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While their colleagues seek hospital employment, some physicians choose to remain fiercely independent

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"It's tough for any small business to navigate the healthcare supply chain."

– Tracey Jeter, president and CEO, Virginia Minority Supplier Development Council

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The C-suite Agenda

Hospitals are responding vigorously to the challenges before them. And they expect their suppliers to do the same.

The current and future state of hospital economics? In a word, daunting. But hospitals are responding to the challenge vigorously, and they expect their suppliers to do the same. That's the assessment of Fred Bentley, managing director, strategic research, The Advisory Board Company. The Advisory Board presented "The New Performance Standard: Prospering on Medicare Pricing" at the 2011 Health Industry Distributors Association Conference & Expo in Charlotte, N.C.

Fred Bentley

Hospitals' response to economic challenges

Hospital margins have bounced back a bit since 2008, said Bentley, speaking with the *Journal of Healthcare Contracting* after the meeting. "But clearly, hospitals still have big concerns." Public and private payers are continuing to hold the line on reimbursement, "and there's the long-term reality of Medicare and Medicaid comprising a much larger percent of hospitals' revenue base," he said. And 18 months after the Patient Protection and Affordable Care Act (healthcare reform law) was signed, the industry is still trying to figure out exactly what it means. But hospital CEOs aren't sitting idly by. Rather, they are responding in a number of ways:

1. M&A activity. "When you have this much upheaval in an industry – and it's safe to say that healthcare has experienced upheaval in the past two years – you see increased consolidation," said Bentley. There has been a "big uptick" in mergers-and-consolidation activity. "Recognizing it's a tough environment to operate in, many hospital executives are recognizing they need to jump in with bigger players with deeper pockets."

2. Redesigning operations. In the past, most hospital executives focused primarily on growing volume, particularly surgical volume, and pursuing commercially insured patients, while keeping costs in line. Today, and in the foreseeable future, they will focus on improving the quality of care their facilities provide, while bringing cost-consciousness to a new level, he said.

3. Information technology. Hospital executives are investing heavily in IT to build what The Advisory Board calls "the information-powered health system," said Bentley. Just as physicians are required to demonstrate "meaningful use" of IT and electronic medical records, so too are hospitals. As a result, there has been a dramatic shift in capital spending priorities, with many administrators postponing purchases of new medical equipment in favor of IT.

4. Partnering with physicians. Even prior to the current recession and signing of the healthcare reform law, hospital executives had been pursuing closer partnerships with physicians, Bentley said.

5. Developing a chronic disease management infrastructure. Having laid the groundwork with information technology, hospitals are developing the ability to track patients across care settings, even helping to develop "medical homes." It's new for them. "There are a whole host of things hospitals will have to do to manage chronically ill patients, that they aren't doing today," said Bentley.

It's difficult to say exactly what form accountable care organizations will take, he said. But with their emphasis on managing care across the continuum (that is, in inpatient and outpatient settings), ACOs will force providers to re-engineer their care delivery systems. "Commercial payers are already moving along that front."

Of course, hospital executives won't move faster than payers will allow them, he added. In other words, hospitals' involvement in non-acute care won't outpace their ability to be reimbursed for it. For that reason, The Advisory Board is advising its hospital clients to move forward cautiously. Even so, "there are some key investments hospitals can and should make that certainly will pay off in the long run in this chronic disease area," said Bentley.

Spending priorities

Hospitals' spending habits will continue to have a profound impact on their suppliers, said Bentley. Spending priorities and the purchasing process itself are changing. So is the way in which providers are defining value.

Hospital administrators have long recognized the value of product standardization in helping them maintain a lid on costs, said Bentley. Increasingly, they are recognizing the value of standardizing treatment processes too, not only in improved patient care, but in reduced costs.

What's more, hospitals are getting smarter about how they spend their money, he said. They have the data and analytics to know how much they are spending, what their utilization is, and whether they are adhering to contracts. "They're coming to the negotiating table… with a lot more insight, and they're making investments in business intelligence software with the idea of achieving further savings down the road."

Suppliers of products and services should be aware that while hospitals are more cost-conscious than ever, and price is still very important, they are also looking for strategic partners who can bring them value, said Bentley. Providers also want to know whether the data that is generated by a vendor's product or system can be electronically linked to the rest of the healthcare system. "That's a value parameter I don't think we saw a couple of years ago," he said.

