PEOPLE *to* KNOW

2014 STATE OF THE INDUSTRY

HEALTHCARE EDITION

The **PAINS & GAINS** impacting **healthcare** today.

CLARK SCHAEFER HACKETT
CPAs & BUSINESS CONSULTANTS

HEALTHCARE LEADERS
AROUND THE TABLE

Ted Clemans
Principal
Clark Schaefer Hackett

Maureen Corcoran
President
Vorys Healthcare Advisors

Lisa Han
Partner
Jones Day

Robert LaFollette
Chief Operating Officer
OSU Physicians - OSU Urology, LLC

Diann Nelson-Houser
President
Ohio Association of Advanced Practice Nurses

Mark Rinkov, O.D.
Chief Executive Officer
Rinkov Eyecare Center

John Schmeling, M.D.
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Beth Traini
Senior Vice President and Chief Transformation Officer
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Ed Walsh
Shareholder
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J. William Wulf, M.D.
Chief Executive Officer
Central Ohio Primary Care

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Welcome to our *lite* paper, an observation on the state of the industry, offered by People to Know in Healthcare.

At Clark Schaefer Hackett, we're proud to be industry specialists. We dig deeply into the industries we serve and share the resulting insight for the good of our clients and communities.

When we gathered the select few recently named "People to Know in Healthcare," we were privy to profound thought, unique perspectives, and intelligent understanding.

These healthcare leaders, recognized as the most influential in Central Ohio, illuminated the universal trends, challenges and opportunities seen nationally across the sector today.

The issues impacting healthcare today, also reflect our society, business and culture.

Exactly how these issues will shape our future is the question that remains.

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It's hard to imagine a time when the country hasn't been debating how to construct the best healthcare system.

Two years ago, the Affordable Care Act became the law of the land, but the discussions haven't ended. The ACA and the resulting increased healthcare awareness of the American people are **changing the industry landscape**.

For instance, the U.S. Department of Health and Human Services predicts only an 8 percent increase in the number of full-time primary care physicians by 2020, but a 14 percent increase in the total demand for primary care services. In its 2010 estimation, HHS says **without changes** in how primary care is delivered, **there will not be an adequate supply** of those physicians.

In response to that statistic and so many others, healthcare delivery is being rethought and reshaped. From the organizational structure of healthcare entities to patient care approaches, **today's industry trends are altering healthcare services for years to come.**

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GETTING PAID

John Schmeling, M.D.
The Medical Group of Ohio

A value-based payment system with appropriate shared risk is where we need to go. In our clinically integrated network, we have a process where extra dollars are available beyond fee-for-service payments if you meet certain clinical quality metrics. Our physicians also get rewarded if the total cost of care in our network is lower than the competition's. We have had this kind of upside risk in our contracts since 2010. Assuming $5 million is saved, the difficulty comes in deciding who gets what portion of the savings, as in, **"What did I personally do to contribute to that total cost savings?"** That's easier to decide with some specialists who, for example, choose to use the most cost-efficient artificial hip for all of their patients. Ultimately, if your physician organization is comfortable with managing the total cost of care for your population of patients, then you are taking one step closer to being able to accept both the upside and downside risk for physicians. **But it will require additional infrastructure and education to go from where we are right now to accepting that kind of risk.**

Maureen Corcoran
Vorys Healthcare Advisors

One very significant change has been with the Affordable Care Act. Medicaid programs can now develop a dual Medicare/Medicaid managed care arrangement that lets them share the savings, which wasn't possible under the law until the ACA. That arrangement became a possibility on July 1 for 29 Ohio counties. **It is a structured sharing relationship** that includes the full expenditures for Medicare/Medicaid long-term services for physical health as well as behavioral health.

GETTING PAID

Lisa Han
Jones Day

Every hospital and large physician group must ask the question of what payment model is going to work the best for them: What's going to make sense, given the increased revenue pressure for the entire healthcare industry? If quality is a concern, where will we retrieve the necessary data or the quality measures to do our jobs? Then, will these measures really produce cost savings? Could the physicians without other providers and institutional providers manage risk arrangements? **Physicians are merely a part of the delivery system.** You don't have the immediate feedback that lets the physician know if she's doing all the right things and whether her efforts are actually saving any health care dollars.

