Physician partnership to lead healthcare transformation

Picking the right model for your market
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Executive summary

“I realize physician employment was embraced and then dismantled back in the 1990s. This time it will be different. There is no more money left and providers will increasingly continue to share and take risk.”

— Health system executive

High costs, regulatory reform, and growing dissatisfaction with the pace of value improvement are all driving transformation in the U.S. healthcare system. A key part of this transformation will be a changing role for physicians in delivering and managing care as they become more team-based, use standardized care protocols, and manage populations more effectively. As a result, the way that health systems engage with physicians has to change as well, for greater alignment around clinical, operational, and financial aspects. Specifically, health systems have four possible physician alignment models: affiliation, partnership, employment, and clinical integration. The right model will vary depending on the market where the provider operates, and the urgency with which it must adapt to evolving market conditions.

By assessing evolution along two dimensions — supply (the degree of clinical integration within the hospital or health system and within competitors) and demand (the pace at which payors and employers are driving change) — most markets will fall into one of four archetypes: traditionalist, follower, visionary, and vanguard.

Traditionalist markets have low levels of clinical integration and slower evolution among payors and employers. Follower markets experience rapid change driven by payors, and providers still offer relatively fragmented care. Visionary markets are characterized by slower demand-side evolution, which allows innovative providers to gain a head start in implementing population management and other mechanisms to handle risk. Vanguard markets see payors and providers consistently delivering care based on collaborative risk models and payment schemes.
Within five to 10 years, many markets will be at the vanguard level. Yet by understanding the pathway to that archetype, hospitals and health systems can adopt the right alignment model and determine the best way to collaborate with physicians during the journey.
A system under stress

Unprecedented market forces are placing significant stress on the U.S. healthcare ecosystem. Costs have risen sharply and are projected to consume 20 percent of GDP by 2021. Relative to other industries, value improvements in care delivery have stagnated, with quality ratings for many organizations effectively flat over the past several years. And while the reforms of the Affordable Care Act were intended to reduce overall spending on care and improve quality, the legislation also expanded access to millions of previously uninsured patients, putting a greater strain on the system.

In response, payors are driving structural changes in healthcare, moving toward more affordable care in a retail environment. For example, retail-like channels such as walk-in clinics are emerging, along with new Web-based tools that improve transparency of costs and quality across providers. These measures tap into the consumerization shift, in which patients are exerting greater influence in how and where they receive care. Such measures shift risk away from payors and toward providers and patients.

Yet providers are making large-scale changes as well. Most progressive systems are now aiming for long-term cost reductions of 15 to 25 percent, far greater than the traditional goals of 5 to 10 percent. M&A activity has tripled since 2010 compared to historical trends. Increasingly, acquirers are seeking strategic partners that can increase the range and depth of care delivery in a given market.

At the heart of the transformational change is a transition to integrated delivery networks, in which providers deliver a continuum of care in a comprehensive, evidence-based, and coordinated way, with consistently high outcomes and costs that are predictable and manageable. The end result is value-based care that meets population health goals, reduces utilization, and enables sharing risk with payors.

To make integrated delivery networks succeed, health systems will need to better align with physicians, a requirement that is increasingly important given the current wave of acquisitions. As in the past,
physicians will continue to exert the greatest control over referrals — and thus downstream patient volumes. More broadly, however, physicians are the “face” of the organization. They have the greatest influence over patient loyalty, which will be critical in accomplishing the goals of population management, including improvements in quality, satisfaction, utilization, and cost. Specifically, physicians can do the following:

- Ensure continuity in the flow of clinical information during handoffs from one specialist to another, without unneeded duplications in care
- Engage the patient in retail settings
- Treat the patient in the most appropriate (and lowest cost) settings, such as home care when it’s a better solution, and limit hospital admissions to when they are truly necessary
- Use standardized care practices and evidence-based protocols
- Focus on prevention and wellness, which requires a patient relationship over time
- Include and collaborate with supporting care team members, such as behavioral counselors, nutritionists, care coordinators, and other specialists

