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Peer-to-Peer Learning Exchange Research Report

Managing Physicians as Hospital Employees in the Era of Reform

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Managing Physicians as Hospital Employees in the Era of Reform

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Introduction

The Patient Protection and Affordable Care Act and other recent changes in healthcare have many health systems and physicians rethinking their business models. The reform law contains a number of incentives for providers to work together to provide coordinated care, including bundled payment and accountable care organizations (ACOs). There are payment disincentives for poor quality care and excessive hospital readmissions. There are clear-cut reimbursement reductions that will place new strains on already financially challenged hospitals and physician practices. And there are new demands for information technology at all levels of healthcare, technology many small physician practices cannot afford. Even before reform, many medical practices were foundering on the rocks of economic change, leading many doctors to think about new alliances with hospitals, including employment models.

The old system of Medicare and private payers simply paying for volume of services provided is drawing to a close. Providers will increasingly be rewarded for efficiency and outcomes of care. Payment will not keep up with the current rise in costs. As a result, many see this as a time when hospitals and health systems ought to create stronger ties with physicians. It seems to make good sense economically, but with so much riding on higher quality care, it makes sense from a clinical perspective as well.

Since the passage of the reform bill, there has been a flurry of activity in terms of hospitals acquiring physician practices. It leads to a discussion of how to better manage employed physicians, following a disastrous experiment in the 1990s, and what role the supply chain can play in that endeavor.

What's different this time?

In the early to mid-1990s, there was a frenzy created by the notion that capitation was going to become the payment system of the future. Hospitals raced to purchase existing physician practices and build new referral channels. The standard procedure was to buy a physician practice after a hasty valuation and pay the physician a guaranteed income, hoping that increased market share would heal all wounds.

The problem was that capitation never really took off, and hospitals were stuck with subsidizing practices to the tune of more than \$100,000 annually per employed physician, according to a study by the Medical Group Management Association.

Many practices had been overvalued, and ongoing compensation included guaranteed pay for physicians but no incentives for physicians to be more productive. In fact, many physicians spent less time seeing patients than they had in private practice. They also lacked incentives to bring new patients into a practice. Administrative difficulties also hurt physician productivity, as many practices experienced a rough transition to contracted billing and management services after acquisition. Few hospitals had expertise in physician practice management.

After the collapse of these deals, hospitals and physicians re-entered the world of unfriendly competition, only on steroids this time, a result of changing economics. By the late 1990s, surgeons turned to owning or co-owning outpatient facilities and ambulatory surgery centers, the latter of which multiplied across the country from 275 in 1980 to 3,700 in 2003. Radiology groups opened imaging centers with sophisticated diagnostic and treatment equipment. Oncologists provided chemotherapy in outpatient settings. And, of course, specialty hospitals grew in prominence.

Today, that movement has stalled as the practice of medicine has started to undergo a profound shift. Running a physician practice is becoming far more complex. Aside from the typical business functions (billing, collections, scheduling, etc.), there are now a host of information technology issues to deal with and many practices don't have the capital or the internal capabilities to manage the shift to electronic medical records.

As a result, some IDNs and hospitals have successfully leveraged their information technology capabilities to lure new physicians and further integrate previously acquired physician practices. There has also been a generational shift. Younger physicians don't want the risk and responsibility of owning medical practices, seeing employment arrangements as offering a better work-life balance. Significant growth of the hospitalist model has also lured many younger doctors to employment.

In recent years, many IDNs and health systems have taken advantage of these changes to form a wide array of alliances with physicians to provide integrated care and reduce risk. Many of the deals don't involve purchasing practices, making them far less expensive.

The revival of hospitals employing physicians in larger numbers is a risky strategy, but one that is rooted in the changes anticipated as a result of health reform.

Accounting for the action

Buying physician practices and employing doctors is a significant trend, though one that is tough to fully quantify. A paper prepared for the American Medical Association in March 2010—but based on 2007-2008 data—found that only about 16% of physicians were employed by hospitals.

Statistics from the American Hospital Association show a steady increase in hospitals employing physicians. The number of facilities with salaried doctors rose to 1,583 in 2008 compared with 1,312 in 2004.

More recently, there are signs of an accelerating pace of medical practice purchases. The physician-recruiting firm Merritt Hawkins & Associates says that the portion of its hospital search assignments had leaped to nearly 50% from 23% five years ago.

The Aon Corp., which provides hospital and physician malpractice liability insurance, found that from 2005 to 2009, the average number of employed physicians per hospital bed increased 12% annually.

More anecdotally, here are a few of the many recent developments:

- Erlanger Medical Center in Chattanooga, Tenn., last summer announced that it had created a hospital-owned multi-specialty physician practice group to help grow academic programs at the teaching hospital and its affiliated medical campus while boosting the hospital's recruitment and retention of doctors. Erlanger had tripled its number of employed physicians in the past three years to more than 120.
- All Children's Hospital in St. Petersburg, Fla., reports that it has almost doubled its number of employed physicians in recent years, absorbing dozens of private practice doctors, including an obstetrics group.
- Advocate Health Care, a major system in the Chicago area, has been on a significant acquisition path, and now has more than 800 employed physicians on its staff, again up more than half in just a few years.

Integrating doctors clinically and financially

Following hard lessons learned 15 years ago, hospitals purchasing practices are generally much more rigorous in valuing practices and growth projections. They are also more skilled at structuring employment agreements to motivate newly employed physicians. These incentives typically include productivity-based compensation as well as targets for physicians to improve efficiency, patient satisfaction and quality.

There are now clear guidelines from the Internal Revenue Service on how to establish salary levels based on fair market value, overcoming past regulatory obstacles.

