

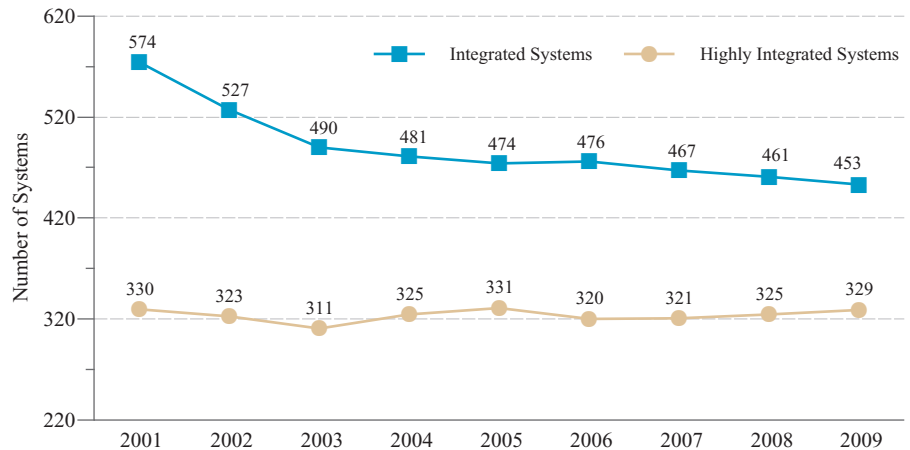


INTEGRATED SYSTEMS EXECUTIVE SUMMARY

Integrated System Demographics

- The integrated system count continued its downward trend in 2009, as the number of such systems fell for a third straight year. Due to acquisitions and mergers among these systems, the number of integrated systems has dropped substantially between 2001 (574) and 2009 (453).
- By comparison, the number of highly integrated systems in the U.S. grew to 329 in 2009 from 325 the year before, the highest such total since 2005 (331).

NUMBERS OF INTEGRATED AND HIGHLY INTEGRATED SYSTEMS, 2001–2009



Data source: SDI © 2010

- While physician practices (64.8%) and hospitals (16.2%) still continued to account for the vast majority of facilities in highly integrated systems in 2009, specialized facilities such as freestanding outpatient surgery centers (FOSCs) and diagnostic imaging centers (DICs) managed to report moderate growth. For example, between 2008 (277) and 2009 (298) the number of DICs affiliated with integrated systems in the top 20 MSAs increased 7.6%.

Highly integrated health care systems either own or contract with at least three components of health care delivery, including at least one acute-care hospital, at least one physician component, and at least one other component of care. Highly integrated health care systems also have at least one systemwide contract with a payer, such as an HMO.

Integrated System Utilization

- System hospital discharges accounted for a notable 62.7% of all discharges at facilities operating in 20 selected MSAs in 2008, a percentage that has increased steadily since 2005 (60.1%).
- At 4.7 days, total average length of stay (ALOS) at system-affiliated hospitals in 20 selected MSAs was lower than the corresponding ALOS for nonsystem facilities in these leading markets (4.9).
- Compared with their system-affiliated counterparts, nonsystem facilities reported lower average occupancy rates in 14 of 20 selected MSAs tracked in this Digest. In 2008, nonsystem hospitals in the 20 MSAs profiled operated at an average occupancy of 60.7%, versus 66.5% for hospitals belonging to systems.

Hospitals/HMOs in Systems

- The number of hospitals owned by, or contracted to, highly integrated systems in the U.S. rose 6.8% in 2009, to 2,045 from 1,914 in 2008.
- Average occupancy at system-tied hospitals rose 7.4 percentage points in the 10-year period between 1998 (49.6%) to 2008 (57.0%).

- The percentage of HMOs that were a part of highly integrated systems was 18.0% in 2008, down slightly from 18.7% in 2007.

Although this share has declined by more than three percentage points since 2004 (21.3%), most of this drop occurred between 2004 and 2005 (19.1%).

INTEGRATED SYSTEM REGIONS

West	Ohio
Alaska	South Dakota
Arizona	Wisconsin
California	Northeast
Hawaii	Connecticut
Idaho	Maine
Montana	Massachusetts
Nevada	New Hampshire
Oregon	New Jersey
Utah	New York
Washington	Pennsylvania
Wyoming	Rhode Island
Southwest	Vermont
Arkansas	Southeast
Colorado	Alabama
Kansas	Delaware
Louisiana	D.C.
Missouri	Florida
New Mexico	Georgia
Oklahoma	Kentucky
Texas	Maryland
Midwest	Mississippi
Illinois	North Carolina
Indiana	Puerto Rico
Iowa	South Carolina
Michigan	Tennessee
Minnesota	Virginia
Nebraska	West Virginia
North Dakota	

Medical Group Practices

- The number of medical group practices tied to integrated systems grew slightly in 2009, to 3,241 from 3,159 in 2008. Since 2003 (2,647), the number of groups belonging to systems has increased a substantial 22.4%.
- Although the number of single-specialty groups has climbed by 15% since 2004, that growth has slowed considerably since 2007.

DEMOGRAPHICS

Recent System Growth Is Primarily Regionally Focused and Plan Initiated

The number of highly integrated systems grew for the third straight year in 2009, to 329 from 320 in 2006, in part owing to the addition of regionally focused and health plan-initiated systems.

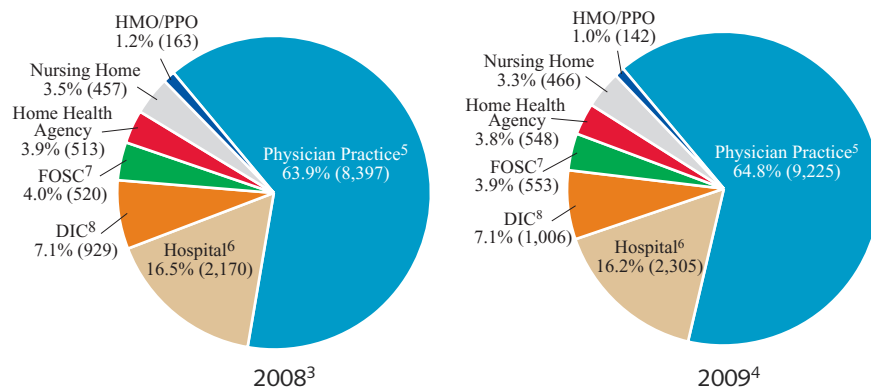
- Over this four-year period, the number of regionally focused systems grew a notable 5.3%. The percentage of all systems with a regional focus likewise increased between 2006 (65.3%) and 2009 (66.9%).
- Between 2006 (10) and 2009 (16), six new HMO/PPO-initiated systems joined the health care marketplace, a substantial 60.0% growth.

