Trends in Physician Employment: The Spectrum of “Employment”

Data, Trends, and Critical Observations

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Immediate Past Chair
AAOS - Health Care Systems Committee
DISCLOSURES

- Veritas Medical Intelligence LLC - Principal Consultancy
- Sr. Medical Director & CHO – IMC/Health Access Services
- NQF Musculoskeletal Measures Standing Committee
- Stryker Performance Solutions - Consultant
- AAOS Health Care Systems Committee – Past Chair
- AAOS Council on Advocacy – Past Member
OVERVIEW

I. Employment vs. “Alignment”
II. Drivers & Trends for Orthopaedics
III. Critical Observations
IV. Payment Reform & Compensation
V. Recommendations
Physician Employment – California Style

• B & P Code 2400: ‘Corporate Bar’
  – “…no professional rights, privileges, powers”
  – “permissible management”
  – Medical Board and Case Law guidance

• Moscone-Knox Prof. Corp. Act (Sec. 13405)
  – Allows non-professionals to handle managerial & clerical tasks – definition?

• Medical Foundation Model
  – Research + Education
  – >40 Indep. Contractors; >10 specialties
  – Structure parallels MSO
  – KP Model → Adds closed-panel Hlth Plan
Employment versus
The “Alignment Continuum”*

Drivers & Trends
Physician Satisfaction Survey 2013*

**SATISFIED**
- Concierge Practice
- Working < 11 hours/day
- Employee status (single/multispecialty group) w/o ownership
- Supported by advanced clinical practitioner

**DISSATISFIED**
- <45 years old; Female gender
- PCPs; Specialties: Emergency Medicine, Hospital-based, Musculoskeletal Specialties, Radiology
- Practice owners or practice owned by a hospital system

Most respondents concur that Medicare reimbursement rates will have the most impact on orthopaedic practices within the next three years. In general, the top five anticipated environmental pressures are similar, regardless of respondent type. However, hospital-employed respondents are less inclined to rate “liability insurance rates,” “Stark,” and pressures to affiliate as challenges that will significantly impact their practices.
What We are Looking For?

Higher Reimbursements
Relieve from management/admin burdens
Focus on patient care
Resources to comply with HC Reform
Better work-life balance

#1......Income Stability
Drivers & Trends

2012 ACQUISITIONS BY SPECIALTY (ACTUAL)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>(n=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>54%</td>
</tr>
<tr>
<td>Internal Medicine, General</td>
<td>26%</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>24%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>18%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>16%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>12%</td>
</tr>
<tr>
<td>Urology</td>
<td>10%</td>
</tr>
<tr>
<td>Hospitalist &amp; Rheumatology</td>
<td>8%*</td>
</tr>
<tr>
<td>Gastroenterology, Nurse Practitioner, Oncology, Orthopedic Surgery</td>
<td>6%*</td>
</tr>
<tr>
<td>Otolaryngology, Pediatrics, General</td>
<td></td>
</tr>
<tr>
<td>Emergency Medicine, Endocrinology, Diabetes &amp; Metabolism, Neurology</td>
<td>4%*</td>
</tr>
<tr>
<td>Neurosurgery, Physical Medicine &amp; Rehabilitation, Psychiatry (Adult), Pulmonary Medicine</td>
<td>4%*</td>
</tr>
<tr>
<td>Allergy &amp; Immunology, Cardiothoracic Surgery, Infectious Diseases, Maternal &amp; Fetal Medicine, Nephrology, Occupational Medicine, Pathology, Pediatrics, Subspecialty, Radiation Oncology, Radiology, Vascular Surgery</td>
<td>2%*</td>
</tr>
</tbody>
</table>

*The percentage represents each specialty individually, not as a group. For example, Gastroenterology=6%, Nurse Practitioner=6%, etc.
Drivers & Trends

**2013 Acquisitions by Specialty (Planned)**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>(n=119)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None/Not Planning to Acquire</td>
<td>48%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>31%</td>
</tr>
<tr>
<td>Internal Medicine, General</td>
<td>22%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>5%</td>
</tr>
<tr>
<td>Cardiology, Orthopedic Surgery</td>
<td>10%*</td>
</tr>
<tr>
<td>Gastroenterology, General Surgery, Urology</td>
<td>6%</td>
</tr>
<tr>
<td>Obstetrics/Gynecology, Oncology</td>
<td>7%*</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>6%</td>
</tr>
<tr>
<td>Neurology, Nurse Practitioner, Pulmonary Medicine</td>
<td>5%*</td>
</tr>
<tr>
<td>Ambulatory Care, Hospitalist, Infectious Disease, Pediatrics, General</td>
<td>4%*</td>
</tr>
<tr>
<td>Cardiac Surgery, Neurosurgery, Rheumatology, Endocrinology, Diabetes and</td>
<td>3%*</td>
</tr>
<tr>
<td>Metabolism, Geriatric Medicine, Orthopedic (non-surgical), Pain Medicine,</td>
<td></td>
</tr>
<tr>
<td>Radiation Oncology, Trauma, Vascular Surgery</td>
<td></td>
</tr>
<tr>
<td>Anesthesiology, Bariatrics, Emergency Medicine, Ophthalmology, Plastic</td>
<td>2%*</td>
</tr>
<tr>
<td>Surgery, Psychiatry (Adult)</td>
<td></td>
</tr>
<tr>
<td>Colon &amp; Rectal Surgery, Critical Care Medicine, Dermatology, Hematology,</td>
<td>1%*</td>
</tr>
<tr>
<td>Maternal and Fetal Medicine, Nephrology, Occupational Medicine, Podiatry,</td>
<td></td>
</tr>
<tr>
<td>Radiology, Sleep Medicine, Sports Medicine</td>
<td></td>
</tr>
</tbody>
</table>