To maximize all potential benefits to the health system, physicians will need to be integrated along several dimensions, including financial incentives, governance, clinical practices, operational and care delivery alignment, patient experience, and cultural coherence. To be sure, some health organizations experimented with physician employment models in the 1990s, only to fail. Yet the current period is different in several key ways. Physician executives have become more prevalent and possess not only clinical experience, but also experience managing large practices and other health provider organizations. Incentives are now better aligned for doctors and health systems to manage risk and deliver value. Physicians’ interest in collaborating with health systems often reflects financial incentives, such as a guaranteed income, or the costs of infrastructure for electronic medical records. Technological innovations have introduced better tools to integrate care. Clinicians have 20 years of experience in managing populations. Most important, the stakes are now higher. For some systems and physicians, successful partnerships will be their only means of surviving.
## Four models to align with physicians

Health systems can use four potential models to align interests and engage physicians (see Exhibit 1):

**Affiliation:** Health systems give admitting privileges to physicians and may appoint medical directors to lead service lines in an administrative capacity. The affiliation model is easy to implement, and physician

### Exhibit 1
Four models to partner with physicians

<table>
<thead>
<tr>
<th></th>
<th>Affiliation</th>
<th>Partnership</th>
<th>Employment</th>
<th>Clinical integration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incentives</strong></td>
<td>Limited</td>
<td>Quality and/or cost gain sharing</td>
<td>Salary with volume and/or quality kicker</td>
<td>Quality, cost control</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td>Most collegial</td>
<td>Very collegial</td>
<td>Departmental leadership</td>
<td>Service-line dyad</td>
</tr>
<tr>
<td><strong>Clinical practices</strong></td>
<td>Physician-specific</td>
<td>Moving toward standardization</td>
<td>Moderately standardized</td>
<td>Protocol-driven, hard-coded in EMR</td>
</tr>
<tr>
<td><strong>Operations</strong></td>
<td>Ad hoc</td>
<td>Moving toward system-ness</td>
<td>Significant alignment in referral patterns</td>
<td>Coordinated system; standard scheduling, staffing, supplies</td>
</tr>
<tr>
<td><strong>Challenges</strong></td>
<td>Variable, with unpredictable volumes, outcomes, costs</td>
<td>Lack of influence over care model; can be hard to restructure for new payment models</td>
<td>Even strongest-form alignment does not guarantee productivity or consistent quality</td>
<td>Requires complex mechanisms for tracking risk and utilization, allocating rewards</td>
</tr>
</tbody>
</table>

Source: Strategy& analysis
leaders can typically balance clinical aspects of care transformation more effectively than administrators. The governance is collegial, in that physicians tend to be more responsive to physician leaders. However, this model can have a limited impact on cost and quality.

**Partnership:** In this model — which may be structured as clinical comanagement agreements, gain-sharing arrangements, or joint ventures — physicians form a separate legal entity for a contractual stake or ownership across a given service line. In exchange, the health system pays some combination of performance bonuses and/or shared savings. As with the affiliation model, partnerships are relatively easy to implement, and organizations can align incentives around the most variable and costly portion of care delivery.

There are challenges to this model, however. Partnerships represent a partial transformation at best, and any potential gains in cost and quality may still be limited by the practice preferences of physicians. Partnerships also have the potential to create a two-tiered system, alienating clinicians who are not part of the agreement. And they often do not emphasize coordination with other aspects of care delivery (such as post-acute services), which may hinder the health system’s ability to succeed with new payment models.

**Employment:** In most states, health systems can employ physicians, either directly or through a separate physician-led but hospital-controlled legal entity. In this arrangement, compensation often consists of a base salary and financial incentives that are linked to productivity and/or quality metrics. Although it is more difficult to implement, the employment model allows the health system to respond more quickly and effectively to evolving market conditions. In addition, organizations can get an exemption from the Stark Law (which requires that patients get a range of options for follow-up treatment after they leave the hospital), allowing them to gain patient volume by controlling such referrals from the doctors they employ.