NUMBER OF HIGHLY INTEGRATED HEALTH SYSTEMS

DELIVERY FOCUS ¹	2008		2009		2008–2009 % Change
	Number	Percentage	Number	Percentage	
Local	85	26.2%	85	25.8%	0.0%
Statewide	17	5.2	19	5.8	11.8
Regional	219	67.4	220	66.9	0.4
National	4	1.2	5	1.5	25.0
INITIATORS					
Hospitals	232	71.4%	232	70.5%	0.0%
Physicians	12	3.7	14	4.3	16.7
HMOs/PPOs	12	3.7	16	4.9	33.3
PHOs	1	0.3	1	0.3	0.0
Other ²	20	6.2	20	6.1	0.0
Combination	48	14.8	46	14.0	-4.2
TOTAL	325	100.0%	329	100.0%	1.2%

Specialized Facilities Attract Systems to Surgery, Diagnostic Imaging Centers

FACILITIES IN HIGHLY INTEGRATED SYSTEMS



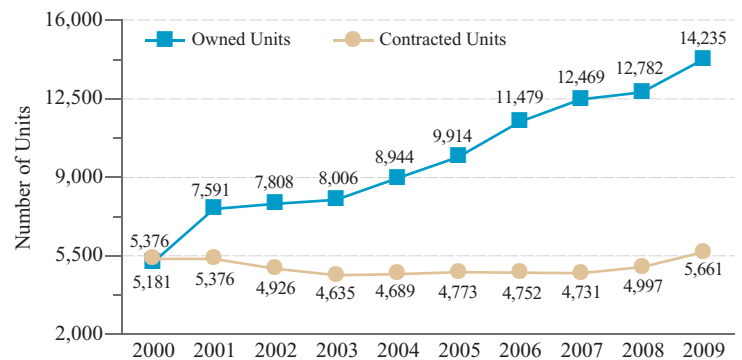
Although physician practices (64.8%) and hospitals (16.2%) made up the bulk of facilities in highly integrated systems in 2009, a greater share of systems incorporated the specialized services offered via freestanding outpatient surgery centers (FOSCs) and diagnostic imaging centers (DICs).

- The number of FOSCs belonging to highly integrated systems grew a substantial 32.9% between 2006 (416) and 2009 (553).
- The number of system-affiliated DICs rose 29.0% over this period, to 1,006 from 780.

Number of Units Owned by Systems Nearly Triples Over 10-Year Period

Provider units include such health care facilities as hospitals, HMOs, nursing homes, home health agencies, physician practices and medical groups, diagnostic imaging centers and freestanding outpatient surgery centers. Each highly integrated system either contracts with or owns at least three of these facility types. However, such a health care facility is not necessarily affiliated with only one integrated system; it may contract with or be owned in part by more than one integrated system. Each such relationship is counted as a “provider unit” of the system with which it is affiliated.

OWNED AND CONTRACTED UNITS IN HIGHLY INTEGRATED SYSTEMS, 2000–2009



Data source: SDI © 2010

¹ Local systems serve a limited number of counties. Statewide systems serve an entire state. Regional systems serve areas of a state or several states.
² Includes systems initiated by universities, clinics, and local, state and federal governments.
³ These data are based on 13,149 unique facilities in the 325 systems.
⁴ These data are based on 14,245 unique facilities in the 329 systems.

⁵ “Physician practice” includes medical group practices, individual physician offices with fewer than three physicians, independent physician associations, physician practice management groups, physician hospital organizations and management service organizations.
⁶ Hospital data are based only on short-term, acute-care, nonfederal hospitals.
⁷ Freestanding Outpatient Surgery Center.
⁸ Diagnostic Imaging Center.

SELECTED INTEGRATED SYSTEMS

Home Health Agency Growth Occurs in Selected Integrated Systems

20 SELECTED INTEGRATED SYSTEMS AND THEIR FACILITIES

INTEGRATED HEALTH SYSTEM	Headquarters Location	# of Owned/Affiliated MCOs		# of Licensed Hospitals		# of Licensed NHs		# of Licensed HHAs		# of Medical Group Practices*	
		2007	2008	2007	2008	2007	2008	2007	2008	2007	2008
Advocate Health Care	Oak Brook, IL	0	0	8	9	0	0	4	9	33	35
Allina Hospitals and Clinics	Minneapolis, MN	0	0	17	16	1	1	1	1	42	42
Banner Health	Phoenix, AZ	0	1	21	22	2	4	3	4	17	17
Baylor Health Care System	Dallas, TX	0	0	18	20	1	1	1	1	16	16
BJC HealthCare	Saint Louis, MO	0	0	12	12	3	3	5	5	6	6
Carle Foundation Hospital	Urbana, IL	1	1	1	1	2	2	1	1	7	7
Carolinas HealthCare System	Charlotte, NC	1	1	16	23	4	7	3	7	46	48
Department of Health Services	Los Angeles, CA	1	1	4	4	0	0	0	0	38	38
Detroit Medical Center	Detroit, MI	0	1	8	8	0	0	0	0	0	0
Geisinger Health System	Danville, PA	3	1	4	4	0	0	0	0	19	33
HCA Houston Division	Houston, TX	0	0	15	16	0	0	0	0	0	0
Henry Ford Health System	Detroit, MI	2	1	7	8	2	2	4	4	29	29
Legacy Health System	Portland, OR	1	1	5	5	0	0	0	0	5	5
Ministry Health Care	Milwaukee, WI	1	1	15	15	2	0	7	7	17	6
Presbyterian Healthcare Services	Albuquerque, NM	2	1	7	7	1	1	2	2	11	15
Sentara Healthcare	Norfolk, VA	4	4	8	8	7	7	4	7	19	20
Sharp HealthCare	San Diego, CA	1	1	7	7	2	3	1	1	16	17
Sutter Health	Sacramento, CA	1	1	36	35	1	1	15	15	44	45
Temple University Health System	Philadelphia, PA	0	0	5	4	0	0	1	1	1	1
Tenet South Florida HealthSystem	Fort Lauderdale, FL	0	0	11	11	0	0	0	0	0	0

Although only four of the 20 selected systems increased their number of home health agencies (HHAs), the overall number of HHAs owned by these 20 systems rose 25.0%, to 65 in 2008 from 52 in 2007.

