BERKELEY CENTER
FOR HEALTH TECHNOLOGY

Physician-Led Organization

Developing and Capturing Competitive Advantage

James C. Robinson
Leonard D. Schaeffer Professor of Health Economics
Director, Berkeley Center for Health Technology
University of California

Overview

- Physician practice: the imperative to achieve scale to manage care, improve quality, and reduce costs
- Physician-led versus hospital-centered partners
- Purchasers focus on ASC v. HOPD
- Ingredients for physician success

"You can't list your iPhone as your primary care physician"

Physicians Choose their Partners

- Health care spending is driven by new technological opportunities and rising consumer expectations
- It will not moderate by itself, as we get healthier. It must be managed, and in a way that improves quality
- Health care is ever more complex, and management requires large scale, evidenced-based clinical protocols, sophisticated supply chains, financial reserves, etc.
- Small physician practices need to choose a partner. Even medical groups and IPAs find themselves needing an organization with larger scale and deeper capabilities
- What are the options?

Physician-Led Organization

- Physicians and medical groups have been the center of the delivery system, but in recent years have found themselves squeezed between ever-larger health plans and ever-larger hospital systems
- Physicians in California long have developed prepaid group practices and IPAs to support their practices and help them manage cost and quality. Many are in the room today.
- But even they increasingly feel the need for larger scale and deeper management capabilities in a market dominated by Kaiser, national insurers, and hospital organizations
  - I have great admiration and affinity for physician-led organizations, beginning 25 years ago with Monarch, NAMM, AppleCare and HealthCare Partners
  - It is amazing to see you come together
- Large physician-led organizations such as OptumCare are approaching or exceeding the scale needed to manage care, but are facing major competitors

The Rise of Hospital Systems

- Hospital-centered organizations ('health systems') are consolidating inpatient facilities locally and regionally, expanding into ambulatory and subacute care, and acquiring physician practices and medical groups
- Some are progressive, pricing their ambulatory services at community levels and using profits from inpatient services to coordinate care across the clinical continuum
  - Some of the most progressive health systems are in SoCAL
- But many health systems use their leverage to raise prices in both inpatient and outpatient settings and devote their margins to strengthen institution-centered rather than community-centered care
- Health plans, self-insured employers, and governmental policymakers are very concerned with hospital consolidation and expansion into ambulatory services, but are unsure of the alternative

Understanding Hospital Systems

- Hospital-centered organizations seek to coordinate care, but sometimes increase complexity, attenuate physician entrepreneurship, sustain high financial overhead, and retain a bricks-and-mortar culture, compared to ambulatory-only organizational options
- What explains their success?
- Inpatient hospitals are very capital intensive and are protected by barriers to market entry and competition
- This allows incumbents to charge high ('monopolistic') prices and earn attractive margins, despite high costs, that can be used to buy and build ambulatory clinics and MD practices
- Many systems then raise the prices for physician and ambulatory services, and use those margins to fund further expansion, both locally and regionally

How Can Physician Organizations Compete?

- If physicians and physician organizations are to retain their role in the center of the delivery system, they must innovate to find more efficient ways of providing care. Large scale is necessary, but not sufficient, for success
- The targets for efficiency and quality gains evolve over time. We cannot save the same dollar twice.
- Moreover, it is not enough to improve. It is imperative to improve more and faster than competing organizations that also are trying to improve
- What are the important efficiency targets today? How can they best be achieved?

Moving the Clinical Site of Care

- Historically, medical groups and IPAs obtained the funds to expand scale and deepen their capabilities by reducing inpatient hospital utilization: admissions and LOS
- Eternal vigilance is necessary, and further movement to same-day settings continues to be a goal for patients who are clinically appropriate
  - Total knee and hip replacement is the most recent example
- However, the biggest targets for cost savings are not from inpatient to outpatient but are across outpatient settings
- These shifts need to be based on clinical protocols that identify patients able to move, often the less severe cases
- Moving to less acute settings often will improve quality, due to less exposure to risk of infection, as well as reduce costs

Many Sites of Care

- There are many outpatient settings, and careful consideration is important for referring patients among them
- Cost reductions, clinical quality, and patient experience can be improved through movements from:
  - Same day procedures: from hospital outpatient department (HOPD) to ambulatory surgery center (ASC)
  - Minor procedures: from ASC to physician offices
  - Drug infusion: HOPD to physician office or patient's home
  - Kidney dialysis: from ambulatory centers to the patient's home
  - Palliative care: from subacute care facility to the home
- The economically most important is from HOPD to ASC
- ASC have much lower cost structure than HOPD as they are more focused, have higher throughput, have greater physician ownership and commitment, and excellent patient satisfaction