Another advantage involves care protocols; employed physicians are more easily influenced to follow standard procedures, and are typically more loyal to the health system where they work. And this model is increasingly attractive to younger physicians, who tend to be less entrepreneurial and are more interested in a work–life balance.

One drawback to the employment model, however, is that some evidence shows reduced productivity among employed physicians. Therefore, achieving goals such as an overall cost reduction of 25 percent may be difficult with a physician employment model. Similarly, though physicians are more likely to follow care protocols, higher quality is not always guaranteed. Financially, in the current fee-for-
service model, the impact of employing physicians can at times be negative — compensation and overhead can outpace revenue, even including the incremental downstream impact of controlling referrals.

Clinically integrated networks: In the fourth alignment model, health systems have a high degree of interdependence and cooperation with their physicians to control quality, outcomes, and costs. The integrated model is effectively “employment-plus”: a tightly governed relationship that allows for differentiated performance in outcomes and quality, a differentiated experience for patients, and tailored value propositions for payors and employers. It applies strong governance and integration along clinical and operational dimensions to reinforce best practices among the staff and thus improve physician productivity. However, clinical integration is challenging and time-consuming to implement. It requires complex mechanisms for tracking risk and utilization and allocating rewards.
To identify the right model among these four, each health system must understand the current state of its market and the likely pace of evolution, by asking several key questions. First, when will the market reach a tipping point at which 15 to 20 percent of volume is “at risk”? This question essentially gauges the degree and speed at which payors and employers are driving change and pushing providers to assume more risk.

Second, health systems must ask when their competitors believe they will hit the 15 to 20 percent tipping point, and how the competitors are behaving given that belief. This question assesses the speed at which delivery systems are consolidating and integrating assets along a continuum of care. (In addition, a health system’s current operating model — e.g., scaled portfolio, geographic cluster, hub-and-spoke, innovative, or location-based — may be a factor in its choice of alignment models.1)

These broad elements — the current structure of delivery systems (the supply side) and the pace of evolution (the demand side) — weigh heavily in a health system’s choice of physician alignment model. Specifically, they point to four distinct market archetypes (see Exhibit 2, next page).

1. **Traditionalist**

The traditionalist market archetype is at the low end in both dimensions. The evolution in care is slow, with only sporadic initiatives (mostly driven by payors) that focus on changing the payment model to improve quality or share cost savings. Hospital systems continue to deliver care in a fragmented and hospital-centric manner. In this archetype, the physician’s role is still primarily that of gatekeeper — i.e., a referral base that can drive inpatient and outpatient volume and market share across the system. In traditionalist markets, health systems should employ physicians as a tool to protect and retain those referrals. (In addition, providers in traditionalist markets may require other alignment models to ensure that they have ties to enough doctors to maintain sufficient volumes.)
2. Follower

In the follower market archetype, demand is ahead of supply. That is, payors and/or employers are driving innovation in payment models and care delivery systems, and the provision of care remains relatively fragmented (i.e., providers are following payors). Minnesota is a good example of a follower market.

Health systems in follower markets must adapt to demand-side changes driven by payors and employers, in part by standardizing clinical practices within alignment models. More specifically, the preferred alignment model is to employ physicians directly, which will allow health systems to move fast and generate quick early wins. The mix of physicians should be weighted toward primary-care physicians (PCPs), who can coordinate care and tightly manage utilization for discrete populations. At a higher level, health systems and medical groups can reduce utilization and medical costs by introducing patient care venues in more retail settings, and by grouping physicians in tighter geographic clusters.
3. Visionary

In the visionary market archetype, supply is ahead of demand. That is, hospitals and health systems are building continuum-of-care assets, integrating clinically, and spurring payors to pilot initiatives. However, overall evolution in the market is relatively slow, in that payors are not aggressively driving newer risk-based payment models. Metropolitan Chicago is an example of a visionary market, as several large systems have vertically integrated.

