Strategies to Successfully Integrate Hospitals and Physician Practices
STRATEGIES TO SUCCESSFULLY INTEGRATE HOSPITALS & PHYSICIAN PRACTICES

MODERATOR:

Paul Greve, Jr., JD, RPLU, Executive Vice President, Willis Health Care Practice

PANELISTS:

Michael Maglaras, CIC, Principal, Michael Maglaras & Company

James W. Saxton, Esq., Chair, Healthcare Litigation and Risk Management Group & Co-Chair, Health Law Group, Stevens & Lee

Dale L. Schultz, System Vice President, Business Health, Banner Health
Overview

- Physician Integration Trends
- Insurance Coverage Issues
- Defense and Claims Issues
- Banner Health’s Experience with Physician Integration
  - Risk Management
  - Claims
  - Insurance
PHYSICIAN INTEGRATION TRENDS
Physician Integration: Key Considerations

• Key Drivers
  – Move from fee-for-service → value-based medical care
  – Medical care needs to be more coordinated than ever
  – Physicians are seeking income security
  – Practice costs are rising
  – Reimbursement for physicians is declining
  – Younger physicians have large educational debt
  – Younger physicians want a better lifestyle
  – Higher reimbursement for hospitals with physician employees
Escalating Costs for Practices

Medicare Updates vs. Practice Costs

Source: 2010 Medicare Trustees report as adjusted by the Medicare and Medicaid Extenders Act of 2010
Hospital Ownership of Physician Practices Has Overtaken Physician Ownership

Tomorrow’s Growth - All About Winning Share

Securing Preference from Purchasers, Physicians, Patients

Three Key Decision-Makers

Wholesale Purchasers (Payers, Employers)

Referring Providers

Consumers

System Growth

Source: Health Care Advisory Board interviews and analysis.
Physicians Still at the Center of Referral Decisions

Specialist, Hospital Choices Especially Physician-Driven

Information Sources Used to Select a Specialist Physician

- 2008
- n=13,500

- 58% rely solely on referral from PCP

- Referral from PCP: 69%
- Friends or Relatives: 20%
- Another Doctor or Health Care Provider: 18%
- Health Plan: 11%
- Internet: 7%

Information Sources Used to Select a Facility for a Procedure

- 2008
- n=13,500

- 69% rely solely on referring doctor

- Doctor Performing the Procedure: 74%
- Another Doctor: 15%
- Friends or Relatives: 10%
- Health Plan: 7%
- Internet: 3%


1) Survey respondents given option to "select all that apply."
Physician Employment by Hospitals: The AMA View

2012 AMA Physician Practice Benchmark Survey

• In 2007-2008, the percentage of practice ownership by physicians was 61.1%

• In 2012, 53.2% were owners while 41.8% were employed

• Ownership less common among younger physicians and women
Physician Integration: Key Considerations

• Not all physician integration leads to employment
• “Alignment” of hospitals & physicians takes many forms:
  – Networks
  – Joint Ventures
  – Contractual Partnering
  – IPAs, PHOs, etc.
• Some disagreement on the numbers & percentages of employed physicians
• Physicians & hospitals need to more closely collaborate to improve outcomes, reduce costs, maximize reimbursement
Insurance Coverage Issues
Defining the Challenge and the Opportunity

Health Care System Clients of Michael Maglaras & Company: Percentage of Employed Physician Exposures to Total Bed Equivalent Exposures
The Risk and Financial Consequences of Physician Recruitment

1.00 Bed Equivalent
= 1 Family Practice Physician

3.89 Bed Equivalents
= 1 General Surgeon

5.89 Bed Equivalents
= 1 OB/GYN
Leaping the Wall to Join Forces

- Hospitals
- Community Physicians
- Captives
- Underwriters

CHALLENGES

- Adversarial claim relationship
- No risk management coordination
- No quality improvement coordination
- Limited shared clinical/business goals & objectives
## Some Commonly-Held Misconceptions
### Commercial Underwriters versus The Captive Market

