Trends in Compensation for Employed Physicians

Presented By

Jim Carr, ASA, MBA | Partner

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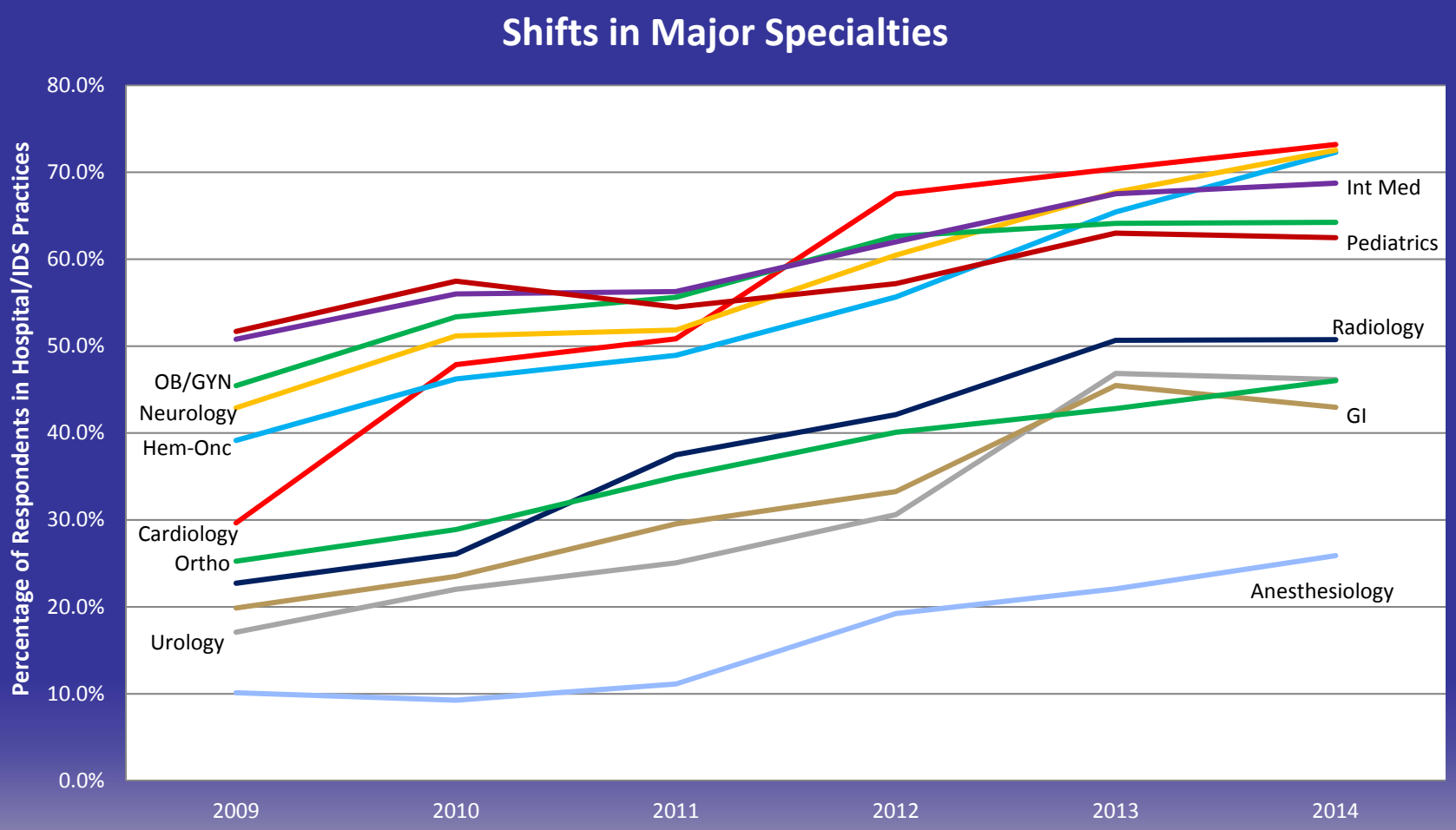
Physician Employment Landscape

