FUTURE OF HOSPITAL OWNED PHYSICIAN PRACTICES

SOUTH CAROLINA MGMA ANNUAL CONFERENCE

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Topics Covered

- Historical Perspective
- Current Market
- Structures
- Governance
- Compensation
- Collective Bargaining
- Other Future Possibilities
Historical Perspective

• Early to mid-1990’s hospitals ownership of physician practice brought on by expansion of managed care and development of capitated networks

• Late 1990s – hospitals lose millions of dollars on physician employment agreements

• Mid 2000s doctors return to “private” practice

• By 2005 more than 2/3 of medical practices were physician owned
Current Market

• Hospitals once again “buying in bulk”
• US: hospital employed physicians doubled in last 10 years
Current Market: South Carolina

- 60% physicians employed by Hospital (or affiliated entity)
  - Approximately a 10% increase since 2009
- 30% independent practices
  - About 4% decrease since 2009
- 10% other employment arrangement
Hospital Owned Practices:

CYCLICAL?

PERMANENT REALITY?
Reasons for Change to Integration with Hospitals

- Differences between baby boomer physicians and younger physicians
- Decline in reimbursement / increase in operating expenses
- Technology: EMR, rapidly developing medical equipment
- Consolidation of hospitals
- Health care reform
STRUCTURES
Structures: Direct Employment

• Simplest model to implement
  – Affords greatest amount of integration
  – Multi-year employment agreement
• Existing practice assets purchased/long-term leased by hospital

• Legal impact on direct employment
  – Covenants not to compete
  – *Baugh v. Cola. Heart Clinic*
    • First non-compete upheld in physician context
  – Peer Review
    • Concurrent termination
    • Greater role of Board/MEC
Structures

• Subsidiary/Affiliated Entity Models
  – Hospital uses subsidiary or affiliate to employ physician
  – “Transition” models
  – Used before a full integration between hospital and physicians
  – Goal is to emulate private practice but with the benefits of an integrated practice
Structures: Subsidiary/Affiliate Entity

- **Physician Enterprise**
  - Physician employed by separate legal entity
    - Physician Enterprise
  - Affiliated with Hospital
  - Compensation partially based on Physician Enterprise financial success
  - Physicians manages the practice

- **Affiliated Subsidiary**
  - LLC/SC Non-profit corp
  - Physician employed by the subsidiary

- **Physician Leasing**
  - Hospital leases physician employees of a specialty practice
  - Usually to provide a service line
Subsidiary / Affiliate Entity

• Can be used as model for physician networks

• Network entity can contain hundreds of employed physicians
GOVERNANCE
Governance Dynamics

• Hospitals do not want to lose money (or as much money) on employment relationships
• Some physicians still want some feeling of independence and control over practice
• Hospitals are highly regulated entities and they need to ensure that operation of employed physician practices operates in compliance with its policies and procedures
• Various governance models may be a way to find a happy medium in a hospital-owned world
Governance

- Command/control
  - Hospital is the “boss”
  - Command/control with certain contractual rights
- Co-Governance with actual voting rights
  - Board seats
  - Physician supervision of other physicians
  - Clinical co-management
- Self-governance
  - Accountability is an issue
  - Who assumes risk of performance
Governance: Command/Control

• Most traditional method of physician employment by hospitals.
• Manage physicians through contractual provisions
  – Hours
  – Call coverage requirements
  – Administrative duties
Governance: Co-Governance

• A newer form of working relationship
• Hospital and physician(s) share obligations on management of the business side of care
• Under these structures physicians will have shared responsibility over financial performance and management
  – Compensated for these duties as well
• Collaborate on development and performance of certain service lines (Cardiology, ortho, etc.)
Governance: Self-Governance

• Exactly what it sounds like: physicians govern the entire operation

• Usually a subsidiary or affiliated entity of the hospital

• Question becomes how will poor performance, financially and clinically, be handled
  – Will physicians be willing to take less compensation for poor performance
ACOs

• Add facts about ACOs
  – Purpose
  – Size and scope
  – Cost to create ($2-4 million)
Governance

• Where do ACO’s fit in?
• Delaware only state without an ACO
• Approximately 430 ACOs
• Physician only ACO’s a way to avoid hospital employment
Governance: ACOs

- Team based approach
- Provide broad set of medical services
- Primary care is the foundation of an ACO
- Provide continuum of care with goal of increased quality
- Payment based on quality, shared savings

- Costly to create
  - Approximately $2 - $4 million
- Large capital investment may be difficult for physicians to implement without hospital
- Additional legal issues
  - Fraud and abuse
  - Anti-trust
COMPENSATION
Compensation

• Compensation remains a critical component of hospital/physician relations

• Physician compensation by hospital is “ground zero” for Department of Justice Office of Inspector General investigation and enforcement

• New or different compensation structures may receive additional government scrutiny
  – Innovation = compliance scrutiny an trouble
Compensation

- Guaranteed base salary
- Productivity compensation
  - Use of RVUs
  - % of collection
- Capitation
- New Models
Compensation: Salary Guarantee

• A popular model for younger physicians, academic settings, etc.
• Straight forward salary usually based off of MGMA or other type of comp survey
• Typically guaranteed for a set period of time
• May include some type of incentive based bonus
Compensation: Productivity

• “Eat what you kill”
• Formula based on certain criteria
  – RVUs
  – Percentage of collections
  – More quality incentives included now
• Requires constant monitoring to ensure comp remains within fair market value
Compensation: Capitation

- Physicians paid a set amount per patient, per period of time
- Amount paid regardless of the amount of care received by patient during applicable period
Compensation: New Models

• At-risk or hold back
  – A portion of salary withheld until certain goals are met
• More quality focused
• Cost of care now a consideration
• Shared risk between hospital and physician
New Models: Different Focus

- Quality based payments
- Bundling
- Population management
COLLECTIVE BARGAINING / UNIONIZATION
Collective Bargaining

• If hospital employs hundreds of physicians, what happens if physicians try to negotiate as a group?

• Antitrust and labor/employment implications
Unionization

• Medical residents have evolved into union-like status
• There have been recent discussions about employed physicians unionizing
• Unlikely in SC but very possible in other places
• Antitrust issues relating collective bargaining
• Very political issue
What Else Does the Future Hold?

- Physician ownership in hospitals
- Payor / HMO owned hospitals
- Payors employing physician networks
- Private equity investing in physician networks
  - Corporate practice of medicine
  - Fee splitting
  - Antitrust
  - Fraud and abuse rules
QUESTIONS
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