<table>
<thead>
<tr>
<th>Misconception</th>
<th>Reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Alternative Risk Transfer Market” is temporary.</td>
<td>✓ The “Alternative Risk Transfer Market” is no longer “alternative.”</td>
</tr>
<tr>
<td>✓ When the market hardens, there will be a return to “insurance.”</td>
<td>✓ Pre-supposes market will harden significantly…and that captives don’t write “insurance.”</td>
</tr>
<tr>
<td>✓ Captives have no professional underwriting, claims management and business back-office capabilities.</td>
<td>✓ Captives have and continue to unbundle services to organizations in direct successful competition with underwriters.</td>
</tr>
<tr>
<td>✓ The traditional PIAA reinsurance market’s first loyalty is to PIAA companies.</td>
<td>✓ True, to the extent premium volume continues to make it true. Reinsurers follow “the money.”</td>
</tr>
<tr>
<td>✓ Health care liability captive business does not contribute to PIAA company organic growth.</td>
<td>✓ Only true if PIAA companies ignore health care liability captives and the changing marketplace.</td>
</tr>
</tbody>
</table>
### Some Commonly-Held Misconceptions

#### Commercial Underwriters versus Themselves

<table>
<thead>
<tr>
<th>Misconception</th>
<th>Reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Commercial insurers have no experience cooperating with insureds with large SIRs.</td>
<td>✓ True in many cases...not true in some.</td>
</tr>
<tr>
<td>✓ Commercial insurers can’t afford to unbundle underwriting, reinsurance, and claims services to support self-insurance efforts.</td>
<td>✓ Why not?...the model of insurers doing precisely that has been here since the late 1960s and exists widely in other P&amp;C lines.</td>
</tr>
<tr>
<td>✓ Captives are heavily dependent on the financial standing of their parent organizations.</td>
<td>✓ Yes...but not as much as they used to be.</td>
</tr>
<tr>
<td>✓ As more physician practices are acquired, PIAA companys’ role will diminish in the marketplace.</td>
<td>✓ Only for the unprepared.</td>
</tr>
</tbody>
</table>
What’s the Underwriting Model We’re All Comfortable With?

- Medical Staff
  - Community Physicians
  - Hospital
  - Employed Physicians
  - Insurance Source: Commercial, Etc.
  - Insurance Source: Hospital-Owned Captive
  - Reinsurance Market

same players?
What’s the Underwriting Model We **Need** to Get Comfortable With?

Possible Alignment Strategies
- Full employment (incl. foundation models)
- Increased use of Medical Directorships
- Leasing arrangements with physician groups
- Gain sharing (subj. to OIG & Stark considerations)
- Service line management ventures: cardiac care, women’s health, cancer care, etc.
- A possible combination of some or all of the above
What Has the Commercial Market Provided to Your Physician and Mine?

Assessing the Current Value-based Business Model

- Underwriting/Risk Selection
- Risk Management
- Transfer of Balance Sheet Risk
- Claims Adjustment
- Risk Education

Commercial Insurers → Physician
What Can the Commercial Market Provide to Your Physician and Mine?

The *Future* Value-based Business Model

- Underwriting/Risk Selection
- Risk Management
- Transfer of Balance Sheet Risk
- Claims Adjustment
- Risk Education

Commercial Insurers ➔ Captives
### Before We Count Out the Commercial Market...

**Hospital Captive Owners versus Themselves**

<table>
<thead>
<tr>
<th>Misconception</th>
<th>Reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ I can increase my physician exposures without significantly impacting my captive balance sheet.</td>
<td>✓ You’re going to need to need a professional underwriter to help you smooth out exposures.</td>
</tr>
<tr>
<td>✓ “The hospital’s risk management dept. can handle an influx of employed physicians in independent practices.”</td>
<td>✓ You will not get the resources you need to do the job right without significant outsourcing.”</td>
</tr>
<tr>
<td>✓ We have to figure out how to make allowances for the fact that there are fewer ‘deep pockets’.</td>
<td>✓ “You bet you will...so why have fewer pockets?”</td>
</tr>
<tr>
<td>✓ Future margins under ACA will be dependent on mining the captive’s claims data.”</td>
<td>✓ “True...but only with regard to mining hospital claim data...where will you get physician claim data?”</td>
</tr>
<tr>
<td>✓ The captive’s surplus can withstand the effects of physician acquisition and increased exposures.”</td>
<td>✓ “Why risk it, when you can have a professional underwriting partner to share balance sheet risk with you?”</td>
</tr>
</tbody>
</table>
SUCCESS: THE ULTIMATE STRATEGY

BUT CLAIMS AND DEFENSE ISSUES DO ARISE!
PHYSICIAN INTEGRATION:
LIABILITY IMPLICATIONS
...from the weeds
Some hospitals are losing money on physicians… Some medical practices are concerned about their revenue sources

- The key: helping physicians be successful (but risk comes with that)
- ACA/ACO/reimbursement reform – what result in courtroom?