- Various reports indicate that 50% to 70% of U.S. physicians are now employed by hospitals/health systems/integrated delivery systems
- Some of the stated drivers of this trend include:
  - Reimbursement cuts and escalating costs
  - Lifestyle/focus on medicine
  - Hospitals battling for market share
  - Loss of referral sources/fear of being left out
- Acquisition activity appears to have slowed; more movement *between* employers
- Other "macro" factors creating challenges in employed physician comp models
  - MACRA/MIPS/Private Payor Initiatives
  - Repeal/Redesign of ACA
  - Stark Law Reform
  - Practice Losses and *Qui Tam* Enforcement Activity

Private Practice Exodus



Data extracted from *MGMA Physician Compensation and Production Report*

Market Undercurrents

- *…employed doctors are not very happy. They have little or no control over what they do, where to refer a patient, or the tests that they are being asked to order.*
- *…operating income plummeted in 2016…The [expense] growth was primarily attributable to…a substantial increase in the number of employed physicians.*
- *…72% of those [physicians] we surveyed also said they envision a significant number of physicians returning to independent practice in the future.*
- *The settlement resolves allegations filed in a lawsuit by…a former physician employed by Lexington Medical Center...*

Base Compensation

- Employees are averse to risks beyond their control
  - Guaranteed base equal to prior total comp to protect against transition issues (when changing employers within same market)
  - Longer guarantee periods
    - "Ask" of 2 to 3 years is common
    - More requests to extend "initial" guarantee
- Example: Dr. Smith is employed by a competitor with base salary of $300,000 and earned $100,000 in production and quality compensation last year
  - Dr. Smith will likely want a base salary of $400,000 (or more) guaranteed for 2 (or more) years when changing employers
  - Employer will likely offer upside incentives (such that Dr. Smith can earn more than $400,000)
  - The new employer takes *all* financial risk in this scenario