That isn't the end of the problem, however. Many physicians have been entrepreneurs for a long time, in charge of their world, and that doesn't change overnight. They may be employees in a technical sense, but don't operate like employees. Hospitals need to know how much a physician is really going to cost, not just in terms of salary. Is he or she going to be generating revenue or be a constant fiscal drain because of demands for specialized equipment, non-contracted supplies and clinical procedures that fall outside of protocols?

It is important in the recruiting process for both physician and hospital to essentially lay all their cards on the table. They need to tell the other side what they are seeking and ensure they are a good match for each other both in the short term and long term. If the interests of a physician are not aligned with the interests of a healthcare organization, then neither party will be happy.

Moody's Investors Service, in an advisory to clients last year, noted that once employed, physicians need to be given an active role in all decision making, especially when it comes to clinical quality improvements and operating efficiencies.

Productivity targets and incentives should represent a far larger portion of overall physician compensation, leading to a sharing of risk between the hospitals and physicians. Hospitals should demand use of standardized products upfront, but an evidence-based value analysis process should be in place to evaluate new technology and opportunities to improve outcomes to ensure that both cost and quality factors are addressed.

In the past, efforts to integrate with physicians focused on securing referrals for hospital services, but that was a volume-based approach. It is a recipe for failure today, as ACOs, bundled payments, and value-based payment methodologies place a premium on quality of care.

To achieve clinical integration and prepare for value-based payment, collaboration between hospitals and physicians to improve coordination of care and produce better outcomes will be critical. That involves adherence to clinical protocols across a broad spectrum of diagnoses and procedures.

In winning organizations, employed physicians are highly engaged in quality initiatives, instead of just cost-cutting efforts. They serve on value analysis committees and teams that seek to reduce readmissions and hospital-acquired infections. They devise and adopt checklists for common procedures to improve patient safety. That's the future of value-driven care.

ACOs and shared responsibility

Another impetus for closer integration between hospitals and physicians is found in ACOs. The Centers for Medicare and Medicaid Services defines an ACO as "an organization of healthcare providers that agrees to be accountable for the quality, cost and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program."

ACOs can participate in the new Medicare Shared Savings Program starting in 2012 if they meet certain requirements. They must have a formal legal structure to distribute shared savings, and they must have enough primary care professionals for a minimum of 5,000 beneficiaries. They must also agree to participate in the federal program for a minimum of three years and must have processes in place to promote evidence-based medicine and report data on quality and costs, according to the CMS. Beginning in 2012, they will be eligible to receive a percentage of any savings if their actual expenditures are a certain percentage below a specified benchmark.

The reform law lists the following kinds of organizations that might participate in the Shared Savings Program:

- Physician group practices and networks of practices
- Partnerships or joint venture arrangements between hospitals and physicians/professionals
- Hospitals employing physicians/professionals

The economic incentives in the ACO model tie some portion of provider reimbursement to cost efficiency and quality benchmarks. Theoretically, this incentive structure should address, at least from the provider side, the two most significant drivers of long-term cost growth. It rewards providers for using high-cost technologies more judiciously and for actively coordinating and managing care of patients with high-cost chronic conditions to minimize demand for acute and ancillary services. But it also penalizes providers that stint on care solely to meet financial goals.

With incentives to drive up quality and drive down costs, ACOs and employed physicians make perfect sense. It remains to be seen whether reality will intrude on this rosy scenario.

Things to remember in employing physicians

Finally, here is a tip sheet on how to structure employed physician deals and manage them going forward. It was issued by the consultancy Health Strategies and Solutions:

Hospitals should:

- Carefully select employed physicians and structure employment contracts with explicit language regarding the expectations and productivity incentives for physicians.
- Provide regular feedback and data to employed physicians on productivity, quality measures, revenue generation, expense levels, overall operations, and other measures of practice performance.
- Establish guidelines for the per-physician operating loss or subsidy that will be tolerated.
- Structure employment relationships for a limited term (one to three years) so that each party can assess the appropriateness of the employment relationship.
- Assign management of the physician practices to experienced professionals who understand the practice operating environment.
- Give the employed physician network and other formal physician-hospital relationships the high-priority attention they deserve; for example, assign oversight of the network to a member of the senior management team.
- Avoid excessive allocation of overhead expenses to physician practices.
- Manage larger administrative functions like billing and collections, allowing physicians to handle day-to-day operations of their practice.
- Continuously evaluate employment relationships to identify if changes in reimbursement, the regulatory environment, or competitor initiatives warrant a change in the structure or terms of the relationship.

Questions for discussion

1. Is the concept of employing more physicians one that is viable for your organization?
2. Will employed physicians help the supply chain in terms of cost-per-physician?
3. Specifically, what impact will employed docs have on physician preference items?
4. What practical steps in employment contracts will have the biggest payoff in terms of cost savings in the hospital?
5. Should all physician employment contracts reflect individually negotiated terms? What supply-chain elements should be included in all employment contracts?
6. When the physician is actually on board, what metrics can be used to accurately assess the physician's use of resources and return on investment?
7. Will the rise of Accountable Care Organizations push organizations to employ more physicians?
8. The greatest demand for employed physicians will likely be in the family practice, internal medicine, general medicine areas yet the pool for primary care physicians is shrinking. How would you see the healthcare environment addressing this need for increased availability of primary care physicians?
9. As more physicians are employed by hospitals or group practices, how do you see the governance structure of the organization changing if at all?
10. Relative to retaining employed physicians, what steps would you suggest to keep employed physicians engaged and interested in the organization?

