Physician Employment: Contracting, Compensation & Financial Performance Improvements (Fall)

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Agenda

- I. Introductions and Objectives
- II. Influences on Employment
- III. Employment Versus Other Alignment Approaches
- IV. Employment Options: Structure and Compensation
- V. Avoiding Excessive Subsidies
- VI. National Survey on Employment
- VII. Questions and Discussion

Learning Objectives

- Describe industry trends and influences that affect joint ventures and alternatives to joint ventures
- Identify opportunities for collaboration with physician partners and assess how reasonable the proposed or current transactions are from a fair market value perspective
- List and develop potential performance and quality measures
- Define characteristics of effective alignment

Influences on Employment

Influences on Employment

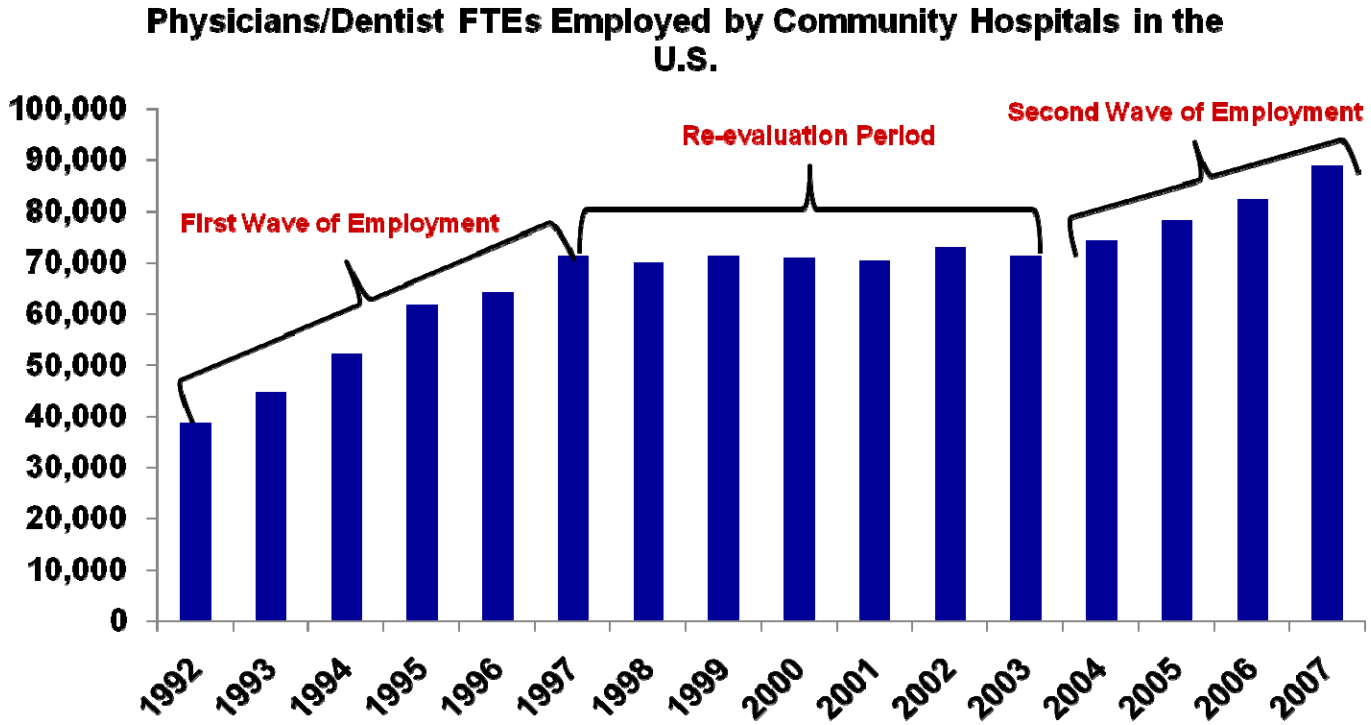
- Historically, separatism and/or competition between hospitals and physicians, driven by pursuit of supplemental income, payor and regulatory environment, hospitalists, and technology development
- Now, desire of physicians for security – employment by group or hospital
- Soured relationships between physicians and hospitals
- Regulations constrain the options for formal business relationships other than employment
- Recruitment failure and difficulty in securing on-call coverage
- The rush to employ by your competitors

Influences in your market?

Influences on Employment (continued)

- Return of employment over past 5+/- years; one major driver is the desire for security
  - In some markets, virtually all physicians are employed by hospitals or large practices
  - Most large employed physician networks are able to negotiate premium reimbursement rates
  - While industry average subsidy is $70,000++ annually, best practice is $35,000-$40,000
  - Employment is appropriate for a portion of the medical staff
  - If a 150-physician group reduces subsidy from $100K to industry average or best practice, a $5-10M savings can result

Influences on Employment (continued)



The 2010 Review shows that 51% of Merritt Hawkins' 2009/2010 physician search assignments were for settings featuring hospital employment of the physician, up from 45% last year and up from 23% in 2005/2006

Source: 2010 Merritt Hawkins review of physician recruiting incentives survey.

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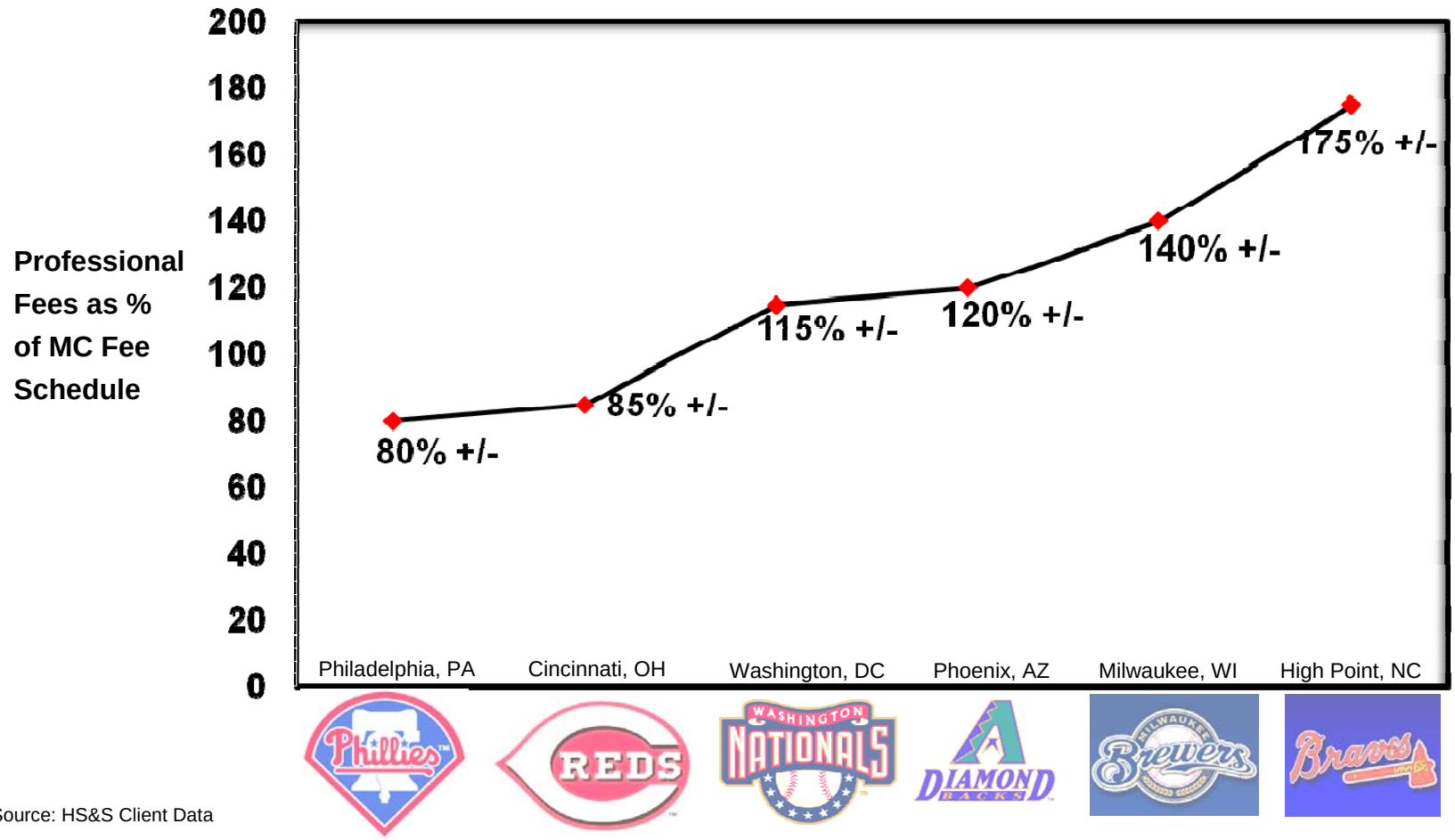
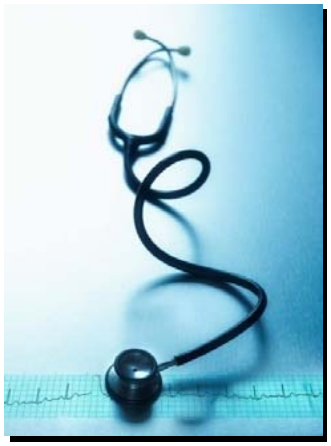
Influences on Employment (continued)

