self-employed physicians and/or physician-owned practices is likely to decrease over the next several years. The audience also believed that quality and outcome assessment will become more important, as 79% believed that compensation, which was previously tied primarily to clinical productivity, will also be connected to quality and outcomes. Furthermore, quality and outcome metrics imposed by the government, private insurers, and health-care systems will force orthopaedic surgeons to change the way they manage patient care. These results emphasize our need to

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actively engage in the coming changes in the health-care marketplace. Options for future practice models will be reviewed further in this manuscript.

The major changes, as exemplified by the Patient Protection and Affordable Care Act, remuneration, and increasing hospital physician employment that have occurred in health care over the past several years, sometimes on a daily basis, have made it difficult to gauge what is "here to stay" and what may be an imminent requirement that is likely to change due to legal or political shifts. Currently, anticipated programs or approaches include the Patient Protection and Affordable Care Act and accountable care organizations. No one knows at what level these will be carried to fruition, but there are certain elements of this change that will not dissipate and, in fact, will only intensify, no matter the political dynamic or judicial decisions that are rendered. It is these trends that orthopaedists need to stay abreast of, as the current health-care delivery and reimbursement system is unsustainable on a national level and a change in the way health care is delivered and reimbursed is inevitable.

It is important for orthopaedic leadership to understand current trends of consolidation in health care as well as what motivates the main players in these mergers: primarily, large health-care systems and insurers. As the marketplace readies for the massive modifications required under health-care reform, the evolutions in efficiencies and economies of scales, the increase in employed physicians, and the drive for quality and/or performance-based patient care management, reporting, and reimbursement models are underway.

These changes will soon impact how orthopaedic care is delivered, evaluated, and compensated. This shift will also require orthopaedic graduate medical education (GME) to adapt so that orthopaedic residents and fellows complete their training ready to provide orthopaedic care that meets quality metrics, is rendered as part of a continuum of care, and that will ultimately be reimbursed as a portion of the total care provided to address a disease state or condition. By its very nature, this shift will mandate increased collaboration with other allied health-care providers to coordinate care and ensure that these quality metrics are achieved and reported.

On June 28, 2012, the American Orthopaedic Association (AOA) presented a symposium at its 125th Annual Meeting in Washington, D.C., that was intended to identify these current trends and issues in the evolving U.S. health-care marketplace[1]. The symposium presented a range of perspectives that were designed to assist orthopaedic leadership in managing these changes, including a hospital integration model, a successful academic medical center's consolidation efforts, and a review of merger models and the key process and cultural issues to consider before, during, and after the deal is executed.

Hospital Integration Models

During the past several years, the health-care industry has witnessed an explosion of integration transactions between hospitals and physicians as both seek alignment opportunities. Integration is being driven by a number of factors: primarily, health-care reform, protection of market share, increasing costs, and declining physician reimbursement. A portion of hospital reimbursement is now directly tied to the ability of the hospital to meet certain patient care and outcome standards set forth in initiatives implemented by the Centers for Medicare & Medicaid Services. Therefore, it makes financial and strategic sense for a hospital to partner with the physicians who have direct impact on patient care and outcomes in order to comply with these new initiatives.

The long-term focus of health-care reform appears to shift away from fee-for-service models and toward payment models that are focused on both the quality and the cost of care delivered. Many believe that reimbursement changes aimed at controlling costs, rather than improving quality, will represent the greatest challenge for orthopaedic surgeons in the future as payers identify ways to limit the rising cost of health care. If this is true, bundled and global payment initiatives and shared savings programs, including *gainsharing,* will become more widespread in the future. Gainsharing refers to provider incentive programs that allow physicians and hospitals to share in the remuneration that results from specific actions taken to improve the efficiency and quality of care delivery. Future payment models will likely include single payments made to a hospital or accountable care organization (ACO) that cover the patient's entire episode of care, including all consults, diagnostics, surgery, and preoperative and postoperative care. Surgeons and hospitals can position themselves to respond to such changes through coordinating care and integrating or otherwise affiliating with providers in the community. It is the coordination with other providers where real gains are achieved, since providers who are accountable to each other under an integrated system are able to exert influence on other providers to control costs and improve quality across the spectrum of care.

Declining reimbursement, when combined with increasing overhead costs and the increasing demand to invest in expensive information technology, practice management software, and electronic medical records systems, has resulted in declining margins for practices. Recent history has proven that cardiologists and other specialists who initiated integration discussions while their practices were still financially strong were able to negotiate more favorable terms than were physicians who waited until after the second or third round of reimbursement cuts.

