

# Physician Employment Is Here to Stay



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The second wave of physician employment that started in the mid-2000s was driven by a variety of factors—physicians’ desire for security, hospitals’ need to increase bargaining power with payers and gain a competitive edge over other providers.

These drivers still exist, but today, health care reform, clinical integration, and securing an optimal position in increasingly competitive markets have emerged as the more pressing priorities health care leaders must grapple with over the next decade. These issues, in turn, will exert powerful influence over physician employment relationships.

With physicians seeking employment in greater numbers than ever before to accommodate their desire for security, improved work-life balance, and assistance with practice administration—and health care organizations looking to employ primary care physicians to align incentives around quality or be prepared for a bundled payment environment—physician employment is no longer a trend but a given in most markets. The data bear this out.

In 2009/2010, 51 percent of Merritt Hawkins physician search assignments were for settings featuring hospital employment of the physician, up from 23 percent in 2005/2006.<sup>1</sup> A new urgency now exists to think more strategically about employment relationships to ensure that both health care organizations and the physicians they employ realize the benefits they are seeking. What is less clear is how to achieve these benefits.

To take a closer look at how health care organizations are managing the challenges of physician employment and what results they are achieving, Health Strategies & Solutions, Inc., conducted a nationwide survey of employed physician networks and examined their current status and future direction.

Sixty-five large physician networks from 26 states participated in the survey that assessed size, composition, compensation and incentive methodology, subsidy levels, and future growth targets.

## Survey results

At nearly two-thirds of the 65 networks, less than 50 percent of the physicians were practicing in primary care, which is a major shift from employment in the 1990s when almost all employed physicians were primary care physicians (PCPs).

This relatively low percentage of PCPs may indicate that some respondents included hospital-based specialists as part of their network. The higher percentage of specialist physicians may also reflect the recent trend for networks to employ hard-to-recruit specialists, such as endocrinologists, infectious disease physicians, and rheumatologists as a result of shortages for these specialists, and orthopedists or neurosurgeons due to difficulties to maintain coverage levels for these specialties.

In the post health care reform environment, where primary care providers will have an expanded role and influence, we anticipate that networks will need to recruit more primary care physicians over the next five years so that they represent roughly more than 50 percent of the total employed network and are able to meet the needs of the 32 million additional people who will become insured by 2015.

The preferred compensation model among survey respondents is productivity-based and the favored methodology is relative value units (RVUs). Of the respondents using productivity-based compensation, less than one-third are currently using percentage of collections.

The survey also polled respondents on rewarding quality measures in compensation. Survey results indicate that quality is not a substantial component in compensation, with just 34 percent of groups polled having rewards in place for quality performance, although this is a much higher percentage than a decade ago.



Commercial payers, however, are moving toward rewarding high quality and favorable outcomes. In some markets, such as Cincinnati, the move toward such a methodology has already occurred.

### Percentage of collections

In our experience, more mature and developed networks use percentage of collections with a percentage (minimum 10 percent) withheld for quality and citizenship incentives. Lack of infrastructure (staffing and information systems) and/or business systems (revenue capture and expense controls) are often cited as the reasons that more networks are not using the percentage of collections methodology.

Employed groups that have not yet moved toward a percentage of collections methodology with a certain portion withheld for quality incentives should consider moving in that direction. At a minimum, confidence in the physician networks' data collection systems and the integration of that data with clinical and financial information systems will be paramount.

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The percentage of collections approach will also position networks well for the future payer and compensation environment that will shift away from payment and compensation for production to payment and compensation for quality and outcomes.

The survey also assessed how much financial support the hospital/health system was providing for each physician. More than 50 percent of respondents indicate subsidy levels in excess of \$75,000. Subsidies are the result of supporting physicians in the initial year to 18 months of practice, paying for more costly hospital benefit structures that physicians would not incur if in private practice, and foregoing ancillary revenue that a private practice physician would normally keep within the practice.

According to survey respondents, improvements to performance (and therefore reduction in subsidies) are most often achieved through restructuring the compensation methodology and practice

promotion. Organizations that have been more vigilant and proactive in this regard have achieved subsidy levels well below \$40,000 per physician.

Medical Group Management Association reported in the 2008 Cost Survey for Multispecialty Practices that subsidies for multispecialty hospital-owned physician groups were \$86,000 per physician.

The 2010 report states that the loss more than doubled to \$190,000 per physician; while this increase is unusually high, it is not surprising that losses have increased dramatically due to providers rushing to employ more physicians in recent years and the changing mix of more employment among specialists.

Fifty-three of the 65 survey respondents indicated that their employed network was expected to grow in the near future, with 41 percent expecting an increase of 10 percent in network size and 42 percent expecting an increase of 20 percent in network size.

With such ambitious plans for significant growth, these networks will need to be poised to accommodate growth by having various employment and alignment options available for providers to consider and having the infrastructure in place to support rapid growth.