A Varying Reimbursement Environment



Source: HS&S Client Data

Physician Employment: The Research Says….



"Physician employment historically has had mixed effects on clinical integration."
- Rob Burns, Ph.D., Wharton School of Business, University of Pennsylvania

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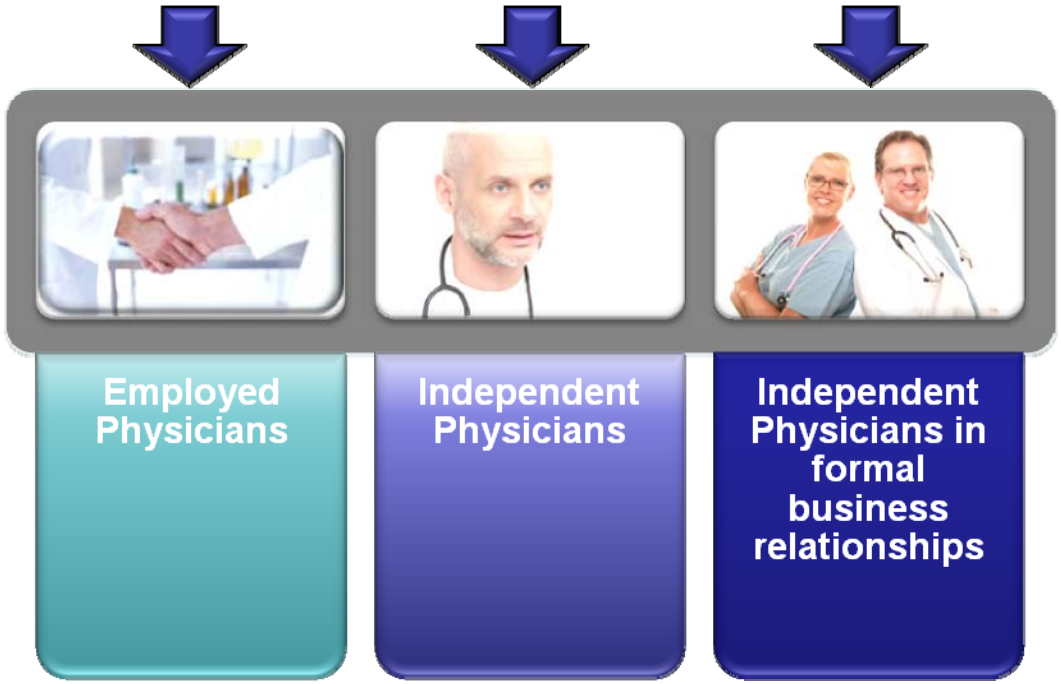
Employment Versus Other Alignment Approaches