Purchasers are Focusing on Shifting Care from HOPD to ASC

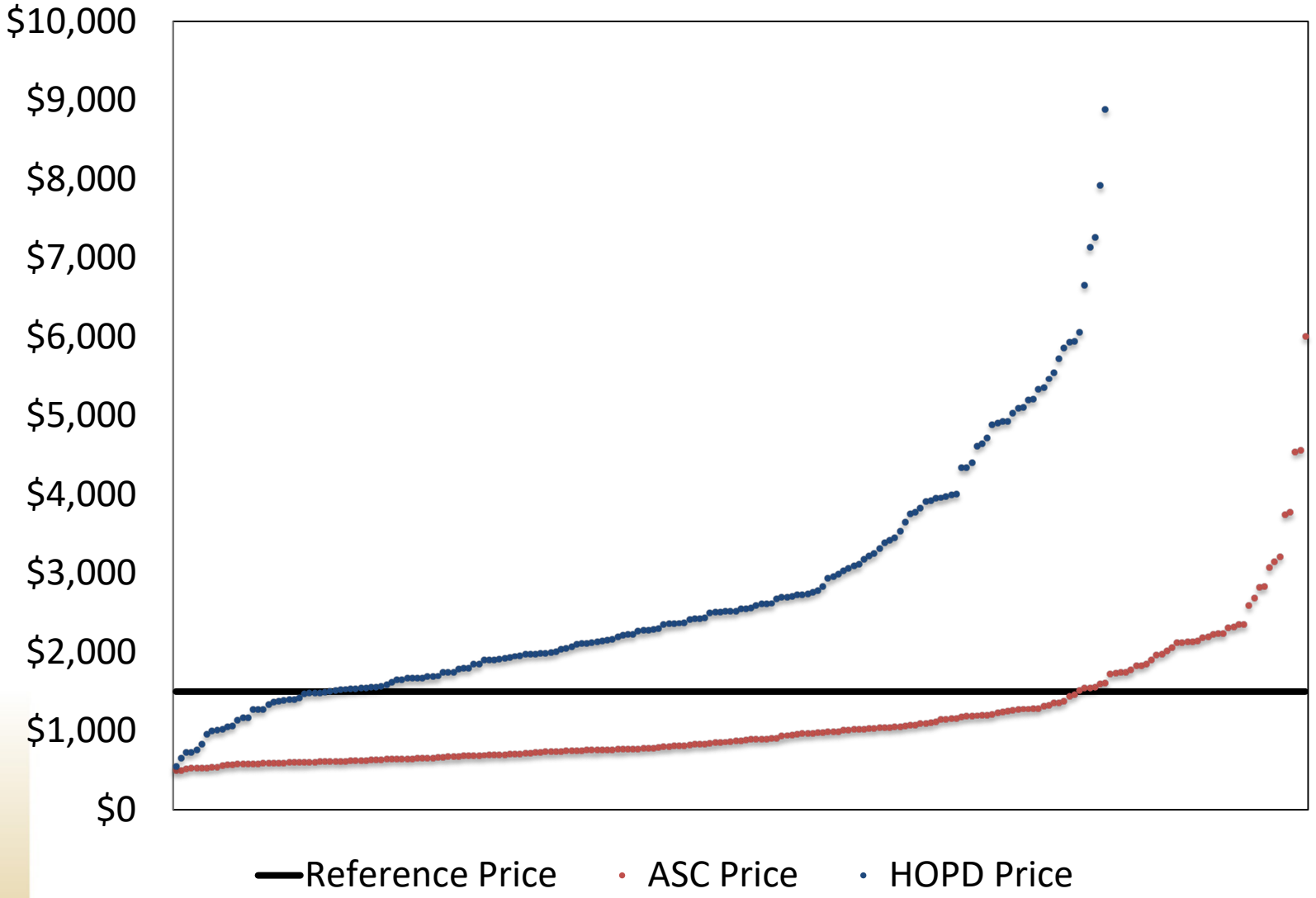
- Policymakers and purchasers recognize the imperative for clinical coordination, and that integrated provider organizations can do this best
- However, they want the value of these efficiencies to be passed to them, and are displeased to experience price increases ('monopoly power')
- When forced to choose, purchasers will channel their members/patients away from hospital-centered systems towards independent and physician-led ASC if this is the way to obtain lower prices
- Their insurance designs now reduce cost sharing for patients who use these freestanding facilities

