BECKER'S
HOSPITAL REVIEW

CONIFER HEALTH SOLUTIONS®

July 2017 | Vol. 2017 No. 7

Redefining the Hospital-Physician Relationship: How Integration is Evolving for Success Under Value-Based Reimbursement

The healthcare ecosystem's shift to value — helped along by programs like the Medicare Access and CHIP Reauthorization Act and the Merit-Based Incentive Payment System, bundled payment demonstrations and commercial payer reforms — requires hospitals and physicians to redefine their relationship.

As reimbursements continue to decline and administrative requirements increase, physicians want healthcare organizations to help provide a more stable infrastructure to support new payment models so they can focus on patients. Meanwhile, hospitals are relying on the performance of physicians on the frontlines for financial security, given that reimbursement and incentives are directly linked to quality performance and patient outcomes.

To put it simply, in an era of value-based reimbursement, physicians and hospitals need each other. And they need to integrate in new ways to succeed in this emerging model.

Successful integration requires hospitals and physicians to rethink how they report and use quality and cost metrics. It requires new financial relationships and contracts, and it calls for restructuring of leadership and governance.

Becker's Hospital Review caught up with finance leaders from two distinct healthcare organizations — a specialty cancer center and a health system — to discuss how they are approaching this shift and how the move to value-based care is redefining the hospital-physician relationship.

Participants include:

- Joanna Weiss, Vice President of Revenue Cycle Management at Moffitt Cancer Center (Tampa, Fla.)
- Jon E. Riggs, Senior Vice President & CFO of Medical Center Health System/MCH ProCare (Odessa, Texas)

Editor's note: Responses have been edited lightly for length and style.

Question: What are employed physician groups looking for from their hospital (i.e. aligned incentives, shared infrastructure, regulatory compliance, increased transparency around payer contracts/negotiations, etc.)?

Joanna Weiss: Our physicians are looking for their hospitals to make their jobs more efficient and to reduce physician burnout. Those are two top-of-mind topics that continue to come up from our physician groups — how can we make our EHR more efficient for the physician and how can we lighten the administrative burden, so they can concentrate on seeing their patients.

Our physicians are a little more unique than other groups because they are in academia. Their focus is research, their academic interests and their clinical interests. The advancement of new therapies and innovative care is promising. As a result, they really rely on administrative folks to find ways to improve reimbursement for the care they provide. There are pockets of physician administrators that are looking for creative reimbursement models.

Jon Riggs: In my opinion, physicians are looking for a consistent paycheck in a time of decreasing reimbursements, increased regulatory responsibility and increased audit recoupment. They are also facing incentive-based reimbursement. That means they will potentially receive lower reimbursement if they have to rely on patient compliance.

Q: What do hospitals/health systems want from their physician group to achieve and sustain organization-wide financial health and clinical goals (i.e. adherence to reporting processes, increased quality standards, cost containment, etc.)?

JW: We are looking for our physicians to document their care in a timely fashion, to provide access in the consumer-driven market and continue to reduce time to treatment, which is ultimately going to support our goal of better patient outcomes.

We have weekly dashboards that show timely documen-

tation. Then to make it easier for providers, we are looking to optimize the EHR so documentation is more efficient, and we are looking to work with our EHR provider to identify ways that we can streamline the workflow.

Our patients are newly diagnosed with cancer. Their tolerance or threshold for wait times is narrow. We expect that, and we want to provide timely access to care. We've had to ask physicians to load-level their templates; we've had to ask them to open up new slots to see additional patients so we can cater to demand that is upon us.

JR: Hospitals are working to improve collaboration as the industry moves to promote clinically integrated networks in an effort to contain costs by providing consistent, high-quality care.

Q: Reimbursement for healthcare organizations is gradually shifting away from the traditional fee-for-service model. How is your organization evaluating and measuring physician performance to support and adhere to new value-based payment programs (i.e. MACRA and MIPS)?

JW: We are still in the evaluation phase of identifying which of the [Advancing Care Information] measures we are going to report on. Being a cancer center, many of them don't apply to us, so we have to be very deliberate in identifying which measures will most accurately reflect the quality and value of care we provide.

We also have a department of payer strategies that is dipping their toes into the water with regard to additional bundle payment models. We are working with our payers to find ways to demonstrate our value and still provide a reduced cost to the payer. We have our clinical pathways that we really believe will streamline care, eventually reduce the cost of care and still provide better outcomes for our patients.

JR: We are currently expanding our physician-owned group in an effort to provide a broad spectrum of care. At the same time, we are aligning our physician compensation models to reflect the changes under the value-based payment models.

Q: Employed physician integration is only possible with right governance structure and management of the physician enterprise. How have your governance and management structures changed to support a successful transition to value-based reimbursement and population health management?

JW: Physicians have been integrated into the health system by their leadership roles, participation in initiatives, board representation, etc. Physicians have an active voice in how the center operates.

JR: The current governance understands the changing reimbursement dynamic and is working with our physician leadership to ensure high-quality healthcare is provided while preserving the margin that will sustain our mutual mission.

Q: How are hospitals and physician groups collaborating to improve the competitiveness of the system in the market, and the care the hospital provides?

JW: Moffitt has a lasting commitment to the prevention and cure of cancer through patient care, scientific discovery and education. That includes bringing these components to areas outside the Tampa region. We are standardizing not only the experience, but also care via clinical pathways designed to reduce variation and increase predictability of outcomes.

JR: We recently implemented a new EMR that is the community standard for Medical Center Health System, Midland (Texas) Memorial Hospital and Odessa (Texas) Regional Hospital, which includes Midland and Odessa, as well as the teaching organization that works with all three facilities.

Q: How are your employed physician groups and hospital addressing and managing leakage within the system when patients are diverted out-of-network?

JW: We have a robust screening process at the front of our new patient process to ensure patients are scheduled with the right provider, especially because we are a specialty cancer center. We address that in several ways: First, we have open access to get the patients who belong at Moffitt Cancer Center here. Then we ensure we get patients to the right provider at the right time, so we can avoid that sort of leakage.

JR: We are working collaboratively with our employed physicians who understand the importance of maintaining certainty of care for our mutual patients. We are also working together to improve the patient flow within the system. This is not only beneficial for the patient, but for the entire organization as a whole. ■