Employment Versus Other Alignment Approaches

- **Employment is just one approach for hospital physician alignment**

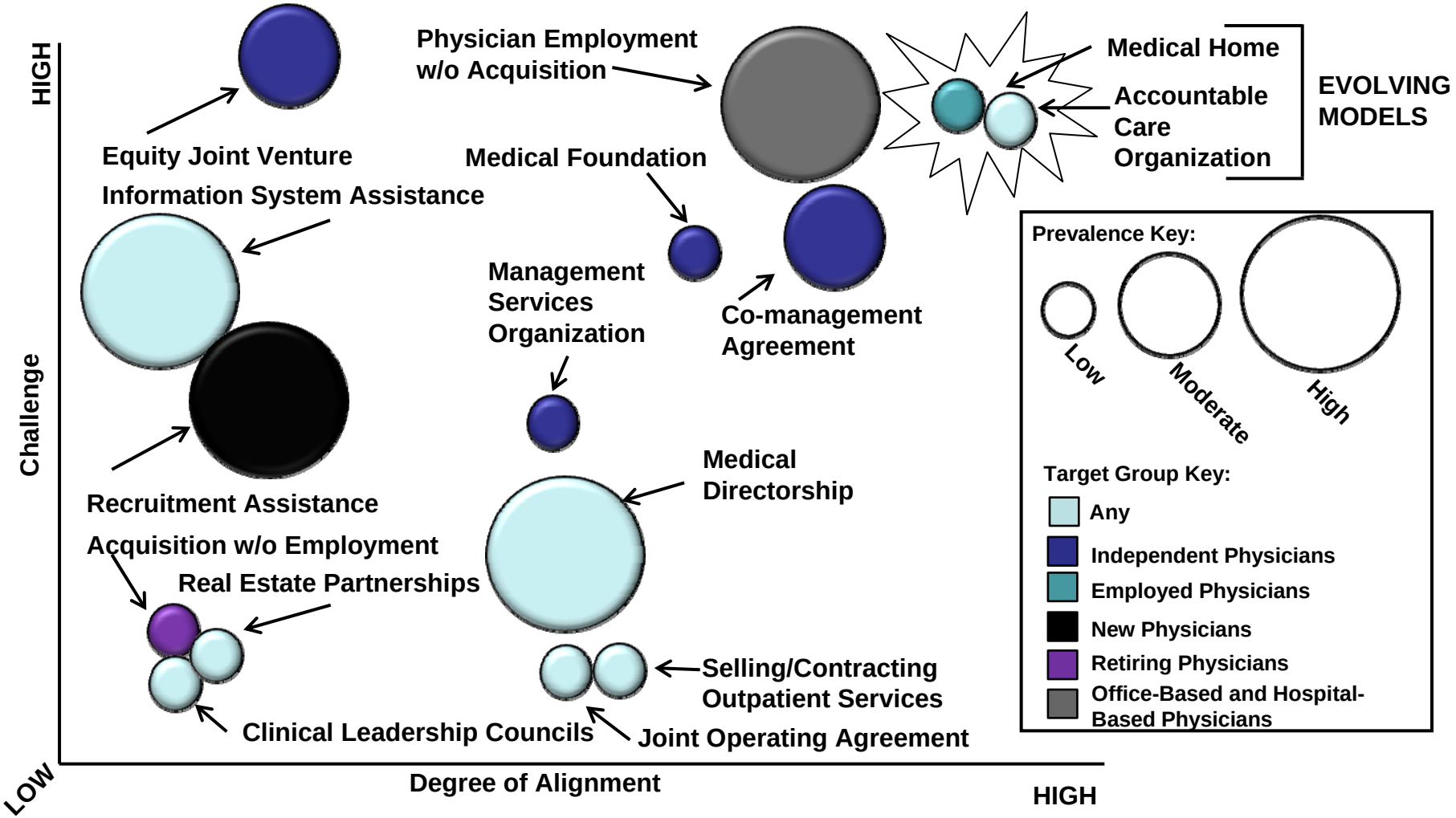


- **Employment is typically for a minority of medical staff**

Employment Versus Other Alignment Approaches (continued)

Physician Alignment Categories	Approach	Common Objectives
Employed	▶ Selectively grow ▶ Improve performance	▶ Strong PCP base, supplemented with hard-to-recruit or hard-to-gain-coverage specialties ▶ Tolerable deficits
Independent	▶ Proactive, comprehensive outreach initiatives ▶ Optimal hospital operations and systems, quality demonstration, IT to earn referral relationships	▶ Strong referral relationships
Independent, but potential partners	▶ Systematic process to evaluate and develop formal business partnerships (i.e., JVs and alternatives)	▶ Selective business partnerships tailored to practice needs and hospital strategic priorities ▶ Market growth

The Continuum of Alignment Models



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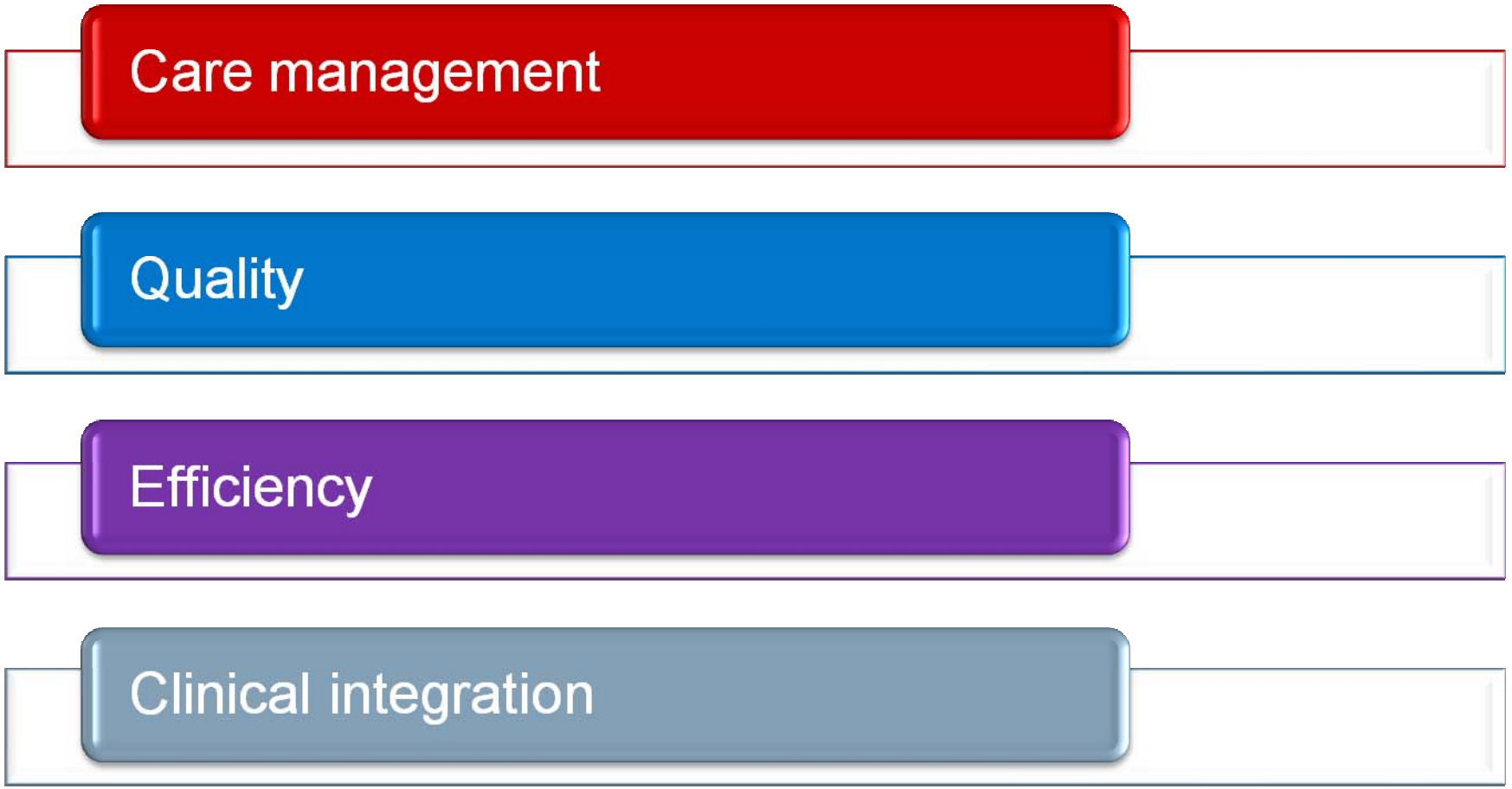
In employment or other business relationships, it's not the model, it's what the model does



Employment Options

Employment Options: Structure and Compensation

- Structure
  - Direct employment
  - Foundation
- Compensation methodology
  - RVUs
  - Guaranteed salary
  - Quality, outcomes
  - Net income
  - Percentage of collections
  - Citizenship
- Model and compensation pitfalls

Compensation Model
Example 1: Family Practice

Base Salary				
	Years in Specialty			
	1 to 2	3 to 7	8 to 17	18+
MGMA Median (less Bonus potential)	$137,724	$148,494	$164,089	$164,741