Example: California Public Employees Retirement System

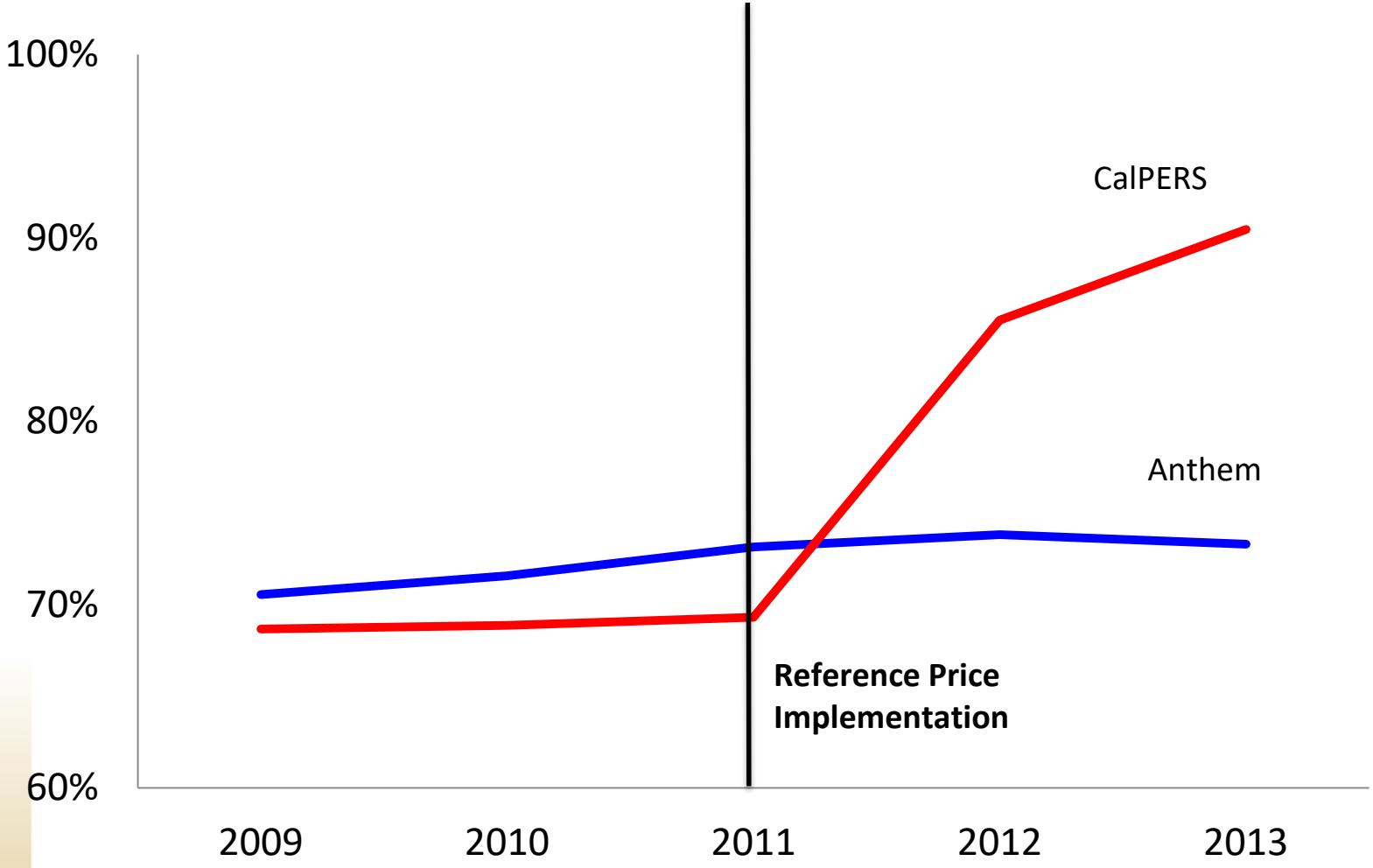
- CalPERS provides health insurance to 1.5 million employees and retirees of the state, cities, and other public entities
- It pioneered a benefit design for ambulatory procedures, with the intent to favor ambulatory surgery centers (ASC) over hospital outpatient departments (HOPD)
- CalPERS established payment maximum for each procedure, with the patient required to pay the difference if a more expensive site of care is used