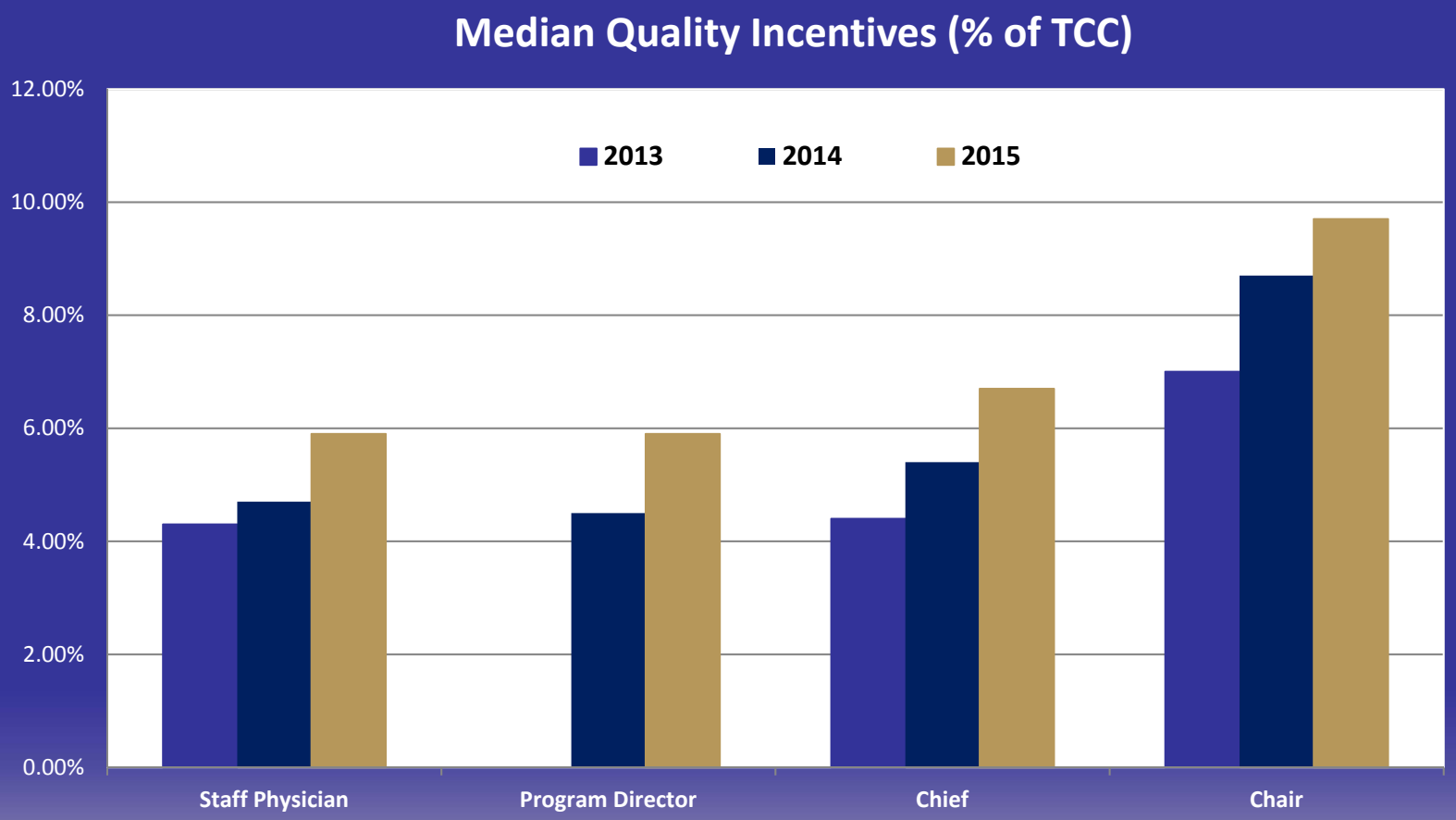
"Volume" Incentives

- Majority of physician employment contracts still contain some form of production requirement/incentive
  - wRVU production
  - Professional collections (becoming rare)
- Additional compensation for "nonproductive" activities
  - Administrative services
  - Midlevel supervision
  - Resident oversight
  - "Windshield" time
  - Satellite clinic coverage
  - EMR implementation
  - Committee participation

"Value" Incentives

- Shifting from volume to value?
  - Value measures commonly represent 5%-20% of total income potential
  - Many employers trying to expand that to 10%-30% with MACRA/MIPS
- Value incentives generally include various components
  - Patient satisfaction (HCAHPS, Press Ganey)
  - Citizenship
  - Outcomes
- Many employers still struggling how to define and measure "quality"
  - Core measures and HEDIS are commonly used benchmarks