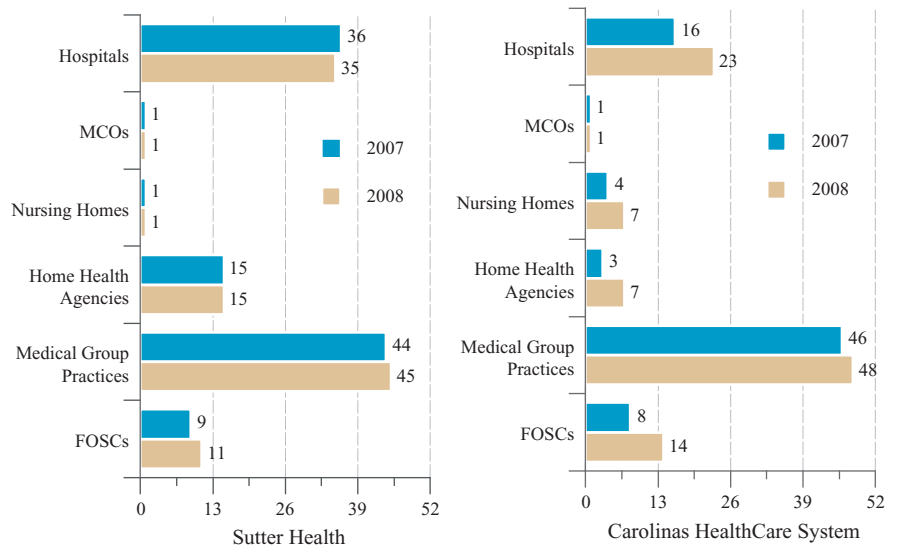
- Advocate Health Care (to 9 from 4) and Carolinas HealthCare System (to 7 from 3) each more than doubled their HHA count between 2007 and 2008.
- This growth demonstrates the increasing popularity of HHAs, which provide less costly sub-acute care compared to assisted living and skilled nursing facilities.

Sutter Health/Carolinas Add Freestanding Outpatient Surgery Centers

Between 2007 and 2008, Sutter Health and Carolinas HealthCare Systems each added freestanding outpatient surgery centers (FOSCs) to their facility rosters.

- The addition of two FOSCs (to 11 from 9 in 2007) improved accessibility to specialized services for Sutter Health patients and provided additional high-margin revenue streams for the integrated system. Aside from FOSCs, Sutter Health facility totals were stagnant during this period.
- Carolinas HealthCare System, the second largest system according to total number of facilities (with 106 owned in 2008), pursued a more diverse approach to system growth. Carolinas added facilities in every component of care delivery except managed care. By spreading growth across hospitals (to 23 from 16) and outpatient surgery (to 14 from 8) and imaging (to 6 from 3) centers, Carolinas expanded its reach to include more health care resources.

FACILITIES WITHIN SELECTED INTEGRATED SYSTEMS



NUMBER OF DIAGNOSTIC IMAGING CENTERS, 2004-2008

SYSTEM	2004	2005	2006	2007	2008
Sutter	6	11	11	12	12
Carolinas	3	3	3	3	6
Sentara	6	12	15	13	14
Allina	1	2	4	4	6

Data source: SDI © 2010

* SDI defines medical group practices as those with five or more FTE physicians whose primary business is seeing regularly scheduled patients for nonsurgical services other than imaging. Physicians must have a share in the practice and offer outpatient care, and the practice must be physically separate from a hospital. Anesthesiology and pathology groups are excluded. Comparative data for 2007 are based on the number of groups that fit this definition.

Geisinger Leverages Medical Group Practices to Boost Hospital Occupancy

Of the 20 selected integrated systems, seven added medical group practices between 2007 and 2008, most notably Geisinger Health System.

- ▶ The number of medical group practices owned by Geisinger jumped to 33 in 2008 from 19 the year before.
- ▶ Occupancy increased a substantial 7.3 percentage points between 2007 (66.8%) and 2008 (74.1%) across Geisinger's facilities, compared with a fractional occupancy rise (to 64.9% from 63.2% in 2007) for all facilities in that market.