Engaged patients

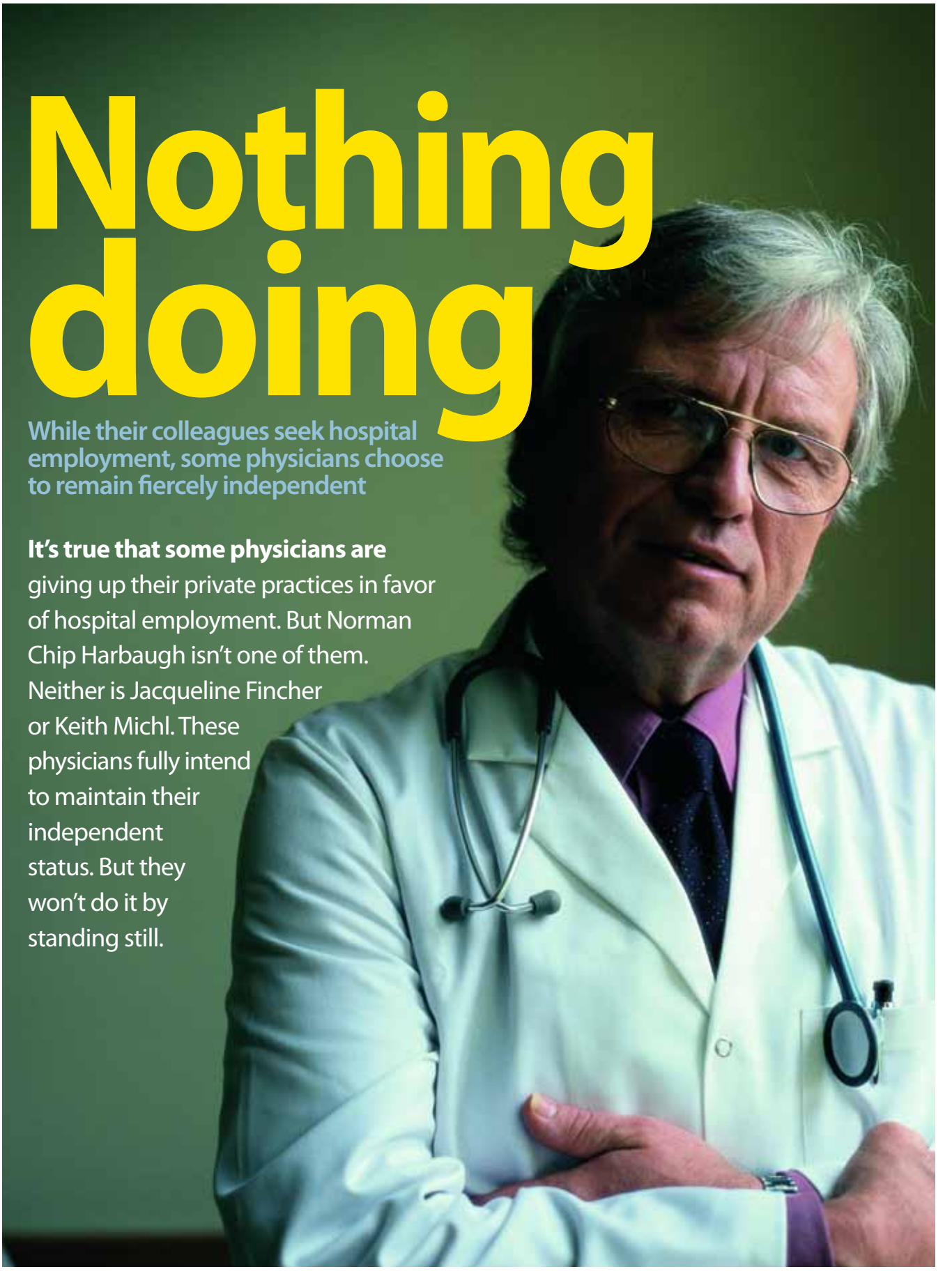
Perhaps the greatest challenge for hospitals will be engaging patients before and after their acute-care stay, said Bentley. How can hospitals help people be aware of their health status and the ramifications of the decisions they make in their daily lives? "They really must engage them in a different way."

They will need the assistance of their physicians. As they did 10 or 15 years ago, hospitals are once again acquiring physician practices. And while they met only limited success in the 1990s, they have gotten much more savvy in managing practices, setting compensation, and, most important, integrating physicians into the decision-making process, said Bentley. **JHC**

Nothing doing

While their colleagues seek hospital employment, some physicians choose to remain fiercely independent

It's true that some physicians are giving up their private practices in favor of hospital employment. But Norman Chip Harbaugh isn't one of them. Neither is Jacqueline Fincher or Keith Michl. These physicians fully intend to maintain their independent status. But they won't do it by standing still.



Dr. Gregory Hickman's goal is to avoid narcotic-based pain control and its potential consequences whenever possible. He succeeds by practicing Regional Anesthesia, "which also gets patients quickly and more comfortably out of the surgery center, opens up beds and makes nurses available to take care of more patients."

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Harbaugh, for example, founded an independent practice association, Kids Health First Pediatric Alliance. Fincher's practice is also part of an IPA, and she and her colleagues are tightly networked with colleagues through national and statewide associations. And Michl is set to embark to transform his solo practice to one based on "affordable personalized healthcare."

"We see a strong trend of doctors who are moving into hospital ownership," says Dave Gans, vice president of innovation and research, Medical Group Management Association. As of December 2010, more than 11 percent of MGMA's 12,000 practices were hospital-owned. Seven years earlier, in 2003, that number was slightly more than 8 percent. While those numbers seem small, they represent a 40 percent growth in hospital-owned practices, notes Gans. As of December 2010, 28 percent of the doctors represented in MGMA's membership were in hospital-based practices, compared to 17 percent in 2003 – a 65 percent increase.

Being part of a large organization, such as an IDN, also offers the opportunity to network with many colleagues and to take advantage of continuing education opportunities, says Gans.

MGMA data, as well as that of the American Medical Association, indicates that it is the larger practices that tend to seek hospital ownership. The average size of MGMA's physician-owned practices is 16.6 doctors, while that of its hospital-owned practices is 70.6, says Gans. Three-fourths of MGMA's physician-owned groups are single-specialty, which tend to be smaller than multispecialty groups.

Reimbursement a big reason

Doctors turn to hospital systems for employment or to sell their practices for many reasons, points out Gans. But reimbursement is king.

- The federal government as well as private payers are forcing doctors and hospitals to lock arms by offering them "bundled payments" or "global payments," that is, reimbursement for episodes of care, both inpatient and outpatient. Accountable care organizations are one manifestation.

- Value-based purchasing, which rewards providers for providing high-quality, cost-effective care, could replace traditional reimbursement methods, which reward physicians for providing *more* care.

- Reimbursement for some outpatient procedures is declining. In the past, Medicare encouraged the use of outpatient care by offering higher reimbursement for procedures performed in the outpatient setting than for similar procedures offered in the inpatient setting. Now, the government is clamping down, allowing the pendulum to swing back to hospitals. As a result, doctors who formed their own freestanding cath labs or imaging centers are being drawn back to the hospital, with its greater capital base.

Personal reasons

Economics aside, many doctors are drawn to hospital employment for personal reasons, says Gans. "The doctor who practices in many of these large institutions has the history and culture of that institution with him, and that's huge." There's a certain prestige to being part of Cleveland Clinic, for example. And

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being part of a larger hospital system or IDN offers opportunities for subspecialization. "It's difficult to subspecialize in private practice, because you need a broad referral network, which you can get if you're part of a large health system."