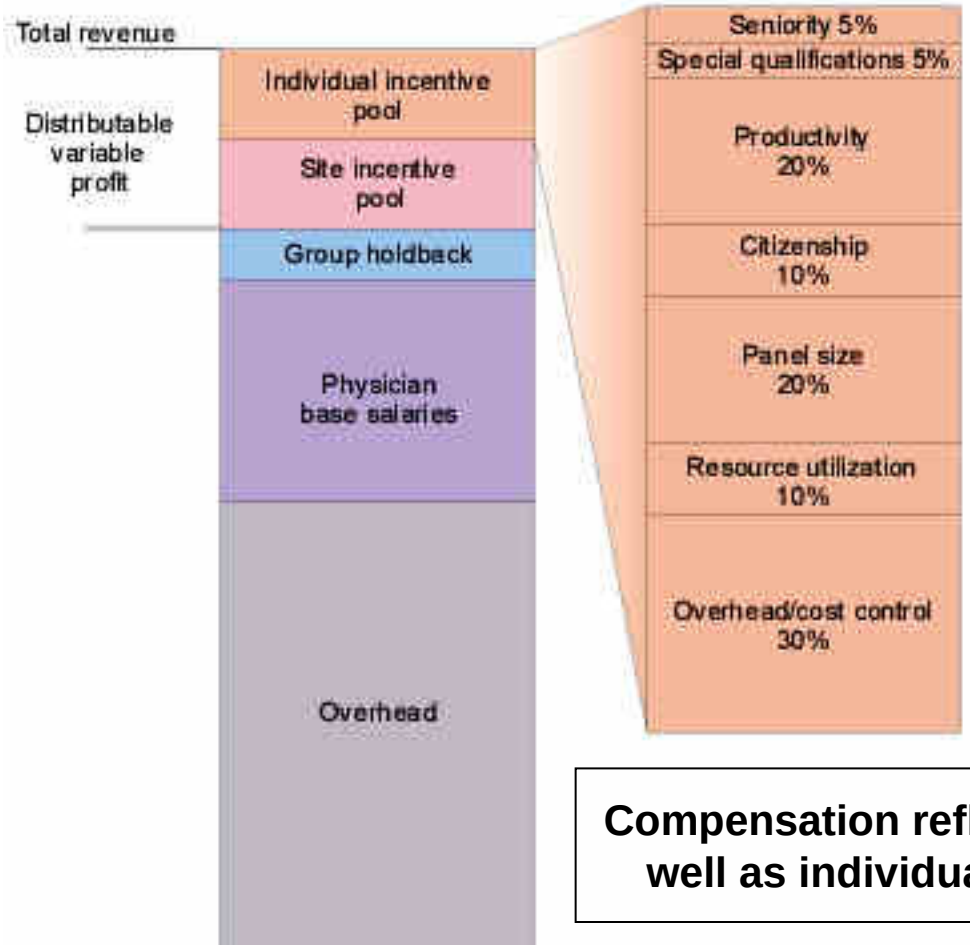
+

Bonus		
Category		Bonus
Seniority		$5,000
Quality	Up to	$10,000
Patient satisfaction	Up to	$10,000
Panel size	Up to	$5,000
Leadership	Up to	$5,000

A disadvantage of this method is trying to incentivize and reward behaviors that are both quantitative and qualitative; method also disregards productivity

Max compensation is equal to MGMA median specific to years in specialty

Compensation Model: Example 2: Family Practice



- The importance of both group and individual effort towards productivity, efficiency and profitability is reflected by the inclusion of two incentive pools, the individual and site incentive pools

Compensation reflects overall practice performance as well as individual performance on a variety of factors

Compensation Model: Example 3: Internal Medicine

Part 1: Productivity-Based Component (Professional Services)								
Tier	Range of wRVUs		Bonus per Incremental wRVU	Base Compensation	Productivity Compensation		Total Productivity-Based Compensation	
1	-	4,700	$40	$180,000				$180,000
2	4,701	6,000	$41	$180,000	Up to	$53,259	Up to	$233,259
3	6,001	8,000	$42	$233,259	Up to	$83,958	Up to	$317,217
4	8,001	+	$43	$317,217	Up to	$177,783	Up to	$495,000

Part 2: Other Incentives		
Category		Bonus
Quality	Up to	$10,000
Leadership	Up to	$10,000

What characteristics of this compensation model make it interesting?

Max compensation is $515,000

Compensation Model
Example 4: Internal Medicine

Part 1: Productivity-Based Component (Professional Services)				
Tier	Range of wRVUs		Compensation Per wRVU	Max Compensation Per Tier
1	-	4,415	$54	$238,410
2	4,416	4,995	$64	$37,056
3	4,996	+	$73	up to $365,292

Part 2: Other Incentives		
Category		Bonus
Quality	Up to	$10,000
Payor Mix	Up to	$10,000
Leadership	Up to	$100,000

Which features of this model would trigger compliance alerts? Why?

Max compensation is $760,758

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Compensation Model: Example 5: Orthopedics

Overall Practice Revenue

↓

Patient Care Revenue

↓

Allocated to individual physicians based on actual production

Overall Practice Expenses

↓

Direct Expenses

↓

Tracked and allocated to individual physicians (includes staffing, personal expenses, CME, etc.)

Shared Expenses

↓

Distribution of overhead expenses based on percent of individual revenue

Resulting compensation is individual revenue less direct expenses and overhead allocation

This model can be referred to as the capitalist model as you are rewarded for your individual productivity and expense management

Compensation Model: Example 6: Orthopedics

Overall Practice Revenue

Equal ($) distribution of practice revenue

Overall Practice Expenses

Equal ($) distribution of practice expenses

All physicians are compensated at the same level based on overall practice performance

In your opinion, could this model be sustainable in today's reality?