Value Compensation

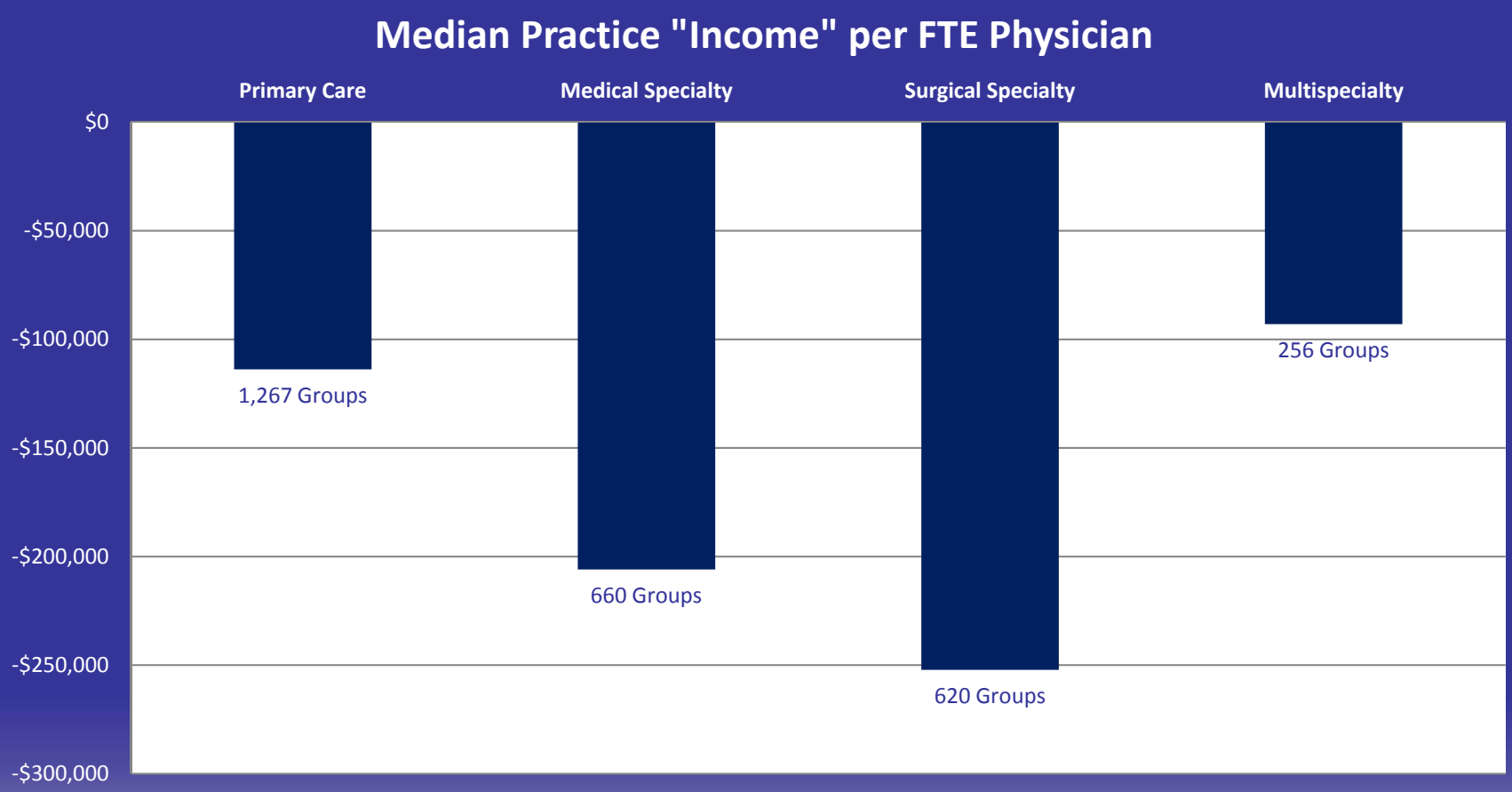


Data from Sullivan Cotter & Associates' *Physician Compensation and Productivity Survey Report*

Effects of Increasing Competition

- Increasing use of One-Time Payments
  - Signing, commencement, and retention bonuses
  - Student loan repayment assistance
  - Resident “stipends”
- Tiered wRVU models
  - Higher rewards for higher producers
- Everyone is a “medical director”
- Significant practice losses

Practice Losses



Data extracted from *MGMA 2015 Cost and Revenue Report: Based on 2014 Survey Data*