There are two primary integration models: professional services agreements (PSAs), and physician employment. Under the physician employment model, the hospital typically buys the physician group and directly employs all physicians and staff. Under a PSA, the physician group remains independent and continues to employ the physicians, but agrees to provide professional services and coverage to the hospital in exchange for compensation. Depending on the goals of each party and other legal issues, nonphysician personnel either continue to be employed by the group and provided to the hospital under the PSA or they become directly employed by the hospital. The PSA model is attractive to physicians who are reluctant to become employed by the hospital due to concerns over practice autonomy. However, PSAs lack the full integration that employment

models offer and therefore may not represent the best opportunity to meet the long-term strategic goals of each party.

Two critical issues that must be negotiated under either model are physician compensation and governance. A guaranteed base salary with no requirement of maintaining a certain level of productivity is rare. Instead, most physician compensation plans will pay a physician a salary that is based in some part on the productivity of that physician. Most commonly, the number of *work relative value units* (i.e., the relative levels of time and intensity associated with furnishing a Medicare physician-fee-schedule service) produced by the physician is multiplied by an agreed-upon fair-market-value conversion rate. Compensation plans should also address whether the physician will receive payment for administrative services, quality and/or cost goal achievement, directorships, teaching, service on hospital committees, and outreach.

Governance is critical to the success of any new arrangement. Many physicians point to governance, and not compensation, as the reason why an arrangement succeeded or failed. The good news is that most hospitals are willing to allow the physicians to continue to manage their day-to-day practice. Therefore, the parties typically negotiate certain aspects of the clinical practice that will continue to be controlled by the physicians (e.g., schedules, personnel decisions, administering time off, and administering the physician's compensation system as permitted by law). In order to address the strategic aspect of integration, physicians should also be willing to become involved in hospital operations. As a result, most integration transactions include the creation of a joint operating committee that consists of integrated physicians and hospital representatives. The council is responsible for improving clinical operations and efficiencies, developing quality standards, and assisting with budgets and strategic plans. It is the work of the joint operating committee that often leads to the greatest success of any integrated relationship.

In most integration transactions, the hospital acquires the assets of the physician's practice. The assets acquired may include both tangible assets and intangible assets. The inclusion of intangible assets can raise regulatory and compliance issues that should be addressed to ensure that the payment is consistent with fair market value and does not take into account the value or volume of physician referrals. For this reason, it is critical that an independent fair-market-value opinion is obtained regarding the value of the physician practice. The intangible value amount that is paid to a practice typically includes such items as the workforce that is in place and the value of medical records, but not "goodwill," which is considered subjective. The value of medical records, whether paper or electronic, is intended to represent the cost of recreating the practice's medical records, including human resource costs, copying costs, and a wide variety of other potential costs. Electronic records are highly valued because of the group's investment in the electronic medical records system and the additional time and expense associated with an electronic medical records system. In a smaller subset of acquisitions, the group continues to own the assets and leases them to the hospital for a fair-market-value rental rate. A leasing arrangement can be appealing because it is easier to disengage.

Integration opportunities are often ignored or rejected by providers who are accustomed to operating independently. However, as health-care reform and reimbursement continues to evolve, it is important for providers to explore integration to determine whether it represents the best opportunity to thrive in the changing landscape.

Integration of Community Physicians into Academic Medical Centers

The verdict is in: Not only are the majority of the nation's hospitals and health-care systems planning to acquire physician practices, but the nation's largest insurers are getting in on the acquisition action, a case in point being the management acquisition of Monarch HealthCare—one of the largest physician groups in California—by United Health Group. Academic medical centers are likewise considering their options as players in this environment. This review explains the employment-ownership and innovative affiliation model approach to physician strategy that was used at one academic medical center.

Emory Healthcare is a wholly owned unit of Emory University in Atlanta, Georgia, in conjunction with the Emory University School of Medicine and the Emory Clinic. This physician-faculty practice of more than 1200 physicians entered the (nonfaculty) physician ownership-management market in 2006, establishing Emory Specialty Associates as its nonfaculty, community-based practice. At the outset, Emory Specialty Associates was organized into divisions of anesthesiology, pathology, and emergency medicine to provide hospital-based services at a newly built hospital in Johns Creek, Georgia, about forty miles north of the Atlanta-based campus of Emory University. The divisions came under the management oversight and organization of the respective specialty chairs who directed the development of practice models and compensation practices that paralleled competitive community practices; soon after, acquisitions were completed of a large multispecialty group practice and multiple primary care practices in the Atlanta area. Six years later, as the Atlanta market consolidated from many to a few major health-care systems and as physicians in the market sought the benefits and strategic positioning of health-care systems, Emory Specialty Associates grew to more than 180 physicians, spanning fifteen specialties, including orthopaedics.

