

Issue Brief:

Physician-hospital employment: This time it's different

Increasing physician-hospital employment is a hot topic in health care, even though it has been occurring in waves for the past 30 years. This latest cycle is different, though, and is mainly a response to the structural changes taking place in the U.S. health care system, specifically:

- Delivery model transformation driven by the government and the Affordable Care Act (ACA), and
- Physicians' generational attitude shifts regarding work-life balance and loss of compensation due to reimbursement cuts.

ACA initiatives around avoidable re-admissions, bundled payments, and value-based purchasing assume a closer and interdependent working relationship between hospitals and physicians: Hospitals depend upon physicians for care delivery and patient volumes, while a growing number of physicians depend upon hospitals for stable employment and income preservation.

Two pathways to hospital employment are trending up – acquisitions of medical groups (139 percent growth in deals from 2010-2011)¹, which can lead to employment; and direct employment (45 percent growth from 2000-2010).² Looking ahead, the Deloitte Center for Health Solutions' *2013 Survey of U.S. Physicians* found that 66 percent of respondents expect physician-hospital integration to increase in the next one-to-three years.³



Lessons learned from the past

The 1990s wave of physician-hospital consolidation, driven by health plan capitation and the creation of Integrated Delivery Systems (IDS), ended for many with divestiture due to hospitals' struggles to effectively incorporate physicians into their organizations. Issues included:

- **Lack of integration:** Newly combined organizations failed to align structure, governance, leadership, and care delivery models.^{4,5}
- **Poorly structured compensation packages:** Physicians were not always incentivized to meet organizational goals.
- **Financial challenges:** Many hospitals that acquired medical groups struggled with physician profitability.
- **Regulatory complexities:** Regulators increasingly targeted physician-hospital relationships for compliance with Stark and anti-kickback laws. (This is still happening.)⁶

There also was a general lack of understanding in the 1990s that the hospital enterprise and the physician practice enterprise operate under different business models (e.g., billing, staffing, revenue) and have some different regulatory requirements.

This time around, hospitals cannot afford to fail because the need to integrate and the competition for essential physicians are heightened by the health care system's overall transformation. Hospitals need to identify, employ, and align with the right physicians or risk being left behind.

Lessons from the 1990s consolidation wave⁷



Over-valuation:

The race to purchase physician groups often made hospitals willing to pay too much.



Poor incentives:

Physician compensation packages did not include productivity incentives nor did they manage productivity effectively.



Lack of shared goals:

Hospitals' focus on cost-cutting held limited interest for physicians.



Fragmented structure:

Hospitals failed to organize multiple physician practices into a single, cohesive, high-performing group.

Current physician employment strategies

Hospitals today are using two primary strategies – acquiring medical groups and directly hiring graduating residents – to increase physician employment.

Acquisition trends