Several relevant takeaways of the survey may shape strategic thinking for employed physician networks:

- Physician networks are growing, with growth likely to be heavily weighted toward, but not exclusively to, primary care.
- Physician networks will be seeking sustainable subsidy levels through compensation methodologies built on percentage of collections with increasing quality incentives, readying providers for a shift toward payment and compensation based on quality and outcomes
- To support these many initiatives, IT must be in place to manage growth, integrate clinical and financial systems, and foster confidence that data collection is being appropriately managed. Health IT is an integral part of the American Recovery and Reinvestment Act, incenting health care professionals and hospitals to become meaningful users of electronic health records by 2015.

## How to handle physician employment

Understanding where physician networks are today and where they need to go allows health care and physician leaders to focus strategies to be successful in the new era of physician employment. Three initiatives should be given priority attention:

- More employed providers in expanded roles
- Multiple options for achieving physician/hospital alignment to accommodate physicians interested in employment and those who are not
- Continued emphasis on information technology integration as an initial step toward clinical integration

Substantial overall growth in the physician networks to meet the demands of a larger insured population and a need for a higher percentage of primary care physicians may add up to big numbers for recruiters of physician networks. Physician networks will need to add capacity wisely and cautiously. Important questions for consideration include:

- What are the priority specialty and geographic areas? A medical staff needs assessment that takes into account both the community and the hospital-specific needs can help ascertain underserved geographies and specialties. Identifying the strategic growth priorities should be a key outcome of the medical staff needs assessment. Improving specialty-specific and geographic access in a phased approach will be required to prevent networks from getting too big too fast.
- Will alternative care models, such as non-physician clinicians or group visits, work in the communities served? Nurse practitioners and physician assistants can play an important role in existing physician primary care and specialty practices to help expand capacity. Non-physician clinicians can work to the full extent that their licenses allows. Group visits are also becoming increasingly popular, especially for chronic conditions such as diabetes and hypertension.

In light of clinical integration and to meet the demands of the health care reform law (e.g., medical home, accountable care) primary care physicians will need to take on a new and greater role.

PCPs cannot only be the caregiver for their patient population, but need to take on the role of care manager. PCPs (and their offices) will become the coordinators of care for all of a patient's health care needs across many, if not all, of the stages of the health care system.

## Employment or alignment

Hospitals must be prepared to offer multiple avenues for aligning with physicians. Approaches should vary depending

on the nature of the physician practice and must accommodate the needs of the physicians who desire employment and those who do not.

In an academic medical center (AMC), for instance, multiple employment models may exist. The traditional faculty practice plan provides the structure for physicians committed to the research, education, and clinical activities typically found in an AMC.

AMCs often provide an alternative practice model, such as a clinical track, that enables providers who are primarily interested in clinical practice to flourish. AMCs, then, are well-positioned to accommodate two types of providers.

Offering alignment opportunities for physicians who may not wish to be employed but who are interested in an alignment or economic partnership may be necessary. Non-employment economic models often work well for specialists, such as orthopedists or cardiologists, and range from medical directorships to comanagement agreements to joint ventures.

Another alternative is to provide information system linkages for those physicians who wish to remain independent, but who may otherwise find investing in IT a daunting proposition. The objective is to tailor the arrangements to meet the physician's needs and the hospital's strategic priorities.

What is the best model under health care reform?

Health care leaders have been inundated with literature and seminars on accountable care organizations and the medical home model. Perhaps one of these options will emerge as the ideal model, and maybe not. Providers would be wise to place more emphasis on what the model should accomplish, rather than getting too wrapped up in the model du jour.

The ideal model will increase access to care, improve the health of patients with chronic care conditions, improve quality outcomes, and create necessary linkages among all providers across the continuum of care.

## IT integration

Physician practices, and primary care providers in particular, are behind in health IT capacity, likely due to the financial investment required to get up to speed. Hospitals and health systems are in a good position to help physicians, employed or independent, with adopting IT and providing access through developing the proper linkages to clinical information.

What can hospitals do to help physician practices?

- Link robust clinical information systems with sophisticated financial systems
- Provide physicians with timely access to clinical and cost data
- Track costs and outcomes in a timely manner at a patient-specific level

The importance of integrating information technology cannot be overlooked due to its central role in physician employment. As employed physician networks move toward mature compensation methodologies (i.e., based on percent of collections with percent withheld for quality rewards), advanced IT that physicians trust must be in place.

Advanced information systems will also help position the PCP as the care manager who is connected across the continuum of services that patients need. For physicians who wish to remain independent, IT linkages and support can be an affiliation mechanism, while truly integrated IT will help physicians and providers be prepared for the rigors of health care reform initiatives.

## Looking ahead

Physician employment and tightly aligned physician-hospital relationships will proliferate in the years to come as hospitals and physicians work together to be successful in a post health care reform environment.

In the near term, both physician and hospital leaders should position themselves and their organizations to meet the challenges of the unknown by thinking strategically about the expanded roles for providers, multiple models for alignment, and information technology integration.

## Reference

1. Merritt Hawkins Summary Report 2010  
Review of Physicians Recruiting Incentives