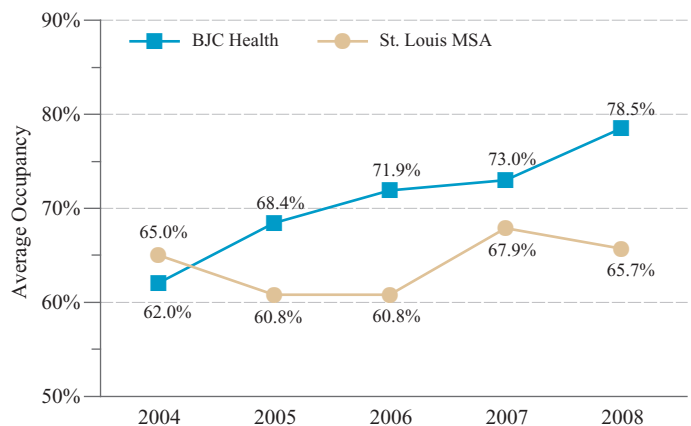
20 SELECTED INTEGRATED SYSTEMS AND THEIR FACILITIES												INTEGRATED HEALTH SYSTEM	
# of FOSCs		# of DICs (free-standing)		# of PHOs		Short-term Staffed Beds		Average Occupancy					
2007	2008	2007	2008	2007	2008	2007	2008	System Hospitals		Overall MSA			
4	4	6	10	9	9	2,198	2,472	68.3%	72.4%	68.7%	68.0%	Advocate Health Care	
2	2	4	6	1	1	1,738	1,631	49.9	53.6	63.0	63.1		Allina Hospitals and Clinics
8	7	4	8	2	3	2,814	3,079	57.2	60.6	65.8	66.2		
16	16	9	9	0	0	2,114	2,466	52.6	49.9	52.6	52.9	Baylor Health Care System	
3	3	1	1	0	0	2,207	2,055	73.0	78.5	67.9	65.7	BJC HealthCare	
2	2	0	0	0	0	254	267	71.9	71.9	69.6	62.3	Carle Foundation Hospital	
8	14	3	6	0	0	2,614	3,135	60.3	59.8	69.7	68.1	Carolinas HealthCare System	
1	1	1	1	0	0	2,415	1,978	46.9	52.1	57.5	57.5	Department of Health Services	
4	4	3	3	0	0	1,568	1,558	65.6	66.1	60.8	60.6	Detroit Medical Center	
2	2	1	1	0	0	550	576	66.8	74.1	63.2	64.9	Geisinger Health System	
3	3	0	0	0	0	3,241	3,291	62.1	62.1	56.9	55.5	HCA Houston Division	
3	3	2	1	0	0	1,672	1,791	65.5	68.1	60.8	60.6	Henry Ford Health System	
0	0	2	2	0	0	909	940	61.6	62.8	62.4	63.8	Legacy Health System	
1	1	0	0	0	0	940	944	60.5	55.7	57.2	56.1	Ministry Health Care	
2	2	4	4	0	0	760	760	49.4	50.9	60.9	59.1	Presbyterian Healthcare Services	
5	5	13	14	0	0	1,564	1,571	75.3	79.2	70.3	73.2	Sentara Healthcare	
3	3	18	17	0	0	1,121	1,121	67.5	71.2	65.0	66.9	Sharp HealthCare	
9	11	12	12	0	0	4,629	4,703	52.1	51.4	69.0	68.3	Sutter Health	
1	1	0	0	0	0	909	719	74.8	76.6	69.6	70.6	Temple University Health System	
2	2	3	3	1	1	2,397	2,425	57.0	68.4	57.4	68.0	Tenet South Florida HealthSystem	

Higher Occupancy Prompts BJC to Initiate Operational Improvement

Of the 20 integrated systems shown above, 14 increased system hospital occupancy between 2004 and 2008. Of these 14, 10 systems added to their number of hospitals during this time, either through acquisition or building projects. Some systems, such as BJC HealthCare, located in St. Louis, Missouri, actually operated fewer hospitals in 2008 than in 2004.

- ▶ BJC HealthCare, which serves an area with large shares of Medicare beneficiaries and Medicaid recipients, likely faced a greater demand for federal reimbursement services.
- ▶ Rather than open new facilities, which would have placed further financial strain on the system, BJC HealthCare instead focused on improving operational efficiencies via the system-wide adoption of Lean Six Sigma to increase capacity of existing personnel and facilities.¹
- ▶ As a result, BJC occupancy has increased 16.5 percentage points since 2004, to 78.5% from 62.0%, versus the MSA average of 65.7%. However they are achieved, operational efficiencies will be vital to systems dealing with increased demand, especially during years of financial downturn.

SYSTEM VS. MSA AVERAGE OCCUPANCY, 2004–2008



Data source: SDI © 2010

Lean Six Sigma

A technique that combines waste reduction principles with statistical standardization and measurement to create a culture of continuous process improvement.

¹ Dupuis, P. J., Kaufman, K. (2007, July). A Disciplined Approach to Capital. *Healthcare Financial Management*. Retrieved from http://findarticles.com/p/articles/mi_m3257/is_7_61/ai_n19377374/?tag=content;col

Integrated Systems Add Imaging Centers to Aid Treatment Strategies

FACILITIES WITHIN INTEGRATED SYSTEMS IN SELECTED MSAs, 2009¹

Home Health Agencies			FOSCs			DICs			Medical Groups ²			METROPOLITAN STATISTICAL AREA (MSA)
in Systems		in MSA	in Systems		in MSA	in Systems		in MSA	in Systems		in MSA	
#	%		#	%		#	%		#	%		
1	1.3%	79	6	4.0%	151	18	18.6%	97	35	14.5%	242	
4	8.7	46	3	2.3	128	8	11.4	70	20	13.0	154	Baltimore, MD
5	5.3	95	2	7.4	27	11	19.0	58	45	23.2	194	Boston, MA–NH
19	6.1	311	18	15.7	115	30	17.6	170	125	33.2	377	Chicago, IL
3	3.9	77	7	16.3	43	28	48.3	58	15	15.6	96	Cleveland–Lorain–Elyria, OH
1	0.2	539	16	15.0	107	9	8.6	105	22	25.6	86	Dallas, TX
9	3.2	285	12	17.1	70	37	41.1	90	69	33.8	204	Detroit, MI
6	0.9	644	11	11.7	94	17	14.8	115	18	14.0	129	Houston, TX
3	4.1	73	5	8.3	60	3	7.9	38	6	5.5	110	Kansas City, MO–KS
9	2.4	373	3	1.2	243	14	9.1	154	75	21.3	352	Los Angeles–Long Beach, CA
2	0.6	354	3	9.1	33	11	15.3	72	5	6.2	81	Miami, FL
3	2.9	105	4	9.8	41	12	19.0	63	94	30.7	306	Minneapolis–St. Paul, MN–WI
7	3.0	230	1	1.8	56	7	3.3	209	27	10.2	265	New York, NY
7	4.9	142	12	10.5	114	29	17.5	166	73	23.1	316	Philadelphia, PA–NJ
3	4.2	71	9	8.4	107	11	9.4	117	18	14.1	128	Phoenix–Mesa, AZ
3	3.5	85	5	11.6	43	15	23.1	65	66	41.8	158	Pittsburgh, PA
6	5.6	107	7	11.1	63	6	9.7	62	18	15.8	114	St. Louis, MO–IL
6	14.0	43	6	10.9	55	23	45.1	51	56	39.7	141	San Diego, CA
6	15.8	38	3	8.3	36	3	12.5	24	26	27.1	96	San Francisco, CA
6	5.2	116	6	4.1	148	6	4.3	138	2	0.9	232	Washington, DC–MD–VA–WV
109	2.9%	3,813	139	8.0%	1,734	298	15.5%	1,922	815	21.6%	3,781	TOTAL

Between 2008 (277) and 2009 (298), the number of diagnostic imaging centers (DICs) affiliated with integrated systems in 20 selected MSAs climbed 7.6%.