Avoiding Excessive Subsidies

Avoiding Excessive Subsidies: The Formation Process

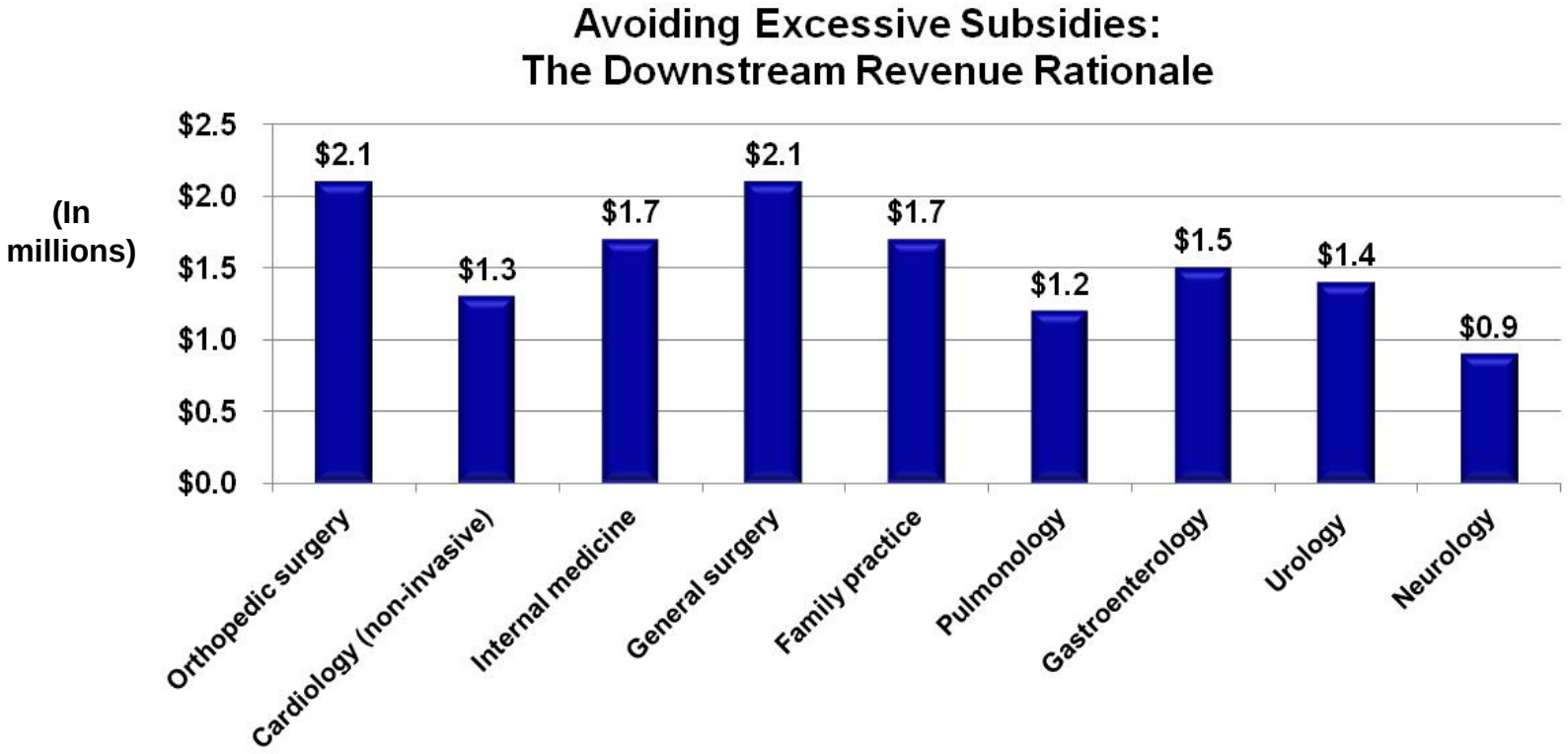
- Careful selection of top-tier, professionally compatible physicians committed to clinical integration
- Acquisition costs exclude excessive goodwill
- Productivity-based compensation and short-term (one- to two-year) contracts
- Medical group managed by practice managers, rather than hospital administrators
- Strong focus on adding incremental practices; incremental downstream revenue offsets practice deficits
- Some practice deficits are inevitable due to ramp-up, rich hospital benefits, and removal of ancillary revenue from practices

Avoiding Excessive Subsidies: Example Selection (or Divestiture) Criteria

Category	Components	Score
Strategic priority	▶ Hospital and community need (specialty-specific) ▶ Precludes competitors ▶ Fit with hospital and health plan initiatives	5
Financial performance targets achieved		4
Other productivity measures achieved	▶ RVUs ▶ NMR	3
Growth potential	▶ Historic growth rate ▶ Physician entrepreneurial/practice building qualities	2
Fulfills coverage requirements		2
Alienation factor	▶ Future competitive threat	2
Other	▶ Quality indicators ▶ Group practice potential	1

Each practice site is reviewed and scored:
<10 Points = Divest; 10–13 Points = Probation; 13 Points = Retain

Avoiding Excessive Subsidies: The Downstream Revenue Rationale



In 2010, physicians continue to generate approximately $1.5 million of average revenue on behalf of their affiliated hospitals.

Source: 2010 Physician Inpatient/ Outpatient Revenue Survey, Merrit Hawkins.

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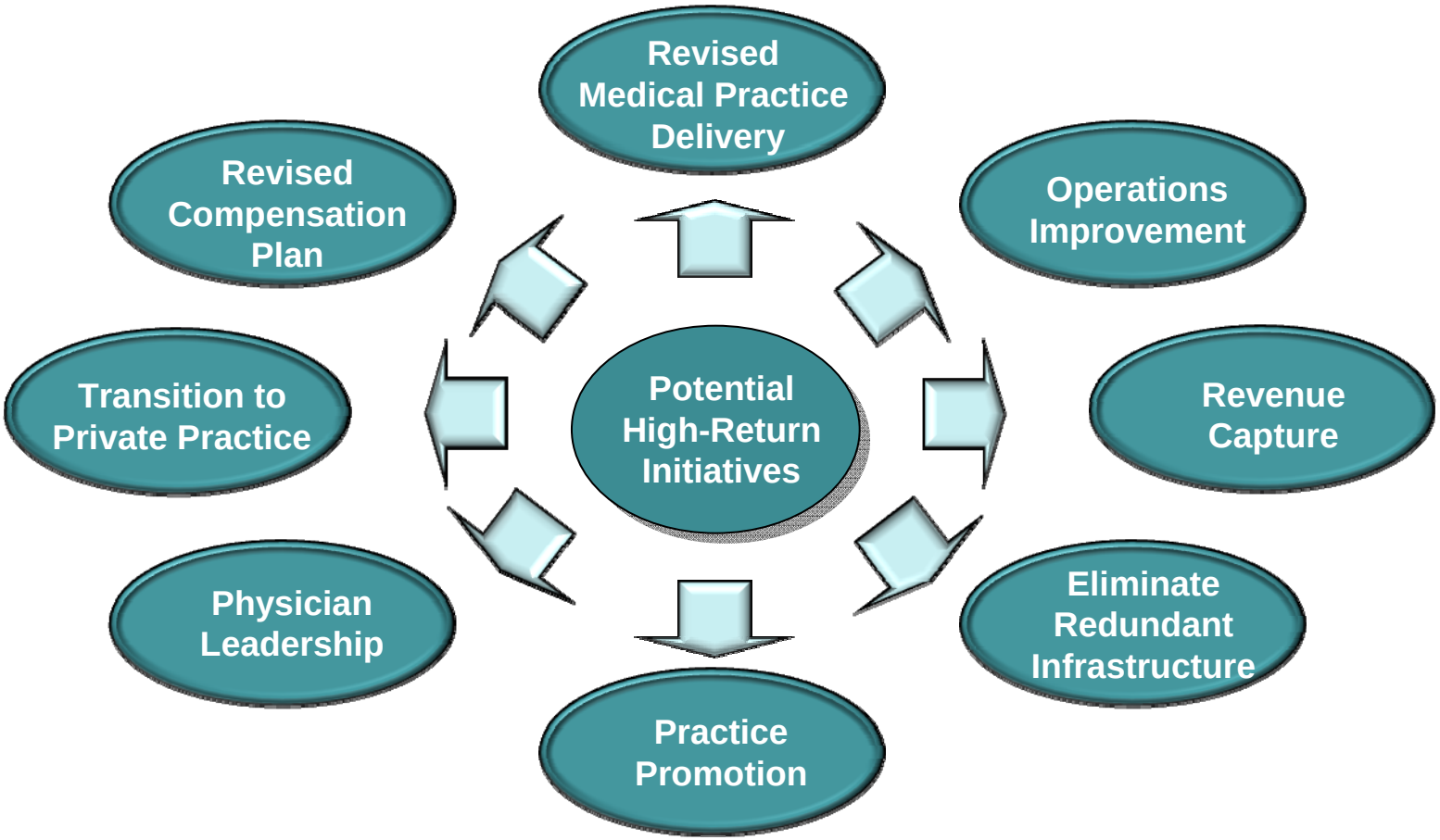
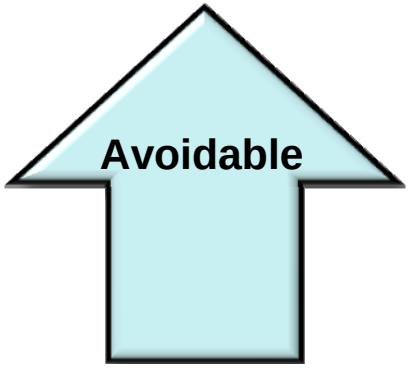
Avoiding Excessive Subsidies: High-Return Initiatives