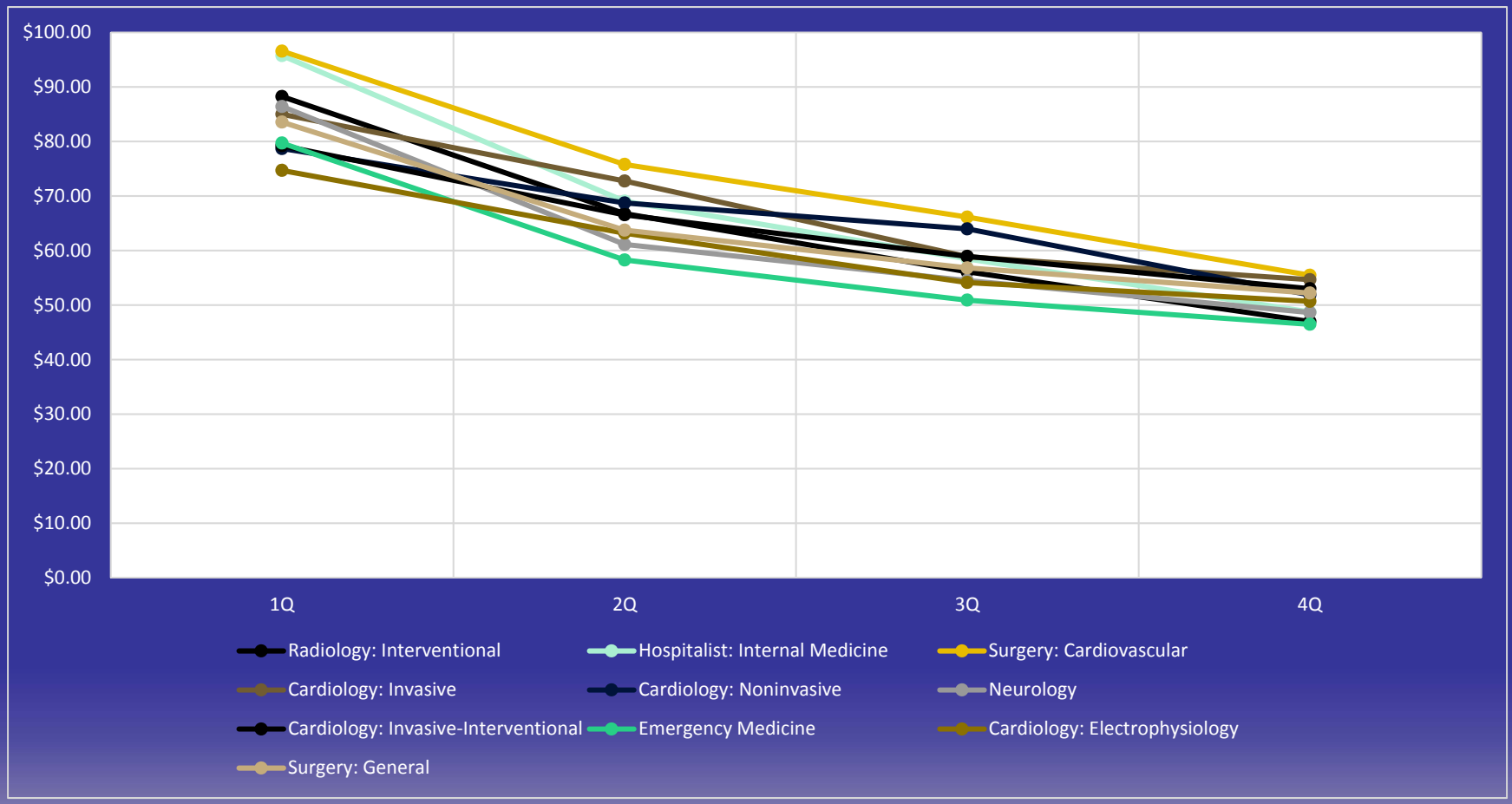
Enforcement Activity

- Along with the rise of physician employment, there has been a corresponding increase in *qui tam* cases related to employed physicians
- Notable recent settlements included:
  - *United States ex rel. Barker v. Columbus Regional System* ($35 million)
  - *United States ex rel. Reilly v. North Broward Hospital District* ($69.5 million)
  - *United States ex rel. Payne v. Adventist Health System/Sunbelt, Inc.* and *United States ex rel. Dorsey v. Adventist Health System Sunbelt Healthcare Corp.* ($115 million)
  - *United States ex rel. Hammett v. Lexington County Health Services District ($17 million)*
- All complaints included allegations that the practice of the employed physician(s) incurred substantial losses
  - DOJ seems to be advocating that compensation cannot be FMV or an agreement cannot be commercially reasonable if a practice loses money
  - Courts seem to be willing to hear that argument