- As preventative medicine becomes a more acceptable practice for physicians, hospitals and health plans, the use of imaging to detect disease earlier has gained importance.
- Imaging services provide useful information that could eliminate the need for exploratory surgery and greatly impact the treatment of many diseases.

Average Number of System Staffed Beds Drops in Most MSAs

In 17 of the 20 MSAs listed in this section of the Digest, the average number of staffed beds per system hospital fell between 2008 and 2009. By comparison, the average number of staffed beds per nonsystem hospital rose in 11 of the 20 MSAs during this period, and remained stable in two other MSAs.

STAFFED HOSPITAL BEDS WITHIN INTEGRATED SYSTEMS IN SELECTED MSAs³

METROPOLITAN STATISTICAL AREA (MSA)	Total # of Staffed Beds in System Hospitals		Total # of Staffed Beds in Nonsystem Hospitals		Percentage of Staffed Beds in System Hospitals		Avg. # of Staffed Beds per System Hospital		Avg. # of Staffed Beds per Nonsystem Hospital	
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
	Miami, FL	4,672	4,692	2,310	2,331	66.9%	66.8%	333.7	335.1	210.0
Minneapolis–St. Paul, MN (WI)	3,337	3,337	1,752	1,833	65.6	64.5	175.6	166.9	134.8	152.8
New York, NY	14,742	12,061	7,889	8,134	65.1	59.7	359.6	326.0	254.5	262.4
Philadelphia, PA (NJ)	7,549	8,247	5,950	5,225	55.9	61.2	260.3	235.6	165.3	174.2
Phoenix–Mesa, AZ	4,368	4,471	2,191	2,344	66.6	65.6	291.2	279.4	121.7	111.6
Pittsburgh, PA	4,823	5,779	2,010	1,427	70.6	80.2	267.9	251.3	134.0	158.6
San Diego, CA	3,585	3,632	1,141	1,053	75.9	77.5	239.0	227.0	163.0	210.6
San Francisco, CA	3,633	3,651	807	807	81.8	81.9	213.7	202.8	201.8	201.8
St. Louis, MO (IL)	3,906	4,066	2,726	2,799	58.9	59.2	244.1	225.9	136.3	140.0
Washington, D.C. (MD–VA–WV)	4,350	4,277	3,761	4,027	53.6	51.5	255.9	267.3	197.9	191.8

Data source: SDI © 2010

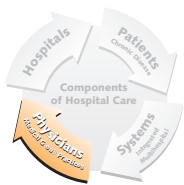
- Some large system hospitals that have expanded their CCU and ICU capacities may also be reducing their bed count in an effort to achieve more appropriate staffing ratios. Nonsystem hospitals, by comparison, may be seeking to add long-term care and other transition beds that provide another layer of care and another source of revenue.

- In recent years, system and nonsystem hospitals alike have been confronted with a multitude of issues regarding capacity and occupancy rates. In some markets, additional staffed bed counts are manageable and necessary for boosting occupancy rates. In others, better management of existing resources might be a more effective solution to balancing occupancy.

¹ Systems included in this table were headquartered in the listed MSAs.

² SDI defines medical group practices as those with five or more FTE physicians whose primary business is seeing regularly scheduled patients for nonsurgical services other than imaging. Physicians must have a share in the practice and offer outpatient care, and the practice must be physically separate from a hospital. Anesthesiology and pathology groups are excluded.

³ Data are based on short-term staffed beds.



SYSTEM-AFFILIATED MEDICAL GROUPS

Multispecialty Practices Comprise Larger Share of Groups in Systems

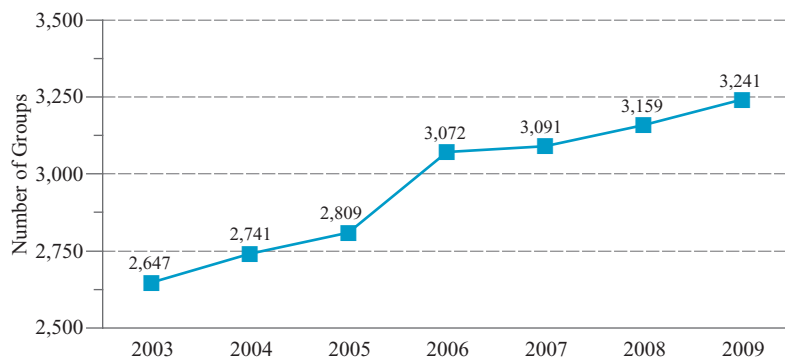
In 2009, 55.6% of medical group practices that were part of an integrated system were multispecialty groups. System membership provides such groups with greater access to specialized technology and better care coordination across health settings.¹ In turn, systems with multispecialty groups gain more referrals for specialty care and access to a patient base with diverse medical needs.

	Medical Group Practices in Systems				Medical Group Practices Not in Systems				
	Number of Groups		Avg. # of Physicians		Number of Groups		Avg. # of Physicians		
	2008	2009	2008	2009	2008	2009	2008	2009	
SIZE (# of FTE MDs)									
5–6	1,199	1,207	5.4	5.4	4,541	4,508	5.4	5.4	
7–9	748	755	7.8	7.7	2,542	2,534	7.7	7.8	
10–14	461	466	11.2	11.2	1,323	1,327	11.4	11.4	
15–19	201	212	16.2	16.2	422	420	16.3	16.3	
20 or More	550	601	64.2	64.0	879	917	52.0	52.1	
SPECIALTY COMPOSITION									
Single Specialty	1,438	1,440	11.3	11.1	5,743	5,769	8.8	8.8	
Multispecialty	1,721	1,801	23.1	24.2	3,964	3,937	15.5	16.0	
TOTAL/ OVERALL AVG.	3,159	3,241	17.7	18.3	9,707	9,706	11.5	11.7	

Number of Medical Groups in Integrated Systems Continues to Climb

The number of medical group practices that belonged to an integrated system grew slightly in 2009, to 3,241 from 3,159 in 2008. Since 2003 (2,647), the number of groups belonging to systems has increased a substantial 22.4%. Affiliation with an integrated system provides many advantages to a medical group practice, including shared financial risks, greater access to administrative and medical technologies and, finally, stronger centralized management.