Being part of a large organization, such as an IDN, also offers the opportunity to network with many colleagues and to take advantage of continuing education opportunities, says Gans.

Then there are the much-talked-about lifestyle issues. "Many doctors are saying, 'I would forego some income for lifestyle,'" says Gans. "That helps to understand why many younger doctors are looking for the security of employment. They want to work hard when they're working, but they also want the opportunity to be somewhere else [in their off-hours], to take vacations and leave their patients behind."

Bucking the trend

All that said, some physicians value their autonomy too much to seek employment by a hospital. "In my opinion, we'll see a resurgence of the IPA," says Gans. "It provides the opportunity for contracting and negotiating clout; it also offers the ability to sustain information systems on behalf of many of its doctors and to help the communication function."

You don't need to tell that to pediatrician Chip Harbaugh, M.D., FAAP, managing partner of Children's Medical Group in Atlanta. Harbaugh has been in practice 22 years. His group has 19 providers – 13 physicians, two physician assistants and four nurse practitioners – in two locations.

"My basic premise is, I want to preserve the physician/patient relationship. I feel doctors who have that relationship with their patients and know them can provide better quality and caring healthcare. I think physicians perform better when challenged by other physicians and not dictated to by payers or anyone else."

If history is any guide, hospital employment of physicians can lead to unexpected results, says Harbaugh. "We saw it in the '90s. Hospital system purchases practice. The doctor says, 'It's a way out, I get a nice chunk of change, my salary is set.'" Later, the hospital – now financially strapped – comes back to the doctor and says, "Your overhead is up, accounts receivable are up; we have to cut your salary back." Staff is trimmed, and the efficiency of the practice declines, further exacerbating the situation. "Then it's, 'Doctor, you're not seeing as many patients as you used to.' The physician is uncomfortable, and [at some point] says, 'I can't take this any more.' That's a bad relationship."

Harbaugh believes that integrated systems ultimately drive up costs for the entire healthcare system, because as hospital systems acquire more and more physician practices, they can demand higher fees from payers.

Eighteen years ago, Harbaugh founded Kids Health First Pediatric Alliance, a physician-owned independent physician alliance, which now comprises 210 primary care pediatricians in about 35 practices. More recently, he co-founded 1st Physicians Resource, a co-operative designed to provide all physicians – not just pediatricians – a variety of outsourced business services, such as medical billing, health insurance review, human resources administration, benefits and pharmacy management, IT review, etc. Another company, 1st Healthcare Payment Systems, offers credit card processing, collections, etc., to physician practices. And a fourth, Kids Time Pediatrics, provides after-hours emergency care for kids, by pediatricians.

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"We have found that within the IPA in the last 18 years, we've been able to increase quality, and partner with payers and the state," says Harbaugh. Physicians within the IPA share ideas and challenge each other to get better. "I can control my own practice. I'm not controlled by a corporate entity. I'm not a slave that punches a time clock."

Harbaugh would probably be the first to admit that while private practice remains a viable option in today's market, doctors must work hard and innovate to maintain their independence.

"After the next 5 to 7 years, with our social system and problems of access to care, someone will look for a [suitable] model. But I don't want to wait. We're starting to build it now."

– Chip Harbaugh, M.D., FAAP, managing partner of Children's Medical Group in Atlanta

"For the private doctor, the game is changing, just as it did for Blockbuster," he says. Today's physicians need to examine all their options. On the one hand, they can sell their practice to a hospital, but lose their autonomy, he says. On the other, they can look at an IPA or some other vehicle. "The IPA may be a little more work upfront. But it's better than blindly selling to the hospital, which is hard to extract yourself from."

Advances in information technology, such as health information exchanges, are paving the way for alternative practice models, says Harbaugh. "After the next 5 to 7 years, with our social system and problems of access to care, someone will look for a [suitable] model. But I don't want to wait. We're starting to build it now."

A sense of independence

Internist Jacqueline Fincher, M.D., MACP, isn't waiting either. A physician for 22 years, Fincher is managing partner of McDuffie Medical Associates, Thomson, Ga., a private practice with four physicians. The practice was founded in 1961 by her father-in-law, Dr. John W. Lemley. (Her husband, James Lemley, is one of McDuffie's four physicians.)

Over the past five or six years, McDuffie has been approached twice by hospital systems about being acquired. "We decided it was not the best thing for us," says Fincher. "The main reason is, we just really value our independence." Physicians in the state of Georgia tend to be conservative and independent, she says. And McDuffie is located in a rural part of the state, where "people have a greater sense of independence, in terms not only of their business model, but of their ability to practice and do all the things they want to do."

Being a family group, McDuffie allows its four physicians flexibility to schedule call as well as free time. And Fincher doesn't want to give that up. "It has been very easy to coordinate our work/life balance here, and to be here for our daughter," she says, speaking for herself and her husband.

But change is occurring, she says. She sees it as governor of the Georgia chapter of the American

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College of Physicians. "There's clearly less risk-taking on the part of new physicians. They are much more afraid of going into private practice, because, particularly in primary care, overhead can run 60 percent straight out of the chute." Keeping up with technology (including electronic medical records) and providing benefits for the staff (such as 401k plans and health insurance), all in the face of flat reimbursement, adds up to significant risk. "And in a private practice, you lose economies of scale in billing, purchasing and things like that," she says.

"There's been great interest among our whole medical staff in becoming closely affiliated with hospital administration, in having an integrated medical practice in our community."

– Keith Michl, M.D., solo practitioner

But Fincher sees opportunity for independent practitioners. Her practice is part of an IPA in a geographic area called the CSRA (Central Savannah River Area). The IPA comprises more than 90 primary care physicians, most in metropolitan Augusta, and the remainder in outlying areas, such as Thomson. Each pays a participation fee, which is used to subsidize the management of the association.

"We see the IPA as a godsend for us," says Fincher. It provides economies of scale with regard to purchasing (and negotiating with payers). Even more valuable is the networking the IPA encourages among practice administrators and physician leaders. "You can't keep up with everything that's changing daily, with every insurance company, not to mention Medicare and Medicaid," she says.