What I have seen is a wide spectrum of risk methods currently being developed or used by the industry. The government has also rolled out many types of payment models different from the fee-for-service system, such as the Medicare shared savings program ACO Model and bundled payment demonstration projects. One of the new payment models involves care coordination fees. The Center for Medicare and Medicaid Services will pay for care coordination apart from claims. One of the easy ones for payers is to simply pay physicians for the development and implementation of a patient's care plan based on the patient's medical condition. However, that does not necessarily translate into cost savings as these are still additional dollars on top of the fee-for-service claims. **It is not always easy to determine the best practice compensation models for providers.**

Overall, it is fair to say that the health care industry is moving away from the fee for service system, and toward various types of risk models that have a combination of cost control and quality as factors in determining physicians' compensation. Many believe that the risk model is the way to provide the right incentives for physicians to provide quality patient care while maintaining the level of compensation physicians deserve.

DOCTORS' INDEPENDENCE

John Schmeling, M.D.
The Medical Group of Ohio

It is extremely unlikely that a time will come when every physician is going to be employed by a hospital system. Physician groups that are large enough or maybe have the support from an independent practice association will be able to handle changes coming down the pike. **However, running a three- to four-person practice all by yourself is almost impossible if you want to survive.** You need an IPA (Independent Physician Association) – where a group of independent physicians of all specialties are organized and work together for their patients. These organizations can also provide support services to physicians who are too busy seeing their patients and don't want to worry about billing, malpractice insurance or contracting with payers. These organizations can also keep physicians abreast of the changes in health care.

Robert LaFollette
OSU Physicians-OSU Urology LLC

The obstacles facing smaller physician groups are many and will make it difficult for them to survive. Many no longer have the expertise to bear the risk, given the technology, staffing and compliance requirements at that size. **Medicine is becoming more of a commodity** and it is seeing the same alignment other industries are experiencing. You have to have scale of operation and access to resources, be it through employer, large groups, specialty society, etc. to manage the expense and have the expertise to stay viable. From what we are seeing, as we train the next generations of physicians, there are very few people choosing to start a solo practice or join a small group. The exception is if they choose to practice in a geographic area, for example, like North Dakota, where the population density is spread out, as opposed to a large, dense metropolitan area. In this case, a four- to six-physician group can thrive. Otherwise, they are going to join an organization that can provide financial stability and a better quality of life.

Ted Clemans
Clark Schaefer Hackett

In some markets there is such an aggressive war going on between three or four hospital systems that are trying to buy practices in order to obtain market share referrals. They have been going after certain specialists and primary care doctors to build their networks to be competitive in their market. **It is a bidding war and turf battle.** Some other markets are more civilized and not as aggressive in pursuit of physician acquisition as a network strategy.

DOCTORS' INDEPENDENCE

Beth Traini
Mount Carmel Health System

There are a lot of reasons why physician groups are acquired by hospital systems like ours. **They are tired of the rat race**, of being independent and the associated time consumed by the business of medicine. They are looking for a broader association. And the courtship works both ways. The physicians evaluate the hospital and its strategy going forward. On our side, we have a governance council that screens physicians, and decides who to accept or reject. Overall, about half of the physicians we end up hiring seek us out versus the other way around. **This is a continuing trend with little abatement in the near future.** In the 1980s, hospitals paid big dollars to own and control someone, and it was done for all the wrong reasons. Today, it is for very different reasons: lifestyle, support, to blend competencies and to collaborate on managing the health of a population. The first question we always ask a physician is, "Why do you want to do join us?"

J. William Wulf, M.D.
Central Ohio Primary Care

So far, facility fees are a drawback to this trend of system-owned physicians. If a large cardiology group in Central Ohio were purchased by a hospital, the price of a cardiac echocardiogram would go from $500 to $2,000 overnight. Right now, it's not going to lower the price of care. The non-independent doctor makes more money, every test costs more and there is a facility fee for every visit. **It is very expensive if you are the patient.**