NUMBER OF MEDICAL GROUP PRACTICES IN INTEGRATED SYSTEMS, 2003–2009

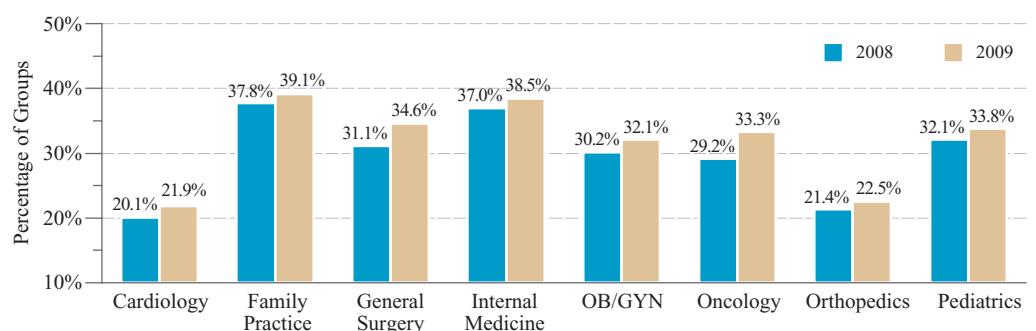


- In spite of these system benefits, groups within systems accounted for just one-third of all medical groups practices nationwide in 2009.
- While system membership provides a number of advantages to medical groups, incentives to remain independent are still considerable.
- For example, groups not tied to systems retain control over the day-to-day decision making and practice operations. Further, physicians in nonsystem groups tend to have more control over the distribution of group revenues.

Narrow Specialty Groups Are Less Likely to Be Tied to an Integrated System

Just 21.9% of all cardiology specialty groups belonged to an integrated system in 2009, making it one of the least common specialties among groups in systems. Orthopedic groups were also less likely to be a part of an integrated system, as just 22.5% of such groups were system affiliated.

MEDICAL GROUP PRACTICES IN INTEGRATED HEALTH SYSTEMS, BY SPECIALTY*



Data source: SDI © 2010

* A medical group practice must have five or more licensed physicians whose primary focus of business is seeing regularly scheduled patients for nonsurgical services other than imaging. The physicians must have a share in the physical setting and office management of the practice, which must offer outpatient care and be physically separate from a hospital. Data are effective as of midyear 2008 and midyear 2009.

¹ See page 15 of the *HMO-PPO Digest* for 2009.

DISTRIBUTION OF MEDICAL GROUPS

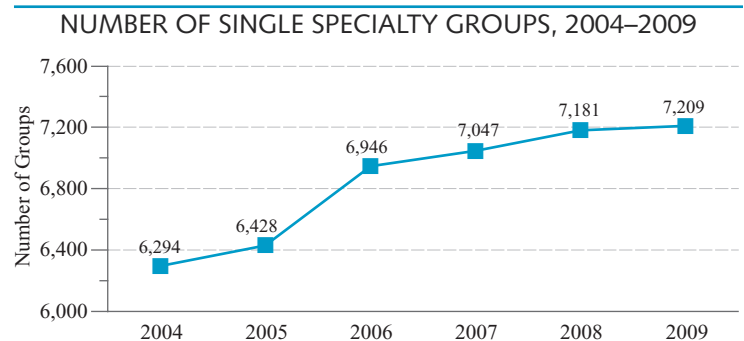
Majority of Group Practices Employ Fewer than 10 Full-Time Physicians

MEDICAL GROUP PRACTICES WITH 5 OR MORE FTE PHYSICIANS*						
SIZE (# of FTE Physicians)	Number of Medical Group Practices		Number of Physicians in Medical Group Practices		Percentage of Medical Group Practices**	
	2008	2009	2008	2009	2008	2009
5-6	5,740	5,715	30,941	30,810	44.6%	44.1%
7-9	3,290	3,289	25,498	25,486	25.6	25.4
10-14	1,784	1,793	20,184	20,315	13.9	13.8
15-19	623	632	10,124	10,278	4.8	4.9
20 or More	1,429	1,518	80,980	86,203	11.1	11.7
TOTAL	12,866	12,947	167,727	173,092	100.0%	100.0%
AFFILIATION						
Corporate	5,186	5,366	83,098	89,487	40.3%	41.4%
Independent	7,680	7,581	84,629	83,605	59.7	58.6
TOTAL	12,866	12,947	167,727	173,092	100.0%	100.0%
SPECIALTY COMPOSITION						
Single Specialty	7,181	7,209	66,596	66,474	55.8%	55.7%
Multispecialty	5,685	5,738	101,131	106,618	44.2	44.3
TOTAL	12,866	12,947	167,727	173,092	100.0%	100.0%
AVERAGE VISITS PER WEEK						
Under 250	1,026	1,039	10,810	11,115	8.0%	8.0%
250-499	2,067	2,073	17,421	17,500	16.1	16.0
500-749	2,046	2,039	16,267	16,285	15.9	15.7
750+	2,771	2,776	34,642	36,168	21.5	21.4
Unknown	4,956	5,020	88,587	92,024	38.5	38.8
TOTAL	12,866	12,947	167,727	173,092	100.0%	100.0%

- Of the 12,947 medical group practices in the U.S. with five or more full-time-equivalent (FTE) physicians, a notable 69.5% employed fewer than 10 FTE physicians in 2009.
- However, nearly half (49.8%) of physicians in medical groups belonged to a practice with more than 20 full-time physicians.
- The number of FTE physicians employed by medical groups in this largest size category rose 6.4% in 2009, to 86,203 from 80,980 the prior year.