Regional hospital is coming

Change is brewing in the city of Thomson itself, says Fincher. The local hospital – McDuffie Regional Medical Center – is facing financial problems due in part to declining admissions. Consequently, the board was at press time entertaining an offer to be acquired by University Hospital in Augusta, about 30 miles east of Thomson.

Thomson's physician practices have already felt the impact of University's acquisition of some specialty groups in Augusta. Specialists from Augusta make the 30-mile trip to Thomson regularly to see patients there. But as those specialists' practices become hospital-owned, practices such as McDuffie now find themselves negotiating contracts with a large medical system instead of another medical practice.

"We feel the ground is changing under our feet, and our job is to try not to fall down," says Fincher.

A squeaky wheel

Keith Michl, M.D., a solo practitioner in Manchester Center, Vt., has seen quite a bit of change himself since starting in practice in 1984. And he's anticipating more.

"When I started in practice, I joined two physicians already in practice," explains Michl. "We were all very idealistic, and a little naïve." The group ultimately faced severe economic and

organizational difficulties, and its members opted to become hospital employees.

"It worked nicely for the first five years, but as my tenure ended, I found I was increasingly frustrated at slow organizational change. I felt I wasn't in charge of my destiny. I couldn't get the kind of employees who I felt were really dedicated to patient care. I found myself a squeaky wheel."

Michl and the hospital worked out an amicable break-up. "I'm still very involved in our hospital," he says, helping out during fund-raising and serving on various boards and committees.

Over the last five years, the pendulum has swung back toward hospital employment of physicians, Michl notes. "There's been great interest among our whole medical staff in becoming closely affiliated with hospital administration, in having an integrated medical practice in our community." But discussions moved slowly, and Michl decided to look at alternatives. He found one with a Boca Raton, Fla.-based company called MDVIP.

Founded in 2000, MDVIP Inc. is a facilitator of what it calls "affordable personalized healthcare." Patients pay MDVIP practices an annual fee. In return, patients have increased access to the physician, next-day service, a personalized wellness plan and more. Physicians agree to limit their practices to no more than 600 patients, ensuring that their patients receive personalized care. MDVIP reports that more than 450 affiliated physicians provide care to more than 150,000 patients throughout the country.

Some refer to the MDVIP approach as "concierge medicine." "It's not a Persian-carpet, terry-cloth-robe kind of practice," says Michl. "Patients will be able to contact me after hours without going through a physician on call. They will receive next-day service. If that's concierge medicine, then that will be part of it."

Michl sees MDVIP as an opportunity to remain independent. "You get very busy in a high-volume practice," he says. Overhead costs keep rising, and the doctor finds himself or herself in a vicious circle. That's why many are selling their practices to community hospitals and medical centers. "I want to stay small," he says. With MDVIP, "I won't need to hire nurse practitioners or physician assistants. Fortunately, I already have a very good electronic medical record system. My expenses will moderate, and we'll get added revenue."

Satisfied, if not ecstatic

While Michl believes he has found a solution that will allow him to remain independent, he understands why colleagues are seeking employment by hospitals. In fact, had he not found MDVIP, he might have joined them.

That's because, unlike 15 or 20 years ago, hospital systems today have people who understand how physician practices work, he says. "They're much more savvy," though they still face challenges in maintaining the profitability of primary care and specialty care practices. "From what I hear from doctors who are employed, they are generally satisfied, if not ecstatic.

"I think there are a number of people who don't want to continue in independent practice, who will find some other line of medicine," he continues. "They may become hospitalists, or work as medical directors for companies or health plans. Maybe they'll go into administration themselves.

"I'm hearing a lot more murmuring by doctors in their 50s and their 60s looking to retire early." **JHC**

Integration not fully as advertised

Hospital employment of physicians has accelerated in recent years. And while the intentions may be noble, the results fall short. That's the conclusion of the authors of a recent study published by the Center for Studying Health System Change, Washington, D.C.

True, greater physician alignment with hospitals has the potential to improve quality through better clinical integration and care coordination. But it doesn't necessarily guarantee that such clinical integration will occur, according to the study's authors. What's more, alignment could actually lead to increased costs in the form of higher hospital and physician commercial insurance payment rates. In addition, some employed physicians are reporting hospital pressure to order more expensive care.

The authors based their conclusions on site visits to 12 metropolitan communities: Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y.

Clinical integration?

Today, most clinical-process integration is focused on single diagnoses or conditions rather than integration across all of a patient's medical needs, according to the study. Hospitals appear to be focusing on "low-hanging fruit," such as reducing preventable readmissions among patients hospitalized for congestive heart failure.

Communication between inpatient and outpatient providers, even between those employed by the same hospital system, continues to be a problem, according to the study. "Hospital systems and clinicians vary widely in their development of integrated care processes and implementation of interoperable electronic health records."

Potential for higher costs

Physician/hospital alignment can actually lead to higher costs, point out the study's authors. That's true for several reasons:

- Incentives to provide more services and increase productivity.
- Facility fees charged by hospitals.
- Greater leverage with payers.