But Bon Secours' acquisition of physician practices hasn't been without bumps. In its fiscal 2013, ended Aug. 31, the not-for-profit system took $158 million in losses as a result of its physician employment strategy, according to Moody's Investors Service. Employing non-physicians has meant a 5.2% increase in salary and benefit expenses, as well as added costs related to renting and staffing office space. The system has been working with a consulting firm since fiscal 2012 on a cost-reduction plan, focusing on better integrating its employed doctors, according to its financial report.

- $158 million in losses as a result of its physician employment strategy
- 5.2% increase in salary and benefit expenses
- Added costs related to renting and staffing office space
- **Now** focusing on better integrating its employed doctors
Level 101 - Liability Issues

• The push to “value”
• Reduction in costs – 15%-20%
• Reduce “unnecessary” tests/procedures
  – Economic claims
  – Shared savings – appropriate but…
  – Managed care-ish
• High quality performance standards
  – Is this a new standard of care?
  – Are you setting your own standard of care?
  – Discovery of data – is a PSO needed?
Level 200

- An attack on the system
  - Corporate negligence
  - Health system – is there a “culture” of safety
  - Can it be shown/\textit{proven}
  - Will Board members be deposed
  - Will punitive damages be claimed

- Consolidation
  - Small community hospitals consolidating into systems
  - Significant profits in front of the jury…Plaintiffs will ask to “reinvest in safety”
  - Consolidation/integration results in multiple defendant cases
Defending claims differently

• Move to a collaborative joint defense model

• New breed of experts
  – Safety, engineering, health policy experts
  – Blinded

• ACA should pre-empt the collateral source rule

• We must invest in interpreting this federal law correctly!
A minute about SUCCESS

• Wanted: leadership/change management
• A new definition of **Rock Star**
• Reducing cost without reducing quality – **HOW?**
  – Understand costs and re-engineer delivery
  – A laser-focus on safety
    • The #1 concern for enhanced patient experience
  – And concurrently, re-focus on post-ACA “**transitional risk**”
    • Engagement may be **everything**
Patient Engagement: Helps Reduce Costs and Decrease Liability
A cornerstone of post-ACA activity:

• Patient engagement required (ACA §3022)
• Multi-faceted patient involvement required (ACO Regulations §425.106, §425.112)
• Foundation for appropriate comparative/contributory negligence

*Meaningful Patient Engagement that improves outcomes and documents “compliance”*
The Key:

• Teaching Patients: *how to be engaged*

• Teaching Providers: *how to engage*

**Reinventing the relationships**
(and educating future jurors)
Banner Health’s Experience with Physician Integration
Banner Health

- 24 Hospitals, including clinics, Surgi-Centers, Long Term Care Facilities, Home Care, Hospice, & DME
- Operating in 7 Western States
- Revenue in excess of $5 Billion
- Over 35,000 employees
- Corporate Office Phoenix, AZ
- Employed Providers: >1,100
- Health Centers: 8
- Clinics: 168
Banner Indemnity, LTD (BIL)

Reimbursement (indemnity) NOT insurance

Cayman Captive / USVI Branch 1986

Assets 200M
Premium 50M
Limits 200M
Primary – Occurrence 10M
1st Xcess – Claims Made 20/20M
Reinsurance – Claims Made 70M
Company: Samaritan Insurance Funding, Ltd.; a wholly owned captive
Policy Form: Occurrence Coverage, so no need for “tail” coverage
Deductible: None
Limits: $10,000,000 each & every claim, no aggregate. (shared limit).
Coverage: Claims arising out of your employment, and volunteer acts
Joint Defense: Banner will select defense counsel for physicians & hospital
Consent: The practitioner does not have the right to consent to settle claims.
Prior Acts: Banner may provide prior acts coverage & maintain retro date
Administrative Defense for disciplinary, licensure, or similar administrative proceedings brought by regulatory agencies or licensing boards is provided.
Excess Liability: Samaritan provides an excess liability policy above the primary limits ($10 Million). Reinsured in the commercial insurance market.
BMG Provider Growth

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>57.17</td>
<td>68.03</td>
<td>79.27</td>
<td>96.04</td>
<td>111.71</td>
</tr>
<tr>
<td>NP</td>
<td>61.23</td>
<td>98.43</td>
<td>124.47</td>
<td>157.58</td>
<td>232.53</td>
</tr>
<tr>
<td>Physician</td>
<td>503.96</td>
<td>629.99</td>
<td>758.80</td>
<td>878.66</td>
<td>1,118.27</td>
</tr>
</tbody>
</table>

- Provider FTE Count
P.R.I.M.E.