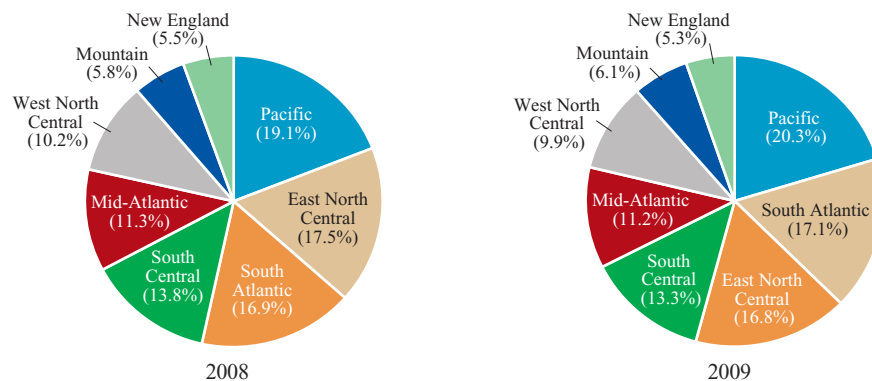
Growth of Single Specialty Groups Flattens in Recent Years

- Although the number of single specialty groups has grown by approximately 15% since 2004, that growth slowed considerably between 2007 (7,047) and 2009 (7,209).
- The growth of single specialty groups has in part been driven by the increased specialization of health care. Although incentives to form multispecialty groups remain—including increased referrals from group primary care physicians—further specialization has often provided greater leverage for single specialty groups.



Group Practice Model Continues to Thrive in Pacific Region

DISTRIBUTION OF MEDICAL GROUP PRACTICE PHYSICIANS, BY REGION*



Just over one in five (20.3%) medical group practices was headquartered in the Pacific region in 2009, up from 19.1% in 2008. Due to higher-than-average managed care penetration in Pacific states, in particular California, physicians were more likely to form groups to gain negotiating leverage with health plans.

Data source: SDI © 2010

* Numbers and percentages reflect group practices located only in the 50 states and the District of Columbia. Data are effective as of midyear 2008 and midyear 2009.

** Percentages may not sum to 100% due to rounding.

MEDICAL GROUP SPECIALTIES

Family Practice, Internal Medicine and Pediatrics Provide Gateways to Care

MEDICAL GROUP PRACTICES, BY MOST COMMON SPECIALTIES, 2009

	Cardiology	Family Practice	General Practice	General Surgery	Internal Medicine	Neurology	OB/GYN	Oncology	Orthopedics	Pediatrics	Psychiatry	Urology
SIZE (# of FTE Physicians)												
5-6	6.4%	25.6%	4.7%	3.3%	17.7%	1.7%	13.1%	1.0%	10.3%	17.1%	1.3%	2.6%
7-9	9.6	26.9	5.6	4.0	21.2	3.0	15.6	1.5	13.4	19.2	2.2	3.1
10-14	12.6	32.0	6.8	4.6	26.1	4.6	16.7	2.3	19.6	23.6	3.3	3.7
15-19	14.8	37.7	9.7	7.8	33.3	7.5	21.4	2.9	23.1	28.6	4.9	5.2
20 or More	28.6	50.1	20.6	17.1	51.9	19.3	38.0	16.3	30.6	42.9	12.3	18.8
SPECIALTY												
Single Specialty	9.2	22.7	3.2	2.3	9.7	1.6	11.8	0.2	11.1	14.0	1.4	3.0
Multispecialty	13.3	39.9	12.7	9.6	43.6	8.8	25.0	7.0	20.8	32.5	5.7	7.3
OVERALL AVERAGE	11.0%	30.2%	7.3%	5.5%	24.4%	4.7%	17.5%	3.2%	15.3%	22.0%	3.2%	4.9%

In 2009, medical group practices that offered family practice (30.2%), internal medicine (24.4%) or pediatrics (22.0%) represented the largest shares of practices nationwide. These specialties likely have the greatest overall representation,

owing to their higher level of demand. For physician groups affiliated with health plans, especially HMOs, primary care physicians, internists and pediatricians are still often used as gatekeepers to more specialized forms of care.

Imaging Services Are Vital to Most Orthopedic Medical Group Practices

Medical group practices that specialized in orthopedics were most likely, by specialty, to provide imaging services in 2009.

- Orthopedics rely heavily on imaging technology to properly diagnose and treat bone and joint maladies. In 2009, 83.6% of orthopedic practices provided at least some form of imaging services, a fractional increase from the year before (83.5%).
- By comparison, just 43.5% of orthopedic practices offered clinical labs in 2009, the lowest percentage, by specialty, by a considerable margin. Meanwhile, oncology specialists were most likely, by specialty, to offer clinical labs in 2008, at 82.6%.

PERCENTAGE OF MEDICAL GROUP PRACTICES, BY TYPE OF SERVICE OFFERED, 2009

SPECIALTY	Perform Surgery		Offer Clinical Labs		Provide Imaging	
	2008	2009	2008	2009	2008	2009
Cardiology	39.8%	40.3%	57.6%	58.0%	73.5%	73.6%
Family Practice	75.0	74.6	70.6	70.7	74.4	74.0
General Surgery	82.3	82.3	57.4	57.9	69.1	69.4
Internal Medicine	58.2	58.3	71.6	71.8	70.5	70.6
OB/GYN	70.3	70.2	62.5	62.9	80.4	80.5
Oncology	72.6	73.0	82.3	82.6	78.5	78.7
Orthopedics	51.9	52.2	43.2	43.5	83.5	83.6
Pediatrics	57.9	57.7	66.2	66.3	62.5	62.5

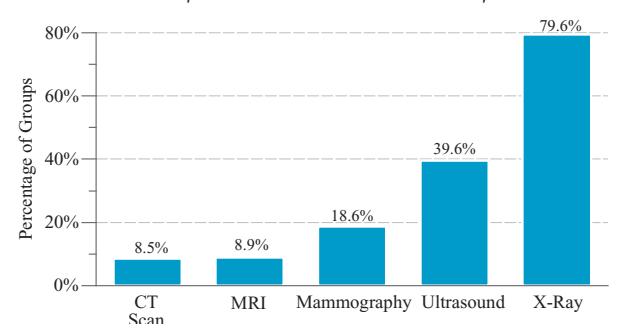
- While the share of cardiology practices that performed surgery rose fractionally between 2008 (39.8%) and 2009 (40.3%), it remained the specialty with the lowest percentage of groups offering surgery.