- For CalPERS, the payment limit was set for HOPDs at the average price charged by ASC
- ASC were paid their full negotiated price (allowed charge)

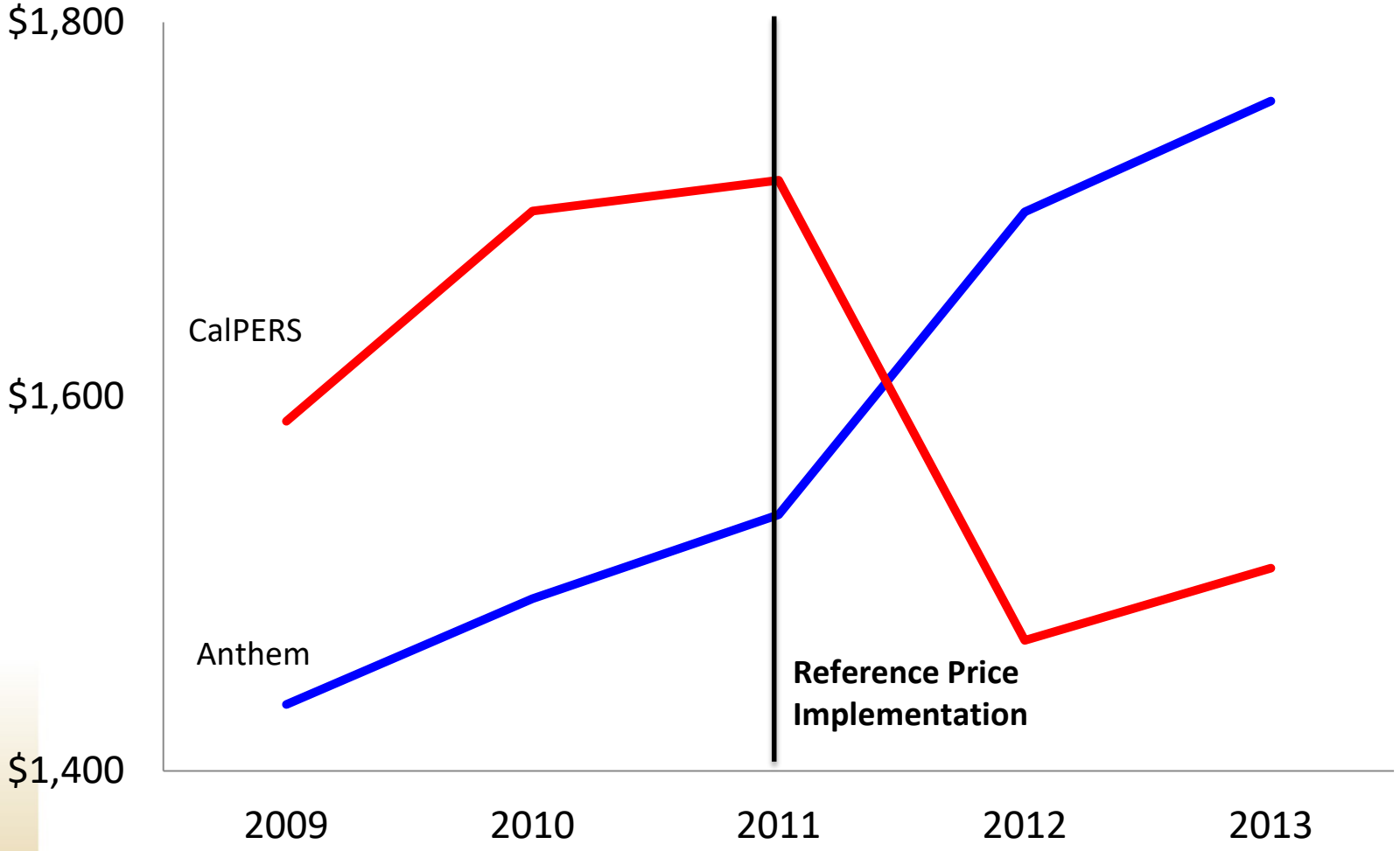
Prices Paid by CalPERS in HOPD and ASC Prior to Reference Pricing: Arthroscopy