Diann Nelson-Houser
Ohio Association of Advanced Practice Nurses

When hospital systems and corporations buy smaller practices, those physicians basically become hospital corporate employees, and it is presenting big problems from the perspective of advanced practice registered nurses. Advanced Practice RNs must have a collaboration agreement. Part of the collaboration agreement ensures 24/7 availability of a physician. Physicians that become employees of hospital systems and larger corporations are taken out of our collaboration pool because they are not permitted, in most cases, to collaborate with an independent like me. I have to collaborate with an independent physician. Having fewer independent physicians with whom to collaborate makes this arrangement more restrictive to our practice. **It is an arrangement that made sense at one time, but one that needs to be retired.**

THINKING & WORKING ANEW

Maureen Corcoran
Vorys Healthcare Advisors

We need to have a conversation about every healthcare professional practicing at the top of their license. As the former director for Medicaid in Ohio, the scope of practice discussions **were always the hardest, ugliest and most contentious** in the General Assembly. We're not reaching our potential if we are not taking advantage of everyone's best professional skills and their passion for why they come into the healthcare field.

Beth Traini
Mount Carmel Health System

Our industry is so far behind from a technology perspective. Tools that are intended to make things easier, actually make our jobs harder. They take more time and make us less productive. There really needs to be a new focus on technology in healthcare. I would love to see an EHR, or electronic health record, that is much more functional from an end-user perspective. Too much of the current design is dominated by meeting governmental "meaningful use" requirements. But it's not just the EHR or telemedicine or all those little hand-held tools. As the market and technology move forward, there are going to be so many other ways for physicians, nurses or social workers to interact with patients than an actual office visit, which is not a very productive process the way it is set up now. **It will really involve a whole team with everyone practicing at the top of their licenses.**

John Schmeling, M.D.
The Medical Group of Ohio

Physicians must now transform their practices to a more patient-centered, team-based approach. A primary care physician who does everything for his or her patients and sees a different patient every 15 to 20 minutes is just not going to work. **There are not enough primary care physicians to meet the demand.** Physicians must become comfortable employing more of a team approach with advanced practice providers, Care managers and mental health providers, and using their staff's expertise as comprehensively as possible. We talk a lot about helping physicians understand that, and how to use the additional team members. The process is difficult because the doctors are trying to get through their very

busy day and get home for family activities, not trying to transform the way they manage their patients. But I believe that the physicians who are able to transform to this type of practice will provide even better care for their patients and will have higher professional satisfaction.

J. William Wulf, M.D.
Central Ohio Primary Care

Revamping just who it is that we are seeing in our offices could go far in setting priorities. Under the existing structure, we are seeing 29-year-old patients who want their physicals because it has been 366 days since the last one, while Mrs. Smith, who is in the first stages of heart failure, can't get in today and ends up in the hospital. That seems backward, and is a population health management issue that needs to be addressed.

FILLING THE PRIMARY CARE VOID

J. William Wulf, M.D.
Central Ohio Primary Care

Increasing the value in primary care should be a primary concern. If you are a medical student and have $150,000 in debt, you may be inclined to become a radiologist or an anesthesiologist where pay is more lucrative and the work less overwhelming. We must entice students into primary care and make it more attractive. We are killing those students right now with all the documentation required of primary care doctors. Doctors are seeing too many patients to deliver quality. We must get doctors off the treadmill of being flooded with patients; we have to decrease the number of clicks in the electronic health record and we need to start paying doctors for quality.

Diann Nelson-Houser
Ohio Association of Advanced Practice Nurses

Too few primary care physicians is not a theoretical problem. By 2020, the gap between the demand for services and supply of physicians will exceed 91,500, and the shortage stretches across the board from primary care doctors to specialists. The problem will worsen if nothing is done to correct the imbalance. Already, we are seeing major problems: Patients are calling for appointments but can't get in for weeks. If they are new patients, they're not getting in for months. **A solution to the shortage is right in front of us.** By utilizing the skills and expertise of advanced practice registered nurses, the effect of having too few primary care physicians could be stunted. The educational training advanced practice RNs get isn't as intense as it is for physicians, but in the context of primary care, it is more than adequate. Our solution to too few primary care physicians is to expand the role of advanced practice registered nurses to include running team-based primary care teams. This step would create more access points for the patients into the system, preventing the longer waits they are facing today.