Avoiding Excessive Subsidies: Focus on Avoidable Losses



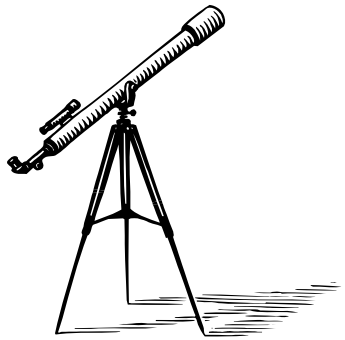
Productivity/compensation gap

Excessive accounts receivable

Reduction in bad debt

Excessive overhead allocation

Practice staffing



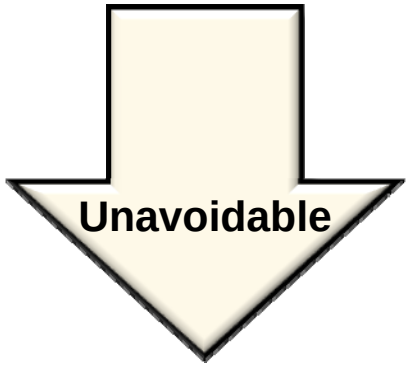
Start-ups

Amortized acquisition costs

Contractual agreements

Long-term leases

Strategic practice locations



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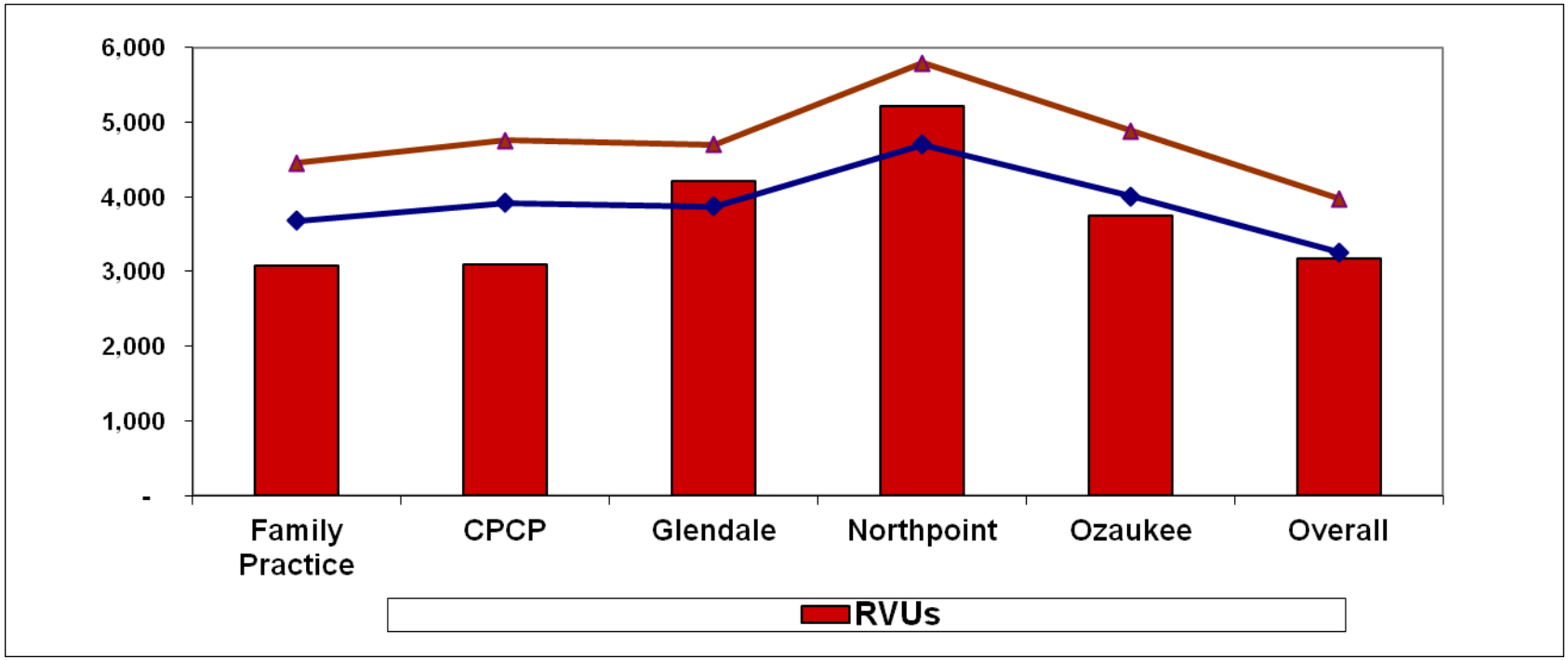
Avoiding Excessive Subsidies: Comparison of Work RVUs per FTE Provider to Benchmark



Overall performance was slightly less than median performance and 20% less than the best practice

Source: HS&S Client Data

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Avoiding Excessive Subsidies: Practice Promotion Observations and Recommendations

Practice	Observations	Recommendations
	▶ IM physicians are at 80% to 100% of benchmarks for office encounters and RVUs ▶ Pediatric physicians are at 60% of productivity benchmarks ▶ Clinic has recently expanded availability for walk-in appointments ▶ Subspecialist physicians (dermatology and ENT) see patients at this site ▶ Comprehensive complement of ancillary services (radiology, PT, OT, etc.)	▶ Increase average office hours per provider ▶ Promote practice accessibility ▶ Add program(s) or an additional practice to the site ▶ Promote availability of ancillary services