*The percentage represents each listed specialty individually, not as a group. For example, Cardiology=10% and Orthopedic Surgery=10%.
Drivers & Trends

**REASONS FOR PHYSICIAN PRACTICE ACQUISITION**

<table>
<thead>
<tr>
<th>Reason</th>
<th>(n=69)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians approach hospital/seek to sell their practices</td>
<td>70%</td>
</tr>
<tr>
<td>Build a competitive advantage</td>
<td>58%</td>
</tr>
<tr>
<td>Part of a physician recruitment strategy</td>
<td>57%</td>
</tr>
<tr>
<td>Maintain a competitive advantage</td>
<td>55%</td>
</tr>
<tr>
<td>Accountable Care Organization formation</td>
<td>30%</td>
</tr>
<tr>
<td>Improve patient safety</td>
<td>28%</td>
</tr>
</tbody>
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**TREND WATCH: PHYSICIAN PRACTICE ACQUISITION**

Tracking which physician practices hospitals are acquiring.
How’s It Working?
Critical Observations

I. “Super Duper” Employment Agreements
II. Operational Control & Execution
III. Compensation Models vs. Payment Reform Trends
IV. Care Model & Delivery Redesign Initiatives
“SUPER DUPER” EMPLOYMENT AGREEMENTS

TWO THOUGHTS……
• unsustainable &
• likely illegal

AMENDMENT TO
MEDICAL ONCOLOGY EMPLOYMENT AGREEMENT

THIS AMENDMENT to Medical Oncology Employment Agreement is entered into by and between HALIFAX STAFFING, INC., hereinafter referred to as the “Company” and BOON CHEW, M.D., hereinafter referred to as “Employee”.

The Medical Oncology Employment Agreement between the parties is hereby amended as follows:

1. Section 3.C is amended to read as follows:

   Beginning with the fiscal year ending September 30, 2005, an equitable portion of an Incentive Compensation pool which is equal to 15% of the operating margin for the Medical Oncology program as defined by the financial statements produced by the Finance Department on a quarterly basis. The amount of the incentive compensation distributed to the Employee shall be determined by the Medical Oncology Practice Management Group. This compensation shall be paid annually according to the operating margin for the fiscal year. Payment will be made on or before March 15 of the following year in order to provide a 90-day period of collections. The Company shall make best efforts to achieve a reasonable collection rate in light of community needs, patient mix, and relevant health care reform efforts.
Operational Control & Execution

Consistent Observations

- Rising Expense Ratios
- Revenue Cycle “Dis-integration”
  - Lower coding intensity
  - Increasing ARs
  - Lower collection ratios
- Bilateral Frustration of varying degrees
  - Harder than anticipated
  - Longer process than anticipated
Physician Compensation

The Comparable-Worth Theory

We trust our health to the physician; our fortune and sometimes our life and reputation to the lawyer and attorney. Such confidence could not safely be reposed in people of a very mean or low condition. Their reward must be such, therefore, as may give them that rank in the society which so important a trust requires. The long time and the great expense which must be laid out in their education, when combined with this circumstance, necessarily enhance still further the price of their labor.

Adam Smith, *The Wealth of Nations*, 1776
Cutting Physician Pay?

To the Editor:
“...cutting doctors' take-home pay would not really solve the American cost crisis.”

“Physicians are the central decision makers in health care. A superior strategy might be to pay them very well for helping us reduce unwarranted health spending elsewhere.”

“If we somehow managed to cut that take-home pay...we would reduce total national health spending by only 2 percent, in return for a wholly demoralized medical profession to which we so often look to save our lives. It strikes me as a poor strategy.”

Uwe E. Reinhardt
Princeton, N.J.
July 30, 2007

*http://query.nytimes.com/gst/fullpage.html?res=9B00EEDE163AF936A3575BC0A9619C8863
Compensation Models vs. Payment Reform

2 Key Questions:

How do volume-based compensation models evolve or adjust to value-base payment reform?

What do you get when you incentivize RVUs?
Figure 6. Distribution of Non-Solo, Owner Physicians by Dominant Compensation Method, Specialty Level Results (2012)

Note: A compensation method is "dominant" if it accounts for all of compensation, or contributes the largest share toward compensation.
Figure 7. Distribution Of Non-Solo, Employee Physicians By Dominant Compensation Method, Specialty Level Results (2012)

Source: AMA 2012 Physician Practice Benchmark Survey.
Note: A compensation method is “dominant” if it accounts for all of compensation, or contributes the largest share toward compensation.
Recommendations

Know your market
  • Competitors, Payors, Systems (M&A), referral bases

Know your potential employment ‘partner’
  • Experience, Financial performance, PCP base

Customize your alignment model!!
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