FILLING THE PRIMARY CARE VOID

Mark Rinkov, O.D.
Rinkov Eyecare Center

I see many patients that don't have healthcare or don't have a primary care physician. We are like a gatekeeper for them. We see a lot of patients with diseases left untreated or are undiagnosed, so we refer quite a few patients to endocrinologists because they are diabetic. When you talk about team, you should include optometry, psychology, dental and physicians to ensure comprehensive care. **We see a ton of patients who don't have doctors. It's simply ridiculous.**

Robert LaFollette
OSU Physicians-OSU Urology LLC

There are multiple entry points for a patient to the healthcare system, whether through a retail clinic, nurse practitioner, primary care physician or technology such as non-mydriatic camera for eye evaluations in many different non-specialty office locations. We must be able to care for that patient, even remotely. The state of Ohio is looking at where the patients who need access are located. The new technologies – telemedicine, for instance – could help deliver that access for populations whose proximity to a hospital is restrictive. **We'll never progress in that respect without technology.**

ABOUT **CLARK SCHAEFER HACKETT**

Often highly successful practitioners become Owners, Presidents, or CEOs of what is essentially a business. But perhaps your strongest interests and talents lie in applying your medical expertise to help patients. At CSH we have a suite of services that were created specifically for the owners and managers of healthcare practices. Whether you need expert counsel to minimize your tax burden, design and administer a retirement plan, or handle your bookkeeping and payroll, we offer a personalized service that fits your situation.

OUR FIRM Founded in 1938, Clark Schaefer Hackett is one of the 65 largest CPA and advisory firms in the U.S. We offer best-in-class technical expertise in audit and assurance, risk management, benefit plan consulting, forensic and litigation support, valuation and transaction services. We combine the insights and ideas of multiple disciplines to provide solutions in a wide range of industries, including manufacturing, construction and real estate, distribution, healthcare, financial services, as well as government entities, higher education institutions and not-for-profit organizations.

INDUSTRY SPECIALIZATION We align resources by industry to better serve the needs of our clientele. Specialization permits us to develop deep knowledge of the issues facing our clients and to anticipate needs based on our understanding of industry trends. We select a team that best fits the needs of the client from our strong bench of firmwide industry specialists.

RELATIONSHIPS MATTER We believe that doing the work and serving the client are not necessarily the same thing. One is about a talent for numbers, the other is about interacting with people. At CSH, relationships matter, and we believe that creating a supportive, helpful, working relationship is perhaps the most valuable talent we can offer.

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CSH AROUND THE TABLE **FOR HEALTHCARE**

DARRIN SPITZER
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Darrin Spitzer works extensively with healthcare entities performing audits, providing tax planning, managing the accounting functions and consulting on special projects regarding various operational issues. His healthcare clients include statewide organizations as well as hospital foundations. Darrin chairs the firm's Healthcare Services Group and serves as the Engagement Shareholder on several large A-133 not-for-profit audits. In the community, Darrin works with the Mental Health Foundation and the Healthcare Continuing Education Committee (OSCPA Committee member).

ED WALSH
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Ed Walsh is the Shareholder-In-Charge of the CSH Columbus office. Ed started his career with a "Big Four" accounting firm more than 25 years ago. His health care experience includes accounting, tax return preparation and planning, and strategic planning for physicians, dentists and other ancillary health care providers. Ed has chaired the firm's Health Care Industry Group and currently serves on the firm's Executive Committee and Strategic Planning Committee. He has extensive experience with business start-up issues, mergers and acquisitions, as well as auditing and taxation for these clients.

BILL CLAYTON
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William Clayton has 20 years experience in healthcare management with responsibilities ranging from Systems Implementation Engineer to Chief Operation Officer. Throughout his career, he has specialized in implementing Management Accountability and Technology Improvement Programs with numerous organizations. Bill spent eight years managing a corporate healthcare holding company. In this position, he operated six of the seven companies; performing a variety of functions ranging from strategic planning to designing and implementing a physician support company/ management service organization.

TED CLEMANS
Principal
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Theodore Clemans has 30 years experience serving healthcare organizations – with a specific focus in providing professional services such as healthcare turnarounds, contract negotiations and HR services. Ted developed a set of "process improvement methodologies" which increase the cash flow of group practices and hospitals. He founded two organizations – the Clemans Group, which grew from one client to a multi-state, multiple client organizations and Clemans, Nelson & Associates, which grew from three employees to over 75 professional consulting staff.


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