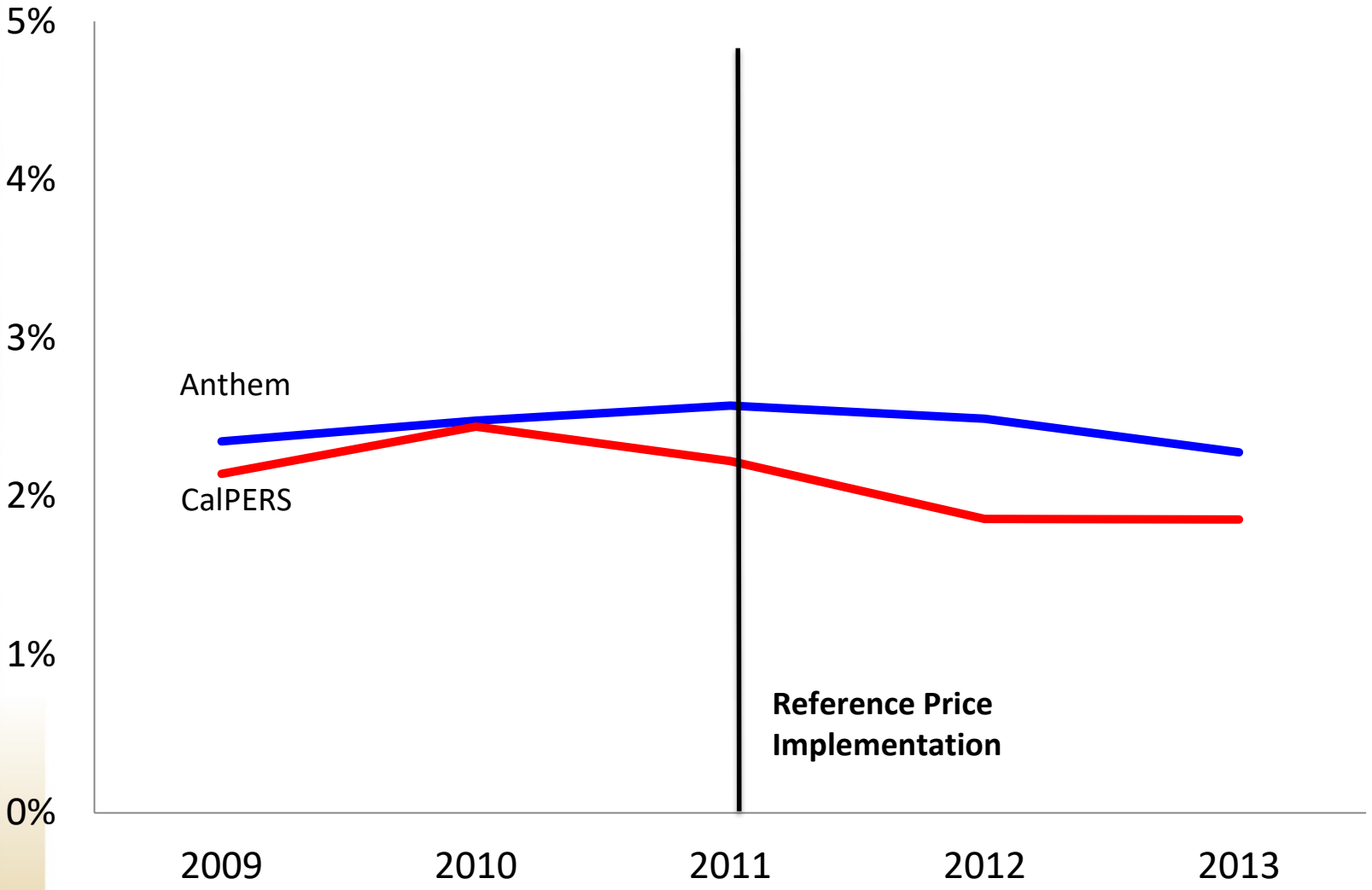
Patients Selecting Ambulatory Surgery Centers (ASC) Before and After Reference Pricing: Arthroscopy



Prices Paid by CalPERS Before and After Implementation: Arthroscopy



Surgical Complications Before And After Implementation: Arthroscopy



CalPERS is Expanding Reference Pricing for Diagnostic and Surgical Procedures

It is focusing on moving drug infusion (biologics) to non-HOPD sites (physician office, community infusion clinic, patient's home)

Reference Pricing for Twelve Procedures Compared to Costs for Ambulatory Surgery Centers and Outpatient Hospital Facilities