Health systems in visionary markets need to expand the breadth and geographic reach of their clinical capabilities. They may elect to employ physicians and/or form partnerships to ensure they have adequate coverage, as well as to lay the groundwork for more advanced value-based care models. The physician mix will likely be weighted toward specialists instead of PCPs, to ensure that the system can address a range of patient conditions. Some physicians may not be ready to move to full employment, and others may be outside payor networks. In these cases, health systems will need to take intermediate steps, such as partnerships or participation in bundled-care products, to maintain volumes in the near term and lay the groundwork for the transition to population management.

4. Vanguard

The vanguard archetype includes markets with rapid evolution driven by payors, and rapid innovation driven by hospitals and health systems toward integrated care. In many cases, the two work in tandem to design and implement population management efforts. California and Massachusetts are both vanguard markets, with large patient pools under “managed” arrangements.

Health systems, tasked with managing populations of patients and taking significant financial risk, need to respond with an alignment model that can consistently demonstrate quality and cost outcomes. Standardized clinical practices, strong physician governance, and operational integration are all paramount in vanguard markets. Accordingly, a clinically integrated physician group is the most effective alignment model to improve quality, reduce the unit cost of care, and manage utilization. In addition to population management and financial risk management, health systems may also choose to use their capabilities to offer health plan products or participate directly with employers or payors in narrow network arrangements.
**How to get there**

If the shift to provider risk and increased consumerism continue to generate momentum for advanced payment models, it is likely that many markets will fall into the vanguard category in five to 10 years. For those markets still in the traditionalist state, three paths exist for how to get there (see Exhibit 3).

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**Exhibit 3**

**Three pathways from a traditionalist to a vanguard market**

![Diagram showing three pathways from traditionalist to vanguard markets]

Source: Strategy& analysis
1. **Traditionalist–Follower–Vanguard**

In this pathway, payors and employers drive the transition, and providers are “price takers,” which accept the contract terms and structures that payors propose. Even though there is rapid market change, it does not allow for clinical or operational integration within provider systems, especially at the early stages. And in some markets (such as New Jersey), market evolution may require some regulatory changes to allow providers to assume greater downside risk.

2. **Traditionalist–Vanguard**

In the second pathway, evolution is driven by the demand and supply sides simultaneously. This enables greater payor-provider collaboration, along with large-scale integrations and/or consolidations. Providers in the markets adopting this path may require large-scale administrative and clinical infrastructure to partner with payors and employers on commercial initiatives. Markets where both payors and providers have large market shares and can collaborate together may evolve in this fashion (e.g., Rhode Island).

3. **Traditionalist–Visionary–Vanguard**

In the third pathway, supply-side dynamics drive market evolution. There are clear advantages for health systems in markets that move in this path. Specifically, it allows providers to assemble integrated assets before assuming significant downside risk. It also allows providers to determine the pace and structure of value-based care payment models. And it allows them to gain experience with risk-sharing arrangements, increasing the likelihood that they will be able to maintain and maximize profitability.

Hospitals and health systems in visionary markets will likely need to enhance certain capabilities. For example, they may need to make technology investments, or fill in gaps in their continuum of care (such as ambulatory care, select physician specialties, and post-acute assets). They may also need to merge with or acquire strategic partners, in order to increase their scale. And they may need to launch small pilot projects that align with their capabilities.
The new world of healthcare, characterized by greater risk for providers and more consumerism among patients, will require that hospitals and health systems better align with physicians. Unlike with the earlier attempts of the 1990s, alignment in the setting of risk and consumerism is not necessarily a money-losing proposition. Instead, clinical integration with physicians will help achieve the objectives of population management — namely improvements in quality and outcomes, at reduced cost, and with better utilization of assets.

Health systems must understand their market — its current state and the pace at which it is evolving — if they are to determine the right alignment model. The correct choice will give them a clear advantage over competitors, both today and in the future.

Endnote

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