Provider
Resolutions
Improving &
Managing
Expectations
Banner PRIME Program Goals

1. Maintain the provider-patient relationship.

2. Counsel providers- encourage open, honest communication, including disclosure and apologies, when appropriate.

3. Engage providers in risk management and loss prevention activities.

4. Facilitate validation of risk through risk assessments, focus groups, and linkage with quality reviews and claims analysis.

5. Partner with BMG Quality Management and BMG leadership as needed.
Do I have to pay the bills first?
Yes. You are responsible for paying your bills after they have gone through your insurance. After you have paid a bill, you can submit a copy of the bill and a copy of your proof of payment or receipt for consideration. The bill must show the date of service, the service provided and the amount you owe. Please do not send the original bill. You can submit bills as you pay them; you do not need to send everything at one time.

What expenses can be reimbursed?
Funds may be available to reimburse certain out-of-pocket expenses related to the unexpected outcome not covered by your health insurance. The limits of this benefit are determined on a case by case basis.

Why do I need to submit a W-9?
Certain types of reimbursement payments may need to be reported to Medicare, the IRS, or other entities. Please discuss any concerns you may have with the Risk Management Plan Administrator assigned to your case.

How long will it take for me to be reimbursed?
Reimbursement checks can take three to four weeks to process. Checks are processed by Banner Health’s Accounts Payable department located in Phoenix. Checks are subject to local mail delivery. Holidays may affect the check processing schedule.

Where do I submit my bills for reimbursement?
You can mail, or fax or email your bills to the attention of the following:
Western Region PRIME Program
c/o North Colorado Medical Center
Risk Management Department
1801 16th Street
Greeley, CO 80631
Secure Fax: (970) 378-3890. (Please include a cover page.)
WRPRIME.program@bannerhealth.com

More Information
For questions, please contact the Risk Management Plan Administrator assigned to your case.

Banner PRIME Program

Our Mission:
We exist to make a difference in people’s lives through excellent patient care.
EPiP
(Emergency Physician's Insurance Program)

- Occurrence form
- Per visit premium (subject to FET)
- $1M/$10M combined limits
- Joint defense
- No physician deductible
- Regulatory coverage
# EPIP Loss Funding and Claim Summary as of 2/28/14