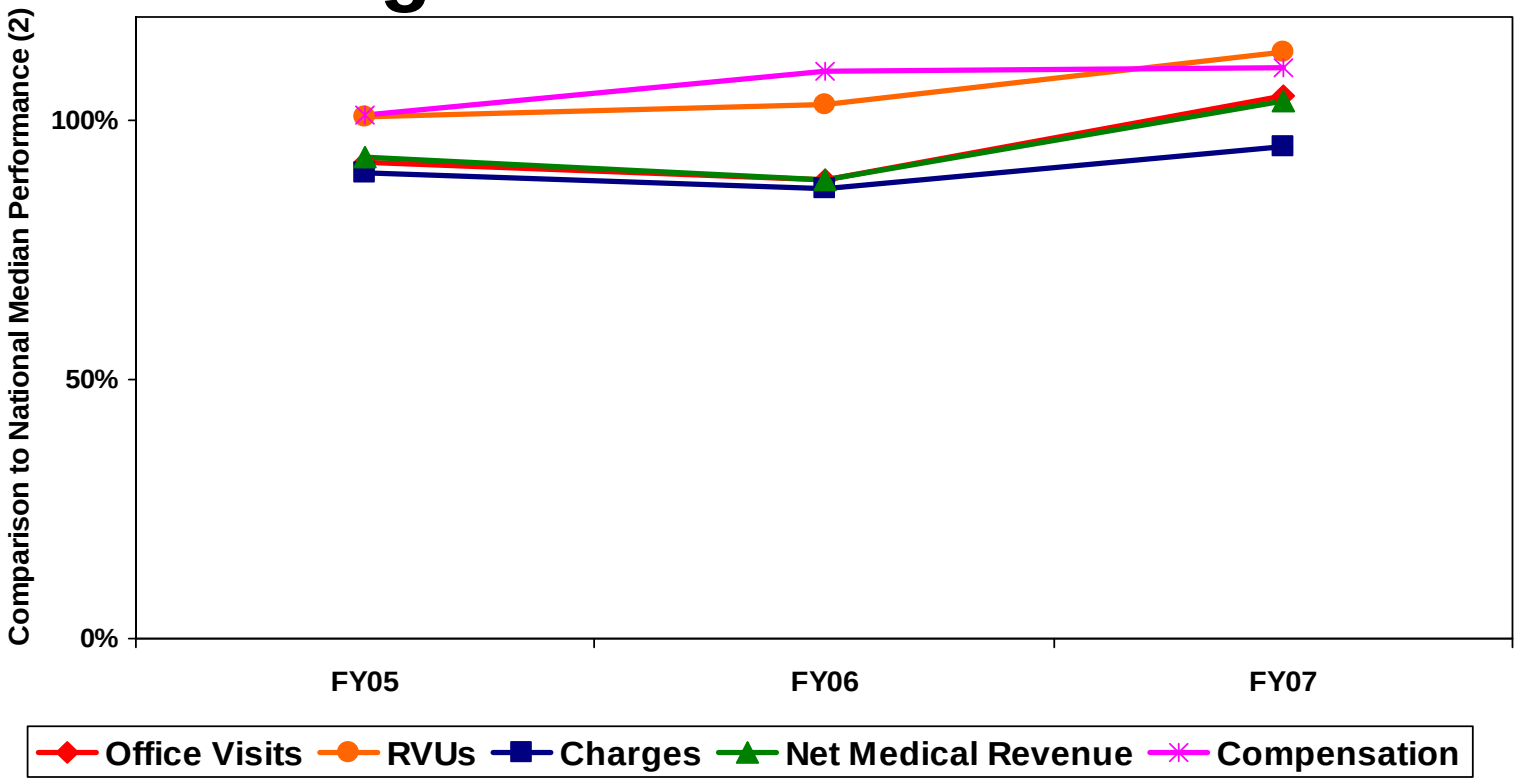
Observations and recommendations developed for each practice site as well as practice group overall

Avoiding Excessive Subsidies: The Analysis of Financial Performance Indicators

	Network	Benchmark	Favorable Unfavorable vs. Benchmark
Accounts Receivable Benchmarks			
Days	40	50	Favorable
Average per Physician	$ 76,435	$ 79,850	Favorable
Collections Rate	55.4%	68.0%	Unfavorable
Percentage of Total Net Revenue Benchmarks			
Bad Debt as %	3.9%	3.0%	Unfavorable
Billing/Collections Cost as %	7.5%	7.0%	TBD
Allocated Overhead Costs as %	8.0%	10%15%	Unfavorable
Ancillary Charges as a % of Total Charges	*Not Applicable*	26.0%	

When applicable, indicators are reviewed for individual physicians, practice, and group overall

Avoiding Excessive Subsidies: The Analysis of Aggregate Performance Against Benchmarks



Volume, charges, revenue, and compensation indicators are reviewed for individual physicians, practice, and the group overall

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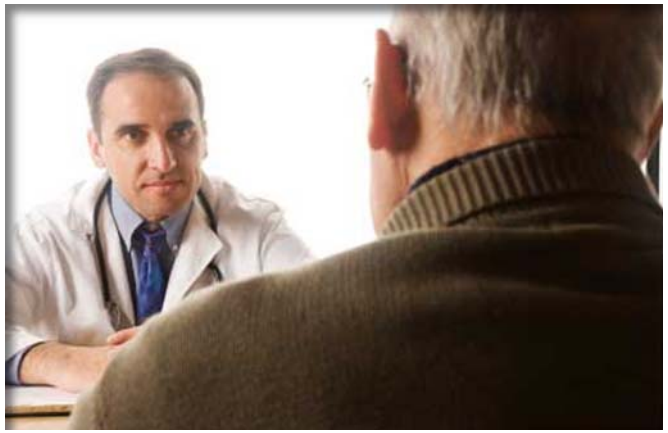
Avoiding Excessive Subsidies: Outreach Programs

- Monitor and communicate with data
- Earning physician loyalty is a long-term process; losing loyalty occurs in a nanosecond
- Represent practice support, not hospital occupancy
- On time, brief, and to the point
- Physician relations staff need no office



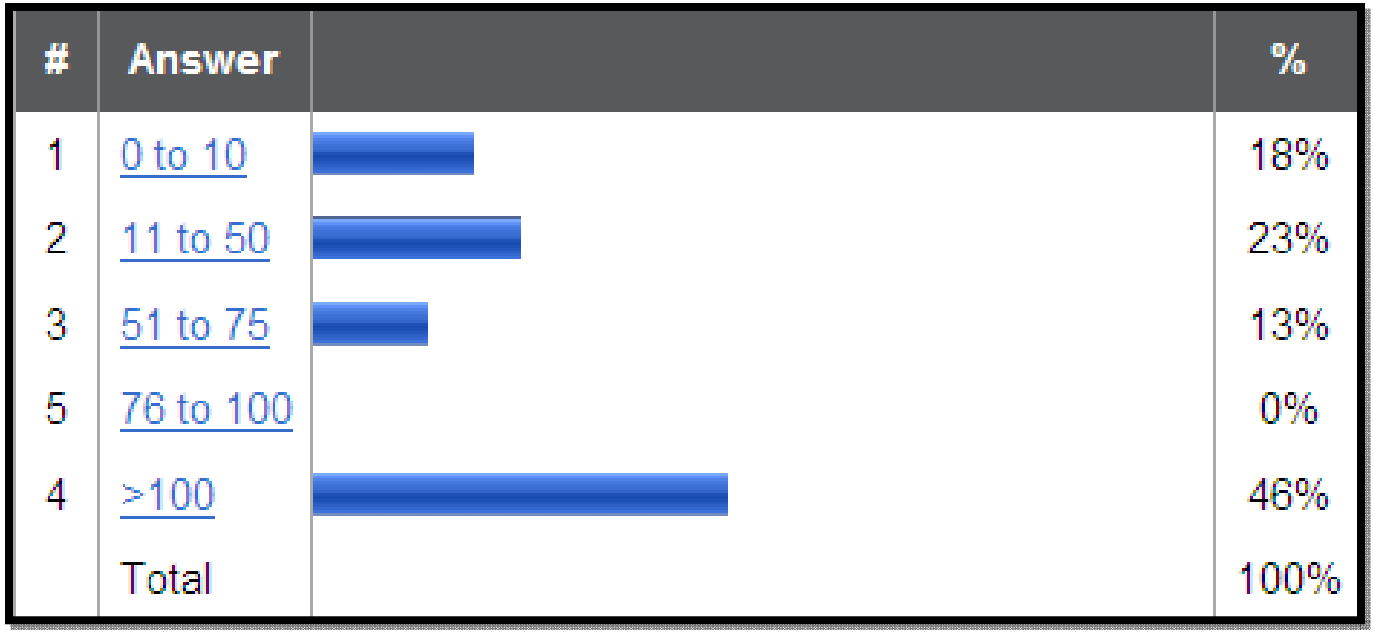
National Survey Results

National Survey on Employment

- 36 hospitals and systems participated in survey on physician employment
- 21 states represented
- Number of employed physicians ranges from 6 to 300 and growing