Emory Healthcare, like other health-care systems, has faced the shifts in the market that have created the need to address the emerging responsibility to have geographically distributed physicians and hospitals positioned for increasing accountability for cost and outcomes. Added to these factors are the academic system's unique pressures of dependence on specialist referrals and its increasing need to secure a strong primary care base. To be competitive, Emory Healthcare needed a population management strategy to meet the emerging demands coming from health-care reform.

Additionally, Emory Healthcare developed a clinically integrated network. The clinically integrated network enables

practices to remain independent, with separate tax identification and billing systems, yet have access to Emory Healthcare's risk-bearing managed-care contracts. Members of the clinically integrated network are required to adopt or integrate with the Emory Healthcare clinical information systems platform and pay a membership fee to secure their bonding to Emory Healthcare's quality and population management infrastructure. More than 485 independent physicians have made application to and been accepted into Emory Healthcare's clinically integrated network.

Emory Specialty Associates is a wholly owned limited liability corporation subsidiary of Emory Healthcare. The organization uses established Emory Healthcare policies and procedures as well as its core business-services platform. It is organized around divisions, led by an appointed division chief. The division chief has broad operational authority over day-to-day management, oversight, and implementation. Budgets are developed and managed through the finance structure of Emory Healthcare's physician services. Scheduling, hiring, and firing are assigned to the local physician manager. Staff and physician compensation is aligned with an Emory Healthcare-approved model and adheres to business standards and compliance matters.

A central management infrastructure ensures alignment of core shared services to each division and serves as a business partner to support the division chiefs in their roles. The central infrastructure maintains financial and reporting systems that keep practices and individual physicians in real-time touch with their productivity, charge capture, billing and collection, and other key practice management variables.

A rigorous acquisition planning process has been devised to vet practices interested in Emory Healthcare ownership. A five-step process is at work, including (1) pre-due diligence (quality-and-risk reporting and assessment), (2) due diligence (assessment of practice needs, practice operations, and financial and business risk review), (3) term-sheet review and approval (by the chief financial officer and chief executive officer of Emory Healthcare's physician practice and by the board members of Emory Specialty Associates and Emory Healthcare), (4) integration (contract creation, credentialing, and training), and (5) rollout with billing, collection, revenue cycle systems, financial accounting, quality and compliance, and adoption of Emory Healthcare's electronic medical record.

Emory Healthcare has maintained a close network with other academic practices that are also employing or seeking to develop employment models that run in parallel with their traditional academic practice models. Here is a set of frequently asked questions about a community-based model, and an explanation of how Emory Healthcare has addressed these issues:

(1) Faculty status: The physicians at Emory Specialty Associates are not on the promotion or tenure track; many of them are designated as "clinical affiliates" who participate in teaching and student interactions.

(2) Benefit structure: The physicians at Emory Specialty Associates have health and welfare benefit plans that have been designed to be competitive with those enjoyed by community-based physicians; as a consequence, benefits as a percent of overall physician personnel costs average under 10%. The physicians of Emory Specialty Associates do not participate in Emory University's retirement plan and they do not participate in the dependent scholarship program.

(3) Malpractice: The physicians of Emory Specialty Associates are on the same malpractice and liability plan as Emory University full-time faculty. The risk pools for the physicians at Emory Specialty Associates are kept separate from the faculty risk pool. To date, the risk rating for the physicians at Emory Specialty Associates is similar to that for faculty.

(4) Other: The physicians at Emory Specialty Associates keep close relations with the faculty practices for their given specialties. Referrals from Emory Specialty Associates to Emory Clinic remain robust.

The Consolidation Imperative: What Is a Physician Practice to Do?

Physician Practice Consolidation

Mergers of unlike entities can be culturally challenging. Important factors to consider are the type of merger partner as well as the degree of practice integration that is desired. From the perspective of an independent physician practice, options include joining a large health-care system, merging with a large independent physician practice, or consolidating with other small independent groups to become a larger independent group. Joining a large health-care system requires the independent group and the academic department to negotiate the details of their relationship, including income distribution, on-call responsibilities, access to residents and fellows, academic titles, committee representation within the medical school establishment, governance structure within the orthopaedic department, and access to operating-room availability, to name a few. Joining a large independent orthopaedic group requires similar decisions regarding on-call responsibilities, compensation, and governance but usually without the issues related to the academic relationships. Finally, consolidating smaller practices can be an option, but this is often a slow and arduous process. Given the degree of market consolidation that has already occurred, it can be challenging to find appropriate merger partners.