Nearly 80% of Medical Group Practices Offer X-Ray Services

In recent decades, X-ray technology has grown to become one of the most commonly used diagnostic tools. The relatively inexpensive cost of X-ray technology, combined with its steady effectiveness, has enabled the vast majority of medical group practices to offer these services.

- Nearly four out of every five (79.6%) groups that provided imaging services had X-ray capabilities, the most popular mode of imaging.
- By comparison, medical group practices with imaging services were less likely to provide ultrasounds (39.6%), mammographies (18.6%), MRIs (8.9%) or CT scans (8.5%) in 2009.

PERCENTAGE OF GROUPS WITH IMAGING SERVICES, BY TYPE OF MODALITY, 2009

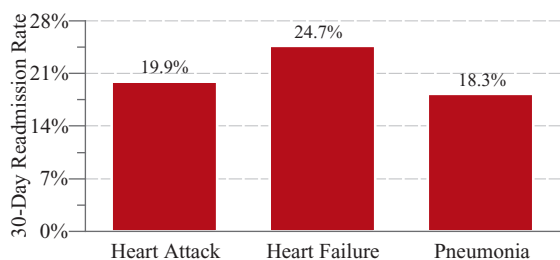


Data source: SDI © 2010



Incentivizing Hospitals to Reduce High Medicare Readmission Rates

PERCENTAGE OF PATIENTS READMITTED

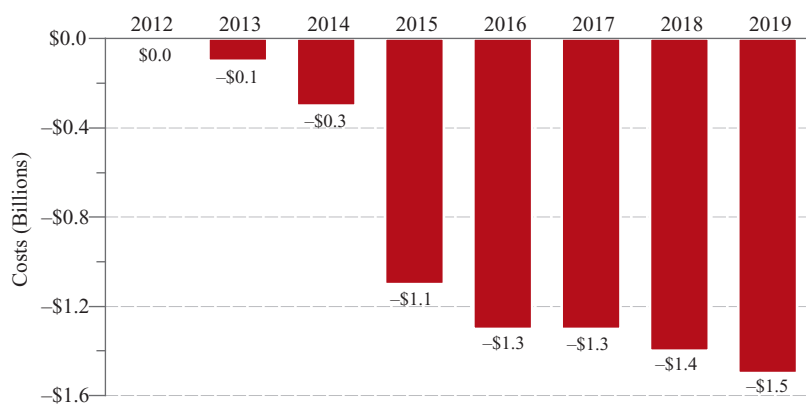


Data source: Hospital Compare Database, Medicare.gov, July 2006–June 2009

In June 2009, the U.S. Department of Health and Human Services (DHHS) began requiring that hospitals report 30-day readmission rates as a quality metric, as such rates were found to be uniformly high at hospitals nationally. (As many as one in every five Medicare patients was readmitted to a hospital within 30 days of discharge.)¹ As part of efforts to manage increasing health care costs, Medicare plans a payment policy change that will incentivize hospitals to reduce high readmission rates. The Patient Protection and Affordable Care Act (PPACA) features language that supports such changes, and provides funds for quality improvement efforts to reduce rehospitalizations.

The PPACA also establishes a shared savings program to encourage the formation of Accountable Care Organizations (ACOs). Participating ACOs will hold responsibility for coordinating services covered by Parts A and B for Medicare fee-for-service patients. To qualify for participation in the program, ACOs must include a minimum number of primary care physicians, and may also include hospitals. The ACO must be capable of managing patients across multiple settings of care and be willing to participate for at least three years. These ACOs will be held to increasingly higher quality standards. Improved continuity of care should result in lower readmission rates.

ESTIMATED EFFECTS ON DIRECT SPENDING, HOSPITAL READMISSION REDUCTION PROGRAM



Data source: Congressional Budget Office (March 2010)

DELIVERY SYSTEMS THAT COULD BECOME ACCOUNTABLE CARE ORGANIZATIONS²

MODEL	CHARACTERISTICS
Integrated delivery systems	<ul style="list-style-type: none"> Own hospitals, physician practices, perhaps insurance plan Aligned financial incentives E-health records, team-based care
Multispecialty group practices	<ul style="list-style-type: none"> Usually own or have strong affiliation with a hospital Contracts with multiple health plans History of physician leadership Mechanisms for coordinated clinical care
Physician-hospital organizations	<ul style="list-style-type: none"> Nonemployee medical staff Function like multispecialty group practices Reorganize care delivery for cost-effectiveness
Independent practice associations	<ul style="list-style-type: none"> Independent physician practices that jointly contract with health plans Active in practice redesign, quality improvement
Virtual physician organizations	<ul style="list-style-type: none"> Small, independent physician practices, often in rural areas Led by individual physicians, local medical foundation, or state Medical agency Structure that provides leadership, infrastructure, resources to help small practices redesign and coordinate care

These provisions of the PPACA represent a clear investment in the effort to reduce readmission rates. No wonder: a recent MedPAC report claimed that avoidable readmissions cost Medicare \$15 billion a year.³ Indeed, PPACA architects are banking on a return of investment. Between 2010 and 2019, the CBO estimates that the Hospital Readmissions Reduction Program (the program established by the PPACA that allows for lower payments to facilities with high rates of preventable readmissions) could generate \$7.1 billion in savings. Lower readmission rates will not only reduce the costs of care for certain Medicare patients, they may also improve access to care for all patients.

¹ Jencks, S. F., Williams, M. V. & Coleman, E. A. (2009). Rehospitalizations Among Patients in the Medicare Fee-for-Service Program. *New England Journal of Medicine*, 360, 1418–1428.

² Shortell, S. M., Casalino, L. P. & Fisher, E. S. (2010). How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations. *Health Affairs*, 29(7), 1293–1298.

³ MedPAC. (2008). June 2008 Report to the Congress: Chapter 4: A Path to Bundled Payment Around a Hospitalization. Retrieved from www.medpac.gov/documents/Jun08_EntireReport.pdf