Be Careful Out There

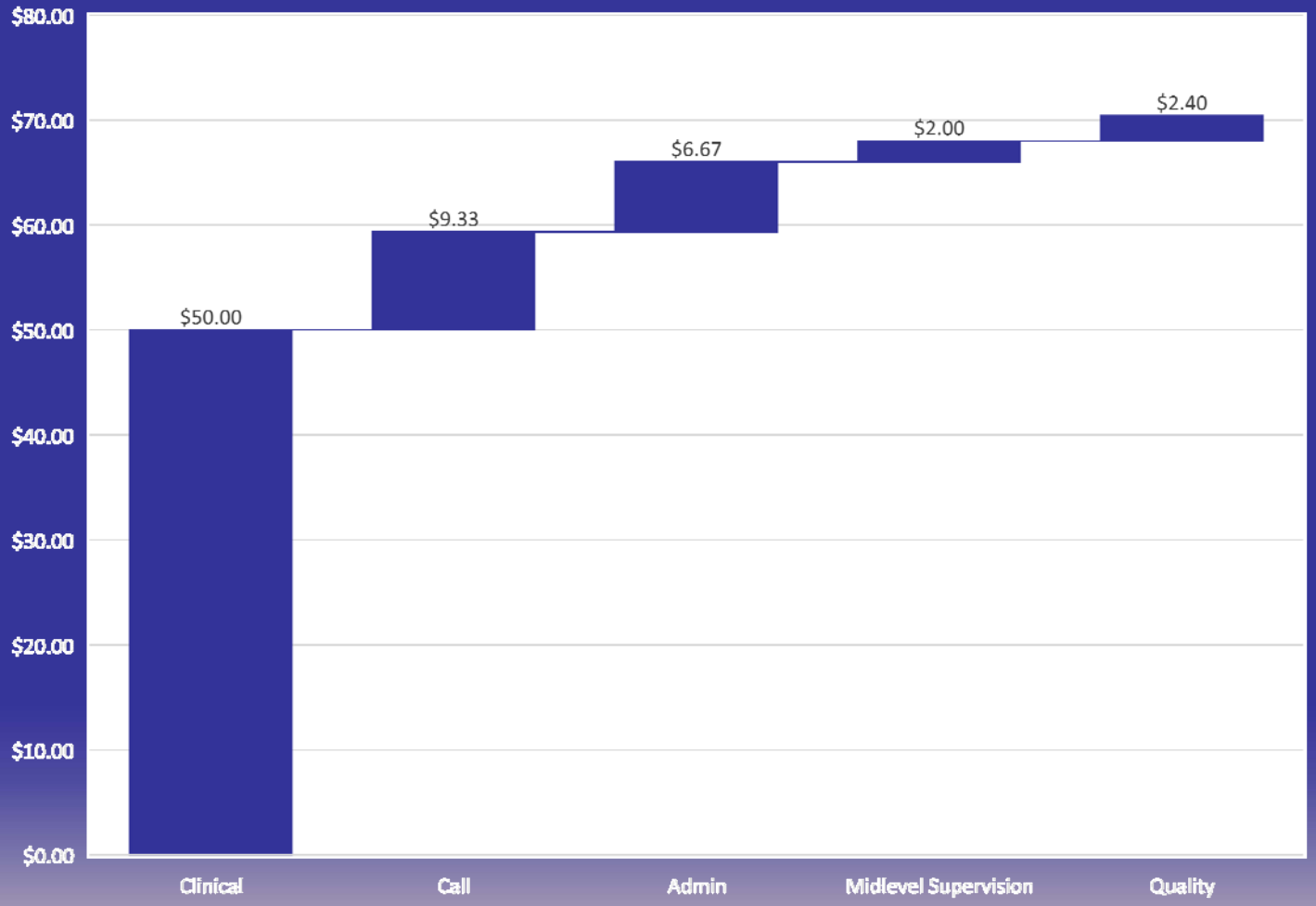
- Understand survey data
  - Definition of total cash compensation
  - Shouldn't pay for _____ be added on top of FMV comp?
- Productivity v. production compensation
  - Shouldn't a 90th P producer should earn 90th P comp per wRVU?
- "Stacking" issues
- Pay equal attention to both commercial reasonableness and FMV
  - Don't assume practice losses are reasonable in all circumstances
  - Be able to explain why all terms would "make sense" if there were no referrals

Comp/wRVU vs Production



Data extracted from *MGMA 2015 Physician Compensation and Production Report*

Impact of Stacking



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