	Upper GI Endoscopy with Biopsy	Laparoscopic Gall Bladder Removal	Upper GI Endoscopy	Esophag-oscopy	Sigmoid-oscopy	Hysteroscopy Uterine Tissue Sample (with Biopsy, with	Nasal/Sinus - Submucous Resection Inferior Turbinate	Tonsillectomy and/or Adenoidectomy, Under Age 12	Nasal/Sinus - Corrective Surgery - Septoplasty	Lithotripsy - Fragmenting of Kidney Stones	Hernia Inguinal Repair (Age 5+, Non-Laparoscopic)	Repair of Laparoscopic Inguinal Hernia
Ambulatory Surgery Center												
Highest Cost	$5,846	$15,586	$4,131	$4,247	$3,766	$7,277	$7,623	$7,638	$12,069	$14,267	$10,491	$13,557
Lowest Cost	$721	$2,661	$530	$1,079	$403	$1,398	$1,564	$1,550	$2,123	$3,916	$2,311	$1,942
Outpatient Hospital Facility												
Highest Cost	$18,589	$78,822	$9,652	$9,030	$9,907	$60,818	$22,695	$20,990	$22,014	$25,759	$20,129	$43,612
Lowest Cost	$786	$3,082	$703	$1,786	$449	$1,601	$4,591	$1,934	$4,950	$3,734	$2,152	$3,924
Recommended Reference Price	**$2,000**	**$5,000**	**$1,500**	**$2,000**	**$1,000**	**$3,500**	**$3,000**	**$3,000**	**$3,500**	**$7,000**	**$4,000**	**$5,500**
CalPERS Annual Projected Savings Per Procedure	$608,102	$560,857	$109,775	$21,137	$24,683	$112,468	$108,900	$94,505	$125,637	$96,731	$99,711	$76,737
TOTAL ANNUAL PROJECTED SAVINGS												$2,039,242

Assumes 10% increase in ASC use

Mixed and Unmixed Incentives

- Hospital systems have mixed incentives (fixed overhead, institution-centered culture) and many are moving care only slowly to lower-acuity sites
- Physician-led organizations have unmixed incentives: with value-based payment methods, there is no disadvantage and many advantages to the shift
- Savings are shared between the physicians and the health plans, with lower cost sharing to the patients

Ingredients for Success: Clinical Pathways & Collaborative Relations

- High acuity patients need high acuity HOPD sites of care
- To shift care from HOPD to ASC, the organization needs evidence-based clinical guidelines, developed and adopted by its practicing physicians, to decide which patient needs which site
  - Contrast this with top-down insurer ‘prior authorization’
- The organization needs data systems and analytics to monitor outcomes across sites. These can come from insurer claims, patient surveys, medical records
  - Procedural complications: e.g., infection, stroke
  - Admission to ED or hospital
- These must be measured at 30 or 90 days post-procedure; patient experience over longer periods

Ingredients for Success: Financial Incentives & Payment Methods

- Physician organizations cannot be expected to do the hard work needed to shift care to lower acuity settings if all the savings go to insurers
- Value-based payments are growing
  - Capitation, shared savings, episode-of-care payment
- The physician organization needs to ensure these are actuarily valid, that spending targets are based on peer organizations and past performance, and that the organization can reinvest the savings
- Gainsharing between the organization and the insurer needs to be complemented by gainsharing between the organization and the practicing physicians and medical groups

Ingredients for Success: Benefit Design and Consumer Incentives

- Patients benefit from lower acuity sites through lower rates of infection, fewer delays, less inconvenience
- They also benefit through lower cost sharing under coinsurance and deductible insurance benefit designs
- Insurers now are developing stronger consumer incentives to favor low acuity sites, including reference pricing and narrow networks
- Physician organizations need to ensure alignment between consumer and physician incentives
- Physicians, consumers, employers, and health plans all need to share in savings from the shift in care to lower cost sites

Ingredients for Success: The Bar Keeps Rising

- The move from high-acuity to low-acuity sites begins with patients with the least severe conditions and fewest clinical and behavioral co-morbidities
- As the shift continues, however, it involves patients at higher acuity and with more co-morbidities
- More monitoring, over longer periods of time, across multiple sources of data, becomes necessary
- New digital tools and sensors can facilitate better self-monitoring and reporting by patients and more extensive passive monitoring and auto-reporting
- New systems can better integrate these new data with EMR, claims, evidence-based benchmarks

Summary and Conclusions

- Health spending will not moderate by itself; it needs to be managed. Who will do this?
- Health plans with restrictive payment methods and administrative controls?
- Hospital systems with employed physicians and an institutional culture?
- Consumers with high-deductible health plans and digital technologies?
- Physician-led organizations with scale, clinical pathways, and organizational capacities?

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