<table>
<thead>
<tr>
<th>POLICY</th>
<th>CTS</th>
<th>IND PAID</th>
<th>EXP PD</th>
<th>IND INCUR</th>
<th>EXP INCUR</th>
<th>IND OUT RESV</th>
<th>EXP OUT RESV</th>
<th>TOT OUT RESV</th>
<th>TOT INCUR</th>
<th>LOSS FUNDING</th>
<th>LOSS RATIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIFLED2003-04</td>
<td>96</td>
<td>$1,151,253</td>
<td>$385,605</td>
<td>$1,151,253</td>
<td>$385,605</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$1,536,858</td>
<td>$1,317,367</td>
<td>117%</td>
</tr>
<tr>
<td>SIFLED2004-05</td>
<td>66</td>
<td>$0</td>
<td>$138,677</td>
<td>$0</td>
<td>$138,677</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$138,677</td>
<td>$1,720,879</td>
<td>8%</td>
</tr>
<tr>
<td>SIFLED2005-06</td>
<td>104</td>
<td>$650,000</td>
<td>$333,406</td>
<td>$650,000</td>
<td>$333,406</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$1,003,406</td>
<td>$2,257,044</td>
<td>44%</td>
</tr>
<tr>
<td>SIFLED2006-07</td>
<td>97</td>
<td>$545,678</td>
<td>$597,760</td>
<td>$545,678</td>
<td>$597,760</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$1,143,439</td>
<td>$2,319,391</td>
<td>49%</td>
</tr>
<tr>
<td>SIFLED2007-08</td>
<td>106</td>
<td>$3,037,208</td>
<td>$1,772,102</td>
<td>$3,037,208</td>
<td>$1,772,102</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$4,809,310</td>
<td>$2,676,852</td>
<td>180%</td>
</tr>
<tr>
<td>SIFLED2008-09</td>
<td>114</td>
<td>$1,589,000</td>
<td>$184,845</td>
<td>$1,589,000</td>
<td>$184,845</td>
<td>$0</td>
<td>$69,755</td>
<td>$69,755</td>
<td>$1,840,600</td>
<td>$2,821,536</td>
<td>65%</td>
</tr>
<tr>
<td>SIFLED2009-10</td>
<td>66</td>
<td>$10,000</td>
<td>$62,455</td>
<td>$10,000</td>
<td>$62,455</td>
<td>$0</td>
<td>$77,455</td>
<td>$77,455</td>
<td>$147,905</td>
<td>$2,784,760</td>
<td>3%</td>
</tr>
<tr>
<td>SIFLED2010-11</td>
<td>117</td>
<td>$33,103</td>
<td>$189,056</td>
<td>$33,103</td>
<td>$221,034</td>
<td>$3</td>
<td>$31,978</td>
<td>$31,978</td>
<td>$254,137</td>
<td>$2,950,344</td>
<td>9%</td>
</tr>
<tr>
<td>SIFLED2011-12</td>
<td>49</td>
<td>$2,699,604</td>
<td>$158,670</td>
<td>$2,699,604</td>
<td>$163,874</td>
<td>$54</td>
<td>$25,004</td>
<td>$25,004</td>
<td>$2,863,533</td>
<td>$2,850,000</td>
<td>101%</td>
</tr>
<tr>
<td>SIFLED2012-13</td>
<td>28</td>
<td>$30</td>
<td>$72,544</td>
<td>$30</td>
<td>$129,104</td>
<td>$18</td>
<td>$56,560</td>
<td>$56,560</td>
<td>$129,104</td>
<td>$2,610,566</td>
<td>5%</td>
</tr>
<tr>
<td>SIFLED2013-14</td>
<td>38</td>
<td>$1,154</td>
<td>$45,002</td>
<td>$1,191</td>
<td>$76,267</td>
<td>$37</td>
<td>$31,285</td>
<td>$31,285</td>
<td>$77,457</td>
<td>$2,247,766</td>
<td>3%</td>
</tr>
<tr>
<td>SIFLEDTAIL</td>
<td>11</td>
<td>$207,000</td>
<td>$255,231</td>
<td>$207,000</td>
<td>$255,231</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$462,231</td>
<td>$556,650</td>
<td>82%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>892</td>
<td>$8,525,027</td>
<td>$4,215,555</td>
<td>$8,926,139</td>
<td>$4,430,117</td>
<td>$112</td>
<td>$214,681</td>
<td>$214,681</td>
<td>$14,356,256</td>
<td>$27,192,214</td>
<td>53%</td>
</tr>
</tbody>
</table>

Prior Month:
- IND PAID: $9,051,027
- EXP PD: $4,208,185
- IND INCUR: $11,226,097
- EXP INCUR: $4,443,546
- IND OUT RESV: $2,175,060
- EXP OUT RESV: $235,360
- TOT OUT RESV: $2,410,420
- TOT INCUR: $15,669,633

% of Change:
- IND PAID: 0.90%
- EXP PD: 8.62%
- IND INCUR: 0.17%
- EXP INCUR: -13.10%
- IND OUT RESV: -3.30%
- EXP OUT RESV: -9.96%
- TOT OUT RESV: -10.22%
- TOT INCUR: -9.15%

37% 5 year ratio
Evidence of Success:

• Stable premiums
• $6M accumulated surplus
• 34% drop in hospital ED claims ($) despite 25% growth in visits
• Improved patient satisfaction scores
• Quality of recruits
Evidence of Success:

Accomplishments!

- Nationally recognized conferences
- Joint defense
- $6M surplus
- Declining premiums
- Joint governance
- Sim Lab training
- Tailored education
- POS satisfaction surveys
- Boot camps
- Physician education incentives
- Pediatric order sets
- Chart review
- Claim panel
- Education incentives
- Physician education reimbursement
- Peer reviews
- Education library
- Chart audits
- Scribes
- Applicable newsletters
- Care maps
- Chart reviews
- Provider scorecards
- Pediatric order sets
- Interactive seminars
- Education incentives
- Recruitment funding
- Airway carts and other equipment purchases
- Chart dives with root cause analysis
- Physician education incentives
- Powerful on-line education tools