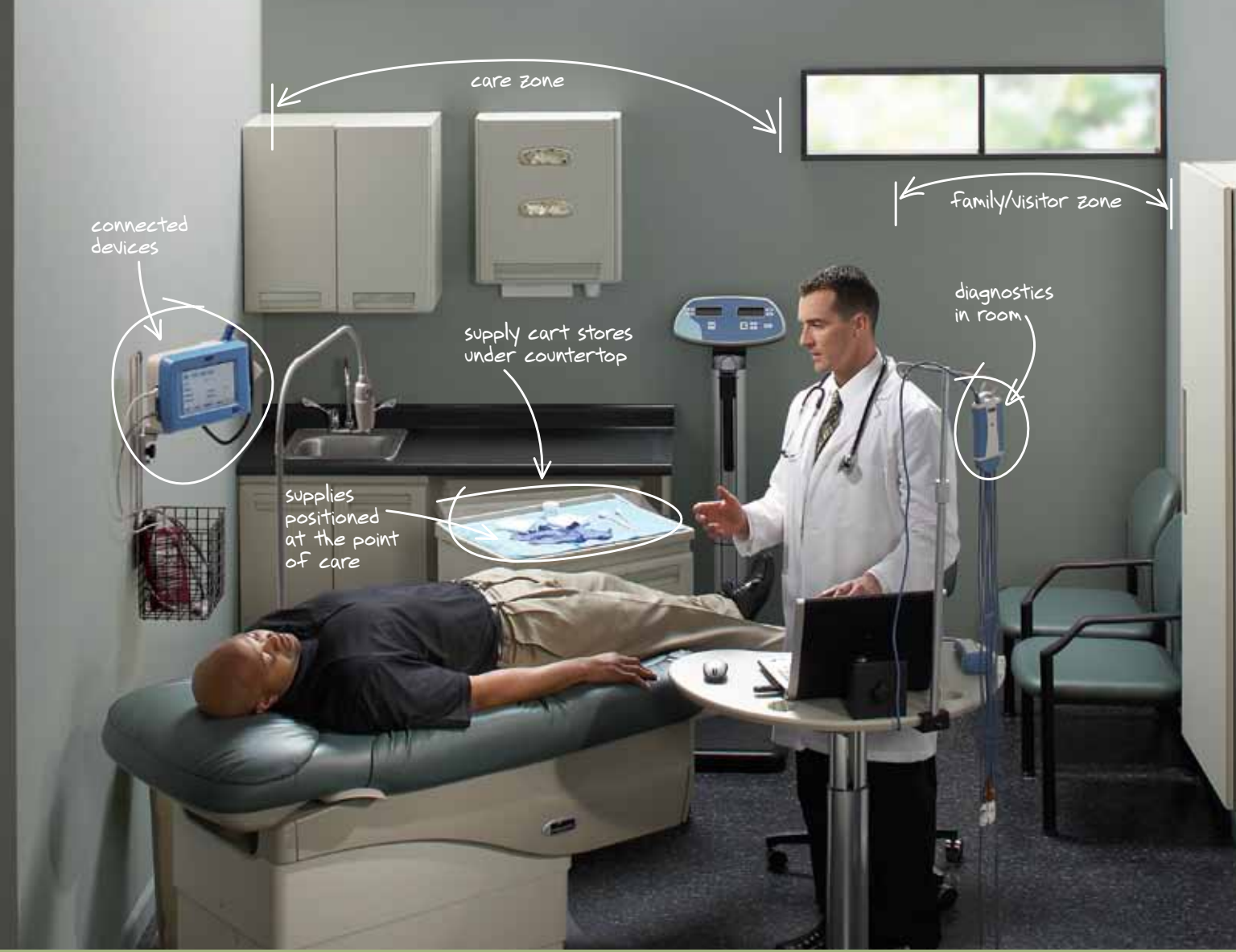
"While hospital-employed physicians may spur clinical integration that will ultimately improve efficiency and help control costs, they are more likely to increase costs in the short run," conclude the study's authors. One reason is that hospitals and their employed physicians continue to practice in a predominantly fee-for-service environment, with incentives to increase the volume of services delivered.

Another reason that hospital/physician alignment might lead to higher costs is the fact that hospitals routinely charge facility fees for office visits and procedures performed in formerly independent physicians' offices. As a result, patients and payers may end up paying more for procedures delivered by employed physicians, even if those procedures are performed by the same formerly independent doctor in the same office building.

The third reason that alignment might lead to higher costs is the fact that it gives hospitals and physicians more leverage in their negotiations with health plans.

On the plus side, physician/hospital alignment can lead to better access to employed specialists for low-income patients, especially those with Medicaid coverage, according to the Center for Studying Health System Change. But there's a downside attached even to that: Access to care can be adversely affected for patients when a major hospital system drops out of a health plan network.

To view the study, go to http://www.hschange.org/CONTENT/1230/1230.pdf.



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Diversity: A strategic imperative

Owens & Minor sponsors 6th Healthcare Supply Diversity Forum

Supplier diversity isn't just a nice thing to do, says Angela Wilkes, director of supplier diversity and small-business liaison officer, Owens & Minor. It's a business imperative. "It brings value to the bottom line as well as value to the communities we serve."

Healthcare providers seem to be getting the message. "We've come a long way," she says. "Other industries – automotive, technology, communications – have been at it for 20 or 30 years. But I've seen progress get ramped up in healthcare over the past five to seven years." Still, much work remains to be done. "There are still tremendous opportunities ahead of us."

Owens & Minor attempts to help minority- and women-owned businesses – and providers – exploit those opportunities through the Healthcare Supplier Diversity Symposium. Sponsored by Owens & Minor, the Virginia Minority Supplier Development Council, the Healthcare Supplier Diversity Alliance and the National Association of Health Services Executives, the symposium brings together representatives from the entire healthcare supply chain for networking and to identify opportunities for the development of new products and

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services. The recent symposium, held in Richmond, Va., was the sixth annual event.

The rationale for supplier diversity

In today's increasingly diverse society, cultivating a diverse supplier base is good business, says Wilkes. If the hospital or

Gregory Fairchild

"At the end of the day, all hospitals want to serve patients well; they want patients to come in, so they will have occupancy; and they want to be paid."

– Angela Wilkes, director of supplier diversity and small-business liaison officer, Owens & Minor

IDN establishes business relationships with diverse businesses in their community, then they are helping ensure the strength of that community, and hence, the financial strength of the people who come to those providers for healthcare, she says. "At the end of the day, all hospitals want to serve patients well; they want patients to come in, so they will have occupancy; and they want to be paid." Working with diverse suppliers can help.

"Hospitals need to look at the demographics of a changing society," adds Tracey Jeter, president and CEO, Virginia Minority Supplier Development Council. In many areas, the minority population consists of the customers of the hospital or hospital system. "These are the customers of today and tomorrow. [Healthcare providers] have to understand not only how to serve them, but they need to understand that if there's an opportunity for [diverse suppliers] to compete for contracts and employ others as a result of those contracts, then providers are essentially reinvesting in the communities in which we all live and work."