Number of Employed Physicians

#	Answer		%
1	0 to 10		18%
2	11 to 50		23%
3	51 to 75		13%
5	76 to 100		0%
4	>100		46%
	Total		100%



Percent of Primary Care

#	Answer		%
1	<10%		22%
2	11% to 50%		41%
3	51% to 75%		27%
4	76% to 100%		11%
	Total		100%

Compensation Model

#	Answer		%
1	Straight salary		21%
2	RVU-based		42%
3	Percent of collections		21%
4	Other		16%
	Total		100%

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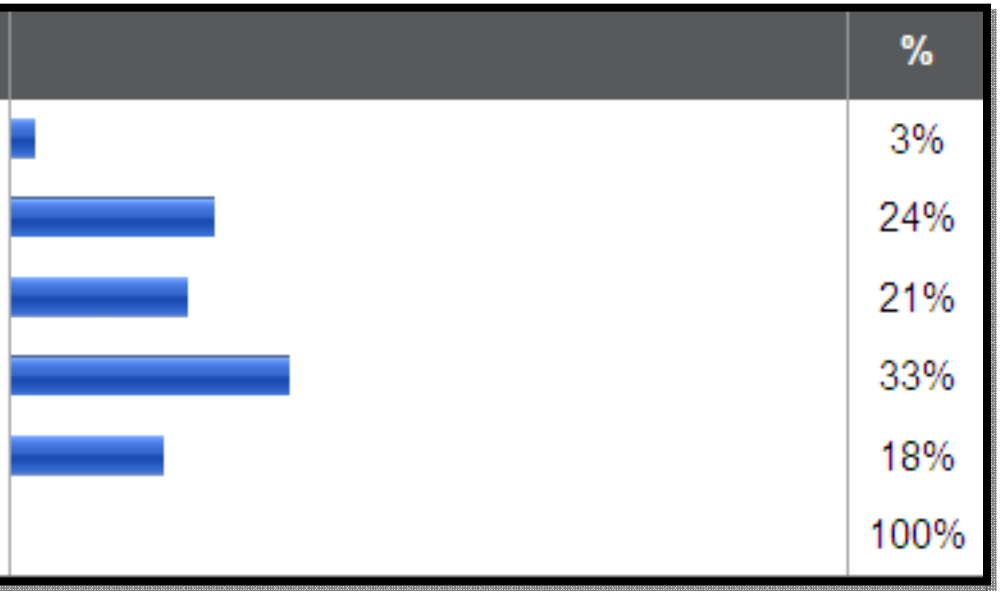
Annual Subsidy Per Physician

#	Answer		%
1	$0 to $30K		3%
2	$31K to $50K		24%
3	$51K to $75K		21%
4	$76K to $100K		33%
5	>$100K		18%
	Total		100%



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Reimbursement Rates for Employed Physician vs. Private Practice

#	Answer		%
1	Same		44%
2	<10%+		12%
3	11% to 15%+		28%
4	16% to 20%+		4%
5	>20%		12%
	Total		100%

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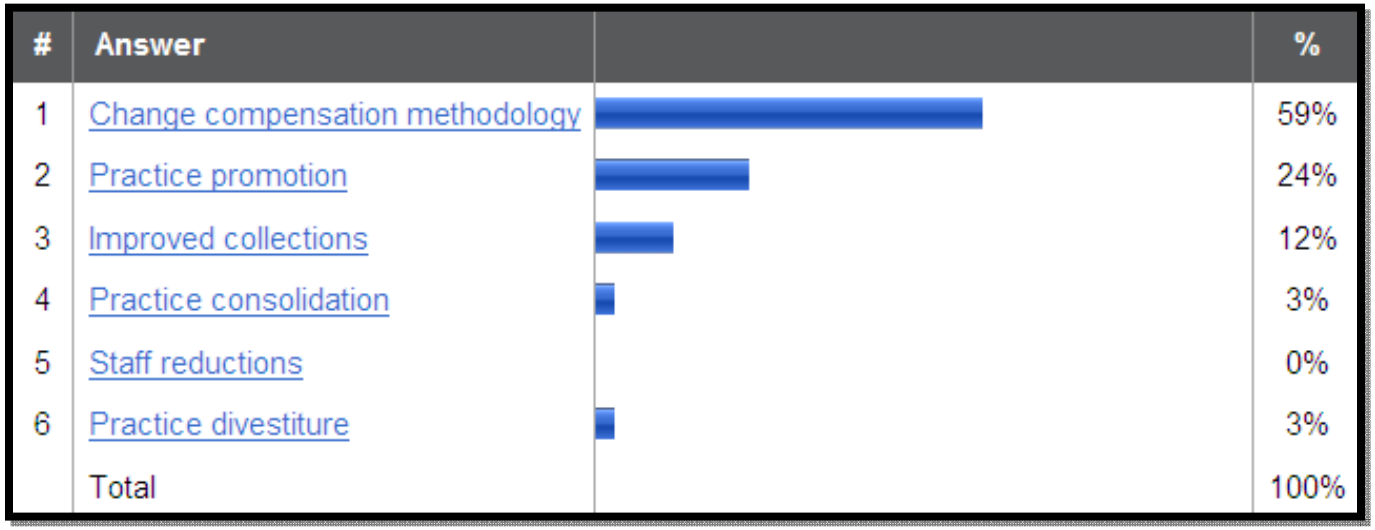
Most Effective Initiatives Used to Improve Financial Performance

#	Answer		%
1	Change compensation methodology		59%
2	Practice promotion		24%
3	Improved collections		12%
4	Practice consolidation		3%
5	Staff reductions		0%
6	Practice divestiture		3%
	Total		100%



Questions and Discussion

Presenter Profiles

Seminar Presenter Profile

Craig E. Holm, FACHE, senior vice president with Health Strategies & Solutions, Inc., directs the firm's physician-hospital integration and physician practice consulting services. He has over 30 years of health care administration and consulting experience and is an expert in medical staff planning, physician-hospital relationships and joint ventures, and ambulatory care planning. Craig is a frequent speaker for national and state health care associations and societies. His second book, *Allies or Adversaries: Revitalizing the Medical Staff Organization*, was published in 2004 by Health Administration Press. He also wrote a column on physician-health system relationships for the *Journal of Healthcare Management*, and is a regular contributor to HFMA's *Healthcare Cost Containment*.

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Seminar Presenter Profile

D. Louis Glaser, partner with Katten Muchin Rosenman, LLP, concentrates his practice on corporate, transactional, and regulatory health care law. He represents a wide variety of clients, including hospitals and multi-hospital systems, alternative delivery systems, ancillary service providers, pharmaceutical companies, physicians and group practices, and medical clinics. Louis has received a host of awards and other commendations. He has been named among "The Best Lawyers in America – Health" (2003-present), published by Corporate Counsel and was named by *Nightingale's Healthcare News* as one of the Country's Outstanding Hospital Lawyers (2003) and Outstanding Healthcare Transactional Lawyers (2004).