In addition to the type of merger partner, the degree of practice integration that the merger is attempting to achieve can have a large impact on how challenging the merger is likely to be. A fully integrated merger with shared call schedules and compensation pools is typically the most challenging but can offer the greatest benefits in terms of strategic impact and governance. Federated partnerships share the same tax identification number, business office, and other centralized functions but often allow local control of on-call responsibilities, compensation, and certain capital expenditures. These can be simpler to accomplish, with less to negotiate initially, but require diligent co-governance to maintain good relations. Finally, some entities

find it safest to test the water with contractual affiliation agreements that do not require dissolution of the independent practice or assumption of the tax identification number of the larger entity. While these arrangements allow both sides to learn the culture of the other and ease into the relationship, they offer more limited governance or contracting benefits.

Merger Phases and Process

Mergers typically go through several phases: courtship, cultural definition and exposition, data-sharing, negotiation, system integration, and cultural integration. In courtship, the entities must determine whether or not they share core values and sufficient motivation to undergo the significant disruption that such a merger would entail. Typically, both entities share the goals of referral and income stability while both also fear a loss of identity, brand integrity, and autonomy. These goals and fears must be shared openly to create common ground and mutual respect.

Cultural definition can be the most important phase of the merger process as the defining element of a practice. It is the outgrowth of values and determines ultimate behavior. Are you service oriented, patient friendly, high quality, cutting edge, financially successful, and respected in the community locally or nationally? How do you prioritize these elements? The answers to those questions will expose the culture of your group. Ultimately, to be most successful, the new group will need to be able to agree upon and mutually espouse the new culture of the combined entity. Doing so will enable the leadership to build a governance structure and negotiate a relationship that will support that culture.

Once there is agreement to move forward with merger exploration, leadership for both sides must be identified and negotiation teams established. Legal counsel is essential, and a mutually agreed-upon facilitator is often helpful. After signing a nondisclosure agreement, the negotiation teams should exchange malpractice claims histories, financial data, and other relevant information, including a pro forma assessment of financial performance on the payer contracts of the surviving entity. Retention or transition of employees must be determined, with particular attention given to any staffing policies that might impact employees who are transitioning into the surviving entity (e.g., an academic medical center's degree requirements for clinic nurses or radiology technicians). The role of the practice administrator must also be clearly delineated. The scope of this position, which previously may have included responsibility for the entire enterprise, may now be narrowed because of the merger with the larger institution, and the transition may prove challenging to the practice administrator. Finally, physician employment contracts must be negotiated, with the negotiations to include discussion regarding not only on-call responsibilities and compensation but also teaching responsibilities and academic appointments.

System integration typically requires, at a minimum, the transition to a single tax identification number and a unified business office. Long-term integration of clinical systems such as electronic medical records, dictation systems, and clinical processes can achieve significant gains, but conversion must be well planned and executed. Achieving the maximum benefit from the affiliation will likely require each of the following to eventually be addressed:

- Establishment of governance
- Financial systems in place
- Operational structure in place
- Expansion of ancillaries and leakage control
- Technological conversions and development
- Office consolidation
- Right sizing of staff
- Quality improvement and operational efficiencies
- Product differentiation
- Growth and expansion
- Hospital liaisons or development

Cultural integration takes time. The transition can be difficult for physicians and long-term employees who still identify themselves with the predecessor group. Strong physician leadership is necessary to build cohesion around the newly merged entity. Over time, the new entity will struggle with integration questions, such as those having to do with the valuation of research and teaching, recruitment, marketing, financial disparities among subspecialties or geographic locations, uniformity of clinical protocols, compliance, and quality reporting. With each contentious issue that the new entity puts behind them, the new culture will be further defined and the merger will move closer to closure.

Conclusions

The models for practicing orthopaedic surgery are evolving rapidly. While there may never be complete loss of traditional private practice and academic practices, there will be many new practice variations driven by multiple entities, including employers, insurers, the government, and hospitals. It is imperative that orthopaedic surgeons remain integral participants in the development of these new models. This was recognized by the audience that was present at the symposium on June 28, 2012, at the AOA Annual Meeting in Washington, D.C., as 88% of the audience responded that fee-for-service may continue in some form but will likely be reduced or merged into a hybrid model of reimbursement. Additionally, 95% of the audience believed that the number of self-employed physicians and/or physician-owned practices is likely to decrease over the next several years. These responses demonstrate the need for orthopaedic surgeons to remain actively involved in this changing marketplace. ■

NOTE: Craig Ferrell was involved in the planning and formulation of the AOA symposium[1] but was unable to present his information due to his untimely death. The authors acknowledge his valuable contributions.

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