Angela Wilkes


Craig Smith


Luke Visconti

Challenges

But it's not easy. "Access to capital for small and minority businesses will be high on the radar screen," says Jeter. What's more, healthcare carries with it more regulatory hurdles than many other industries.

And diverse suppliers face the same challenges as any other small or emerging businesses, most notably, gaining the attention of hospital decision-makers. "It's tough for any small business to navigate the healthcare supply chain," says Jeter. But those who do their homework, study their potential customers' needs and decision-making processes, can crack the code. "Healthcare isn't something that you wake up one morning and say, 'I want to get into it,'" she says.

A more fundamental challenge is educating minority businesses and healthcare providers on the opportunities that exist, says Wilkes. "These entrepreneurs are brilliant people, and they come up with ideas that become part of a deliverable that is very creative and innovative," she says. "The opportunities for networking and getting involved have not been as readily apparent and open, and that's where I see the biggest changes taking place. Doors are being opened."

"It's tough for any small business to navigate the healthcare supply chain."

– Tracey Jeter, president and CEO, Virginia Minority Supplier Development Council

For example, Owens & Minor's healthcare supplier diversity program has grown to include

about 300 companies, she says. And other organizations are getting involved, including GPOs, Fortune 500 manufacturers, and organizations such as the National Association of Health Services Executives and the Virginia Minority Supplier Development Council.

In Virginia, the Healthcare Supplier Diversity Alliance provides a forum for diverse suppliers to learn how to engage hospitals, how to work with distributors, and how to transition from non-healthcare businesses into healthcare-related ones, says Jeter. Regarding the last point, she says that HSDA has worked with suppliers of information technology services to adapt those services to healthcare.

"If they feel supplier diversity or supplier development is important to the culture of the organization, and that it does in fact contribute to the bottom line, then it really does have a much greater success rate."

– Jeter

Providers face challenges too

Providers face their own set of challenges, not the least of which is time. "Their sense of urgency is, 'How do I get ahead of the game and make the connections that are necessary in order to satisfy my market or my healthcare system today?'" says Wilkes. Simultaneously, they must work on long-term strategies to increase the presence of minority-, women- and veteran-owned suppliers in their supply chain, she adds.

"Timing is critical. There are companies out there that have the scale to assist some of the major IDNs, but we have to get to the table and get everyone talking, and we don't have a lot of time."

The very top members of provider organizations must be seated at that table, agree Jeter and Wilkes.

"We have found that those organizations – no matter how large or small – that have top down support, meaning support from the CEO and board of directors," will have a successful diversity program, says Jeter. "If they feel supplier diversity or supplier development is important to the culture of the organization, and that it does in fact contribute to the bottom line, then it really does have a much greater success rate. These programs are much more seasoned and sustainable over a long period of time, because it's ingrained in the culture. It's not just HR or community relations." **JHC**

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By Robert T. Yokl

Value Analysis: Going Back to Fundamentals

I just had a conversation with a vice president of supply chain who asked my firm for help in coaching her value analysis (VA) manager in the classic philosophy, principles and practices of value analysis. It seems her VA manager is spending all of her time on new product evaluations and group purchasing contract renewals, which the vice president realizes isn't value analysis at all.

The reason this vice president wants her VA manager to go back to value analysis fundamentals, which has a 71-year history of success in industry, is that she understands that just adding more products (usually at an increased price) or renewing group purchasing contracts, typically at a higher cost due to inflation, isn't going to offset the dramatic reductions in Medicare, Medicaid and insurance reimbursement that is coming her hospital's way over the next few years.

As this vice president sees it, value analysis isn't about price, standardization or GPO contracts, but is really all about functional analysis, utilization and demand management which most of us in the supply chain would consider savings beyond price. These are the operative words (savings beyond price) you use when you comprehend the true meaning of value analysis: The study of function, the search for lower cost alternatives and the elimination of all waste and inefficiency in your supply streams.

Just adding more products (usually at an increased price) or renewing group purchasing contracts, typically at a higher cost due to inflation, isn't going to offset the dramatic reductions in Medicare, Medicaid and insurance reimbursement.

For instance, one of our clients who "gets it" about value analysis, is reducing the cost of his hospital's I.V. catheters by $100,000 annually by drastically reducing the aesthetic features (i.e., nice to have, but not functionally required) that have always been considered absolutely necessary by his clinical staff, until this supply chain manager conducted a functional analysis of their I.V. catheter and proved that they weren't needed after all. By the way, when this same supply chain manager

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first asked his I.V. catheter vendor to drop his price on his I.V. catheters all this vendor could come up with was a one-time discount of $20,000. While this sounds like a lot of money, just consider what this supply chain manager would have left on the table ($80,000) untouched if he had accepted this price concession alone and then went back to business as usual.

As this case study suggests, "Going back to fundamentals with value analysis" isn't about revamping or reinventing your value analysis team(s), but instead refocusing their efforts on savings beyond price where the greatest savings opportunities (7% to 15%) are now hidden from view. Just as important, value analysis is all about understanding the products, services and technology functions you are buying and then searching for lower cost alternatives that meet those functions reliably and consistently, while at the same time driving out all waste or inefficiency in supply streams. That's the difference between value analysis and anything else you might be doing and then calling it value analysis. With this in mind, let's get back to the fundamentals of value analysis and save even more, in less time and with less effort. **JHC**

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Robert T. Yokl is president and chief value strategist of Strategic Value Analysis® In Healthcare, which is the acknowledged healthcare authority in value analysis and utilization management. Yokl has nearly 38 years of experience as a healthcare materials manager and supply chain consultant, and also is the co-creator of the new Utilizer® Dashboard that moves beyond price for even deeper and broader utilization savings. For more information, visit www.strategicva.com. For questions or comments, e-mail Yokl at bobpres@strategicva.com.

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By Richard Cowart

Beneficiary Inducements

Beneficiary inducement rules and guidelines for ACOs

Television commercials offer free testing kits when you order a company's products. Power wheelchair advertisements exclaim that the products are free; just contact their sales representative. Medicare Advantage salespersons are paid sales commissions based upon how many new beneficiaries they sign up. What's right? What's legal in promoting beneficiary sales? Like Medicare Advantage Plans and Medicare DME suppliers, ACOs will be held to strict guidelines on beneficiary inducements. Let's look at a snapshot of the new guidelines.

Under CMS guidelines, the beneficiary inducement rules will apply to not only ACOs, but also ACO participants, ACO providers/suppliers, and other individuals or entities performing functions or services related to ACO activities. As a rule, each of these ACO entities, whether acting individually or collectively, will be prohibited from providing gifts or other remuneration to beneficiaries as inducements for receiving items or services to join or to remain in an ACO.

The principal exception to prohibition will be items involving care coordination or health awareness. CMS recognizes that it may be beneficial for an ACO to provide items or services to beneficiaries for free or less than fair market value to encourage care coordination and health awareness. Accordingly, CMS provides an exception to the general prohibition to allow ACOs and related entities to provide in-kind items or services to beneficiaries so long as: (a) there is a reasonable connection between the items and/or services and the medical care that the beneficiary is receiving, and (b) the items or services are either preventive care items or services, or advance a clinical goal of the beneficiary. Acceptable clinical goals include adherence to a drug regimen, adherence to a follow-up care plan, or management of a chronic disease or condition. For example, blood pressure monitors may be provided (at less than FMV) to patients with hypertension.

In the originally proposed ACO regulations, it was unclear how much care management services an ACO could offer a beneficiary without violating the Civil Monetary Penalty Law provision prohibiting beneficiary inducements. In the final ACO regulations, additional guidance was provided which should assist ACOs in directing their resources in a manner to positively impact the health, and overall healthcare costs, of beneficiaries without fear of inadvertently subjecting the ACO and its participants to civil monetary penalties or other compliance concerns.

Beneficiary inducements and ACO sales practices should become an area of first concern as ACOs commence their formative efforts and seek to achieve critical mass for efficient operations. Take note to instruct the ACO sales force and build the ACO business model with these precautions in mind. **JHC**

Richard G. Cowart, Chair Health Law and Public Policy Department; Baker, Donelson, Bearman, Caldwell & Berkowitz; dcowart@bakerdonelson.com

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 *Calculations based on these sources; sample calculations available upon request. 1. Computers, Informatics, Nursing: September/October 2009, Volume 27, Issue 5, pages 318-323, Connected Care: Reducing Errors Through Automated Vital Signs Data Upload, Smith, Laura B. MSN, RN; et al. 2. Automated Vital Sign Documentation for Medical Surgical Units: Saving Time and Increasing Accuracy: Fact or Fairytale?, Meg Meccariello, RN MS; Jennifer Johnstone, RN MS, Presented at The Nursing Management Congress 2008 Las Vegas, NV. 3. Vital signs measurement frequency estimates from "Lippincott's Textbook for Nursing Assistants: A Humanistic Approach to Caregiving," Pamela J. Carter, 2007, page 292. 4. Hospital beds (most recent) by country estimates from NationMaster.com, www.nationmaster.com/graph/hea_hos_bed-health-hospital-beds. 5. Population, Source: U.S. Census Bureau, Population Division.

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UHS (University Health Systems) changes name again

University Health Systems of Eastern Carolina (Greenville, N.C.), which recently changed its name to University Health Systems, or UHS, will change its name to Vidant Health effective January 25, 2012. At that time, Pitt County Memorial Hospital (Greenville, N.C.) will be referred to as Pitt Memorial Building. The name change will enable the health system to trademark the name. An earlier decision to shorten University Health Systems of Eastern Carolina simply to UHS was scrapped when a Pennsylvania health system protested due to a trademark conflict. The name change will be accompanied by a new logo with a stylized capital V and will use the same blue and white colors currently in use. Other hospitals in the system also will incorporate Vidant in their name, with the exception of Outer Banks Hospital (Nags Head, N.C.) and Albemarle Hospital (Elizabeth City, N.C.).

CMS loses leader, appoints Tavenner as replacement

CMS (Baltimore, Md.) administrator Don Berwick stepped down, effective December 2, 2011. The White House intended to appoint Marilyn Tavenner, currently second-in-command at CMS, as Berwick's replacement. Republicans regularly attacked Berwick's admiration for Britain's National Health Service as an "example" for the U.S., and would have blocked his next confirmation, which was due to take place at the end of 2011.

MedCath sells Harlingen Medical Center to Prime Healthcare Services

MedCath Corp (Charlotte, N.C.) completed its previously announced sale of its 34.83 percent ownership interest in Harlingen Medical Center (Harlingen, Texas) and HMC Realty LLC to Prime Healthcare Services Inc (Ontario, Calif.) on November 30, 2011. MedCath retained Navigant Capital Advisors to assist with the transaction. Harlingen Medical Center is a 112 licensed bed general acute care hospital and HMC Realty LLC is a single-purpose entity that owns the real estate and building in which Harlingen Medical Center is located and leases the property and improvements to the hospital. MedCath estimates that the proceeds from the sale will result in a tax gain on the transaction of approximately $20.4 million, providing MedCath with $0.3 million net after tax proceeds from the transaction.

CHW signs $4.3M deal with AirStrip Technologies for iPhone telemonitoring app

Catholic Healthcare West (CHW) (San Francisco, Calif.) signed a three-year, $4.3 million deal with AirStrip Technologies (San Antonio, Texas) for its mHealth AirStrip OB system, which will be implemented in CHW's three hospitals. The iPhone app will connect CHW physicians to patients in labor and allow them to see up to four hours of data.

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Aetna enters accountable care collaboration with Banner Health, introduces Aetna Whole Health

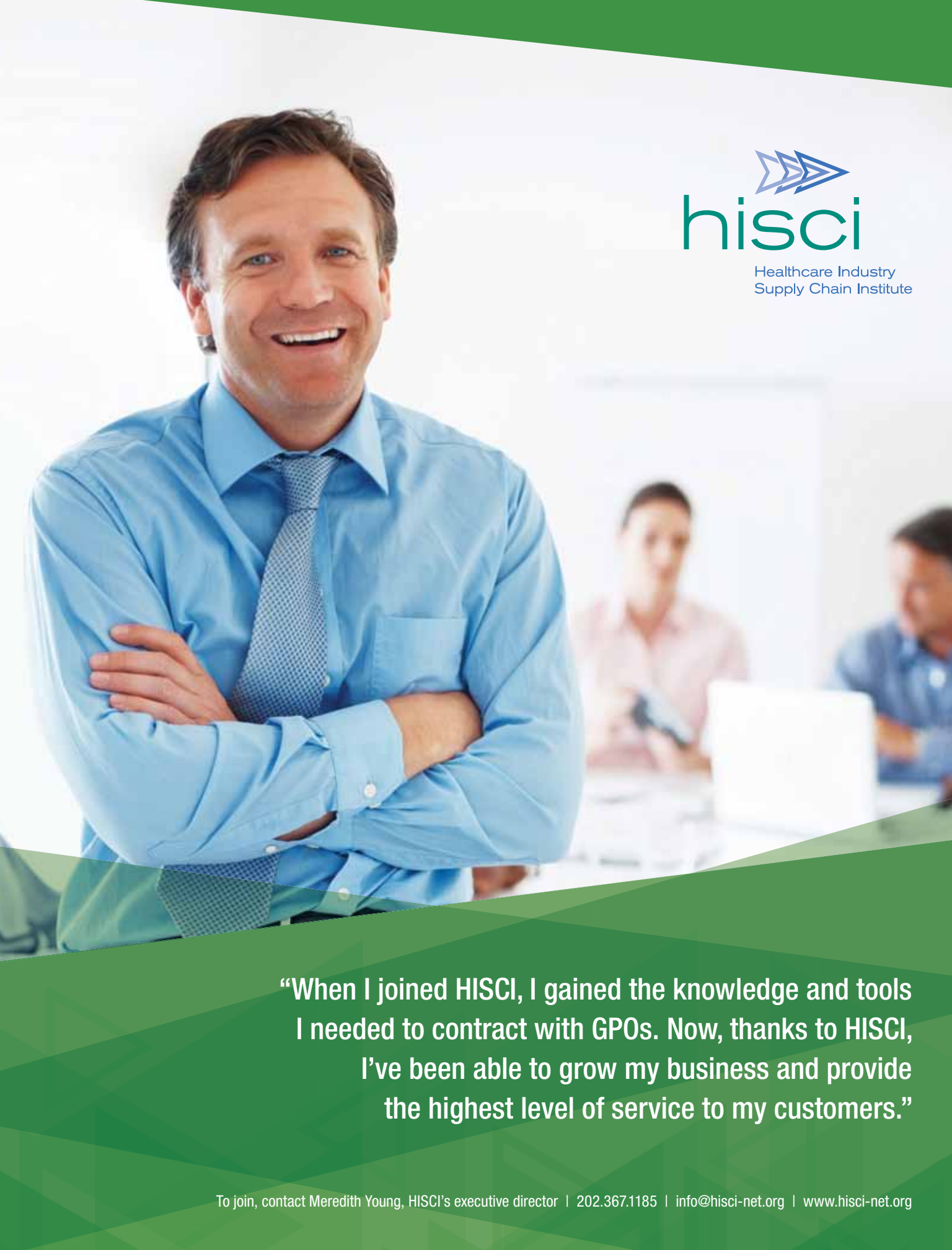
Aetna Inc (Hartford, Conn.) announced an accountable care collaboration with Banner Health (Phoenix, Ariz.), as well as the introduction of a new commercial healthcare product, Aetna Whole Health, that will offer access to highly coordinated care in the Banner Health network of facilities and physicians. The Banner Health network is comprised of Banner-employed and affiliated physicians and hospitals in Arizona, and is a new accountable care organization (ACO) focused on improving patient care outcomes through better coordination and access to patient information. The network is also a fully integrated delivery system that is able to connect patients and network providers via an enhanced electronic medical records (EMR) system in real-time. Aetna Whole Health members within the network will reap the following benefits: pay less out of pocket; receive a more coordinated approach to managing their chronic conditions; and have access to Aetna's online tools. The new product will be made available to Maricopa County and some Pinal County employers in late Nov. 2011. The accountable care collaboration will involve the implementation of a risk-sharing agreement that compensates and rewards Banner Health based on achieving certain quality, efficiency and patient satisfaction measures.

AMGA launches next phase of Accountable Care Collaboratives

American Medical Group Association (AMGA) (Alexandria, Va.) announced the launch of Phase II of its Accountable Care Collaborative: Transforming to a Value-Based System of Care for medical groups. This phase of the shared learning program focuses on the fundamental organizational, systems, and culture changes necessary for successful transformation to a value-based system of care, regardless of the path chosen-CMS' Shared Savings Program, the Pioneer ACO Program, commercial ACOs, or other models yet to emerge. In 2011, AMGA launched two collaboratives focused on practical steps toward creating Accountable Care Organizations: a Development Collaborative and an Implementation Collaborative. The new collaborative will build on their work and provide resources for continuing development. The deadline to register for Phase II is January 31, 2012. Additional information is available at www.amga.org/Research/Research/ACO/phase2_aco.asp.

Henry Medical Center joins Piedmont Healthcare

Henry Medical Center (Stockbridge, Ga.) was renamed Piedmont Henry Hospital after joining Piedmont Healthcare (Atlanta, GA) on Jan. 1, 2012. The affiliation was approved by the board of directors of Henry Medical Center and Piedmont Healthcare and the Hospital Authority of Henry County (Stockbridge, Ga.) in August 2011. And the Georgia Attorney General's Office signed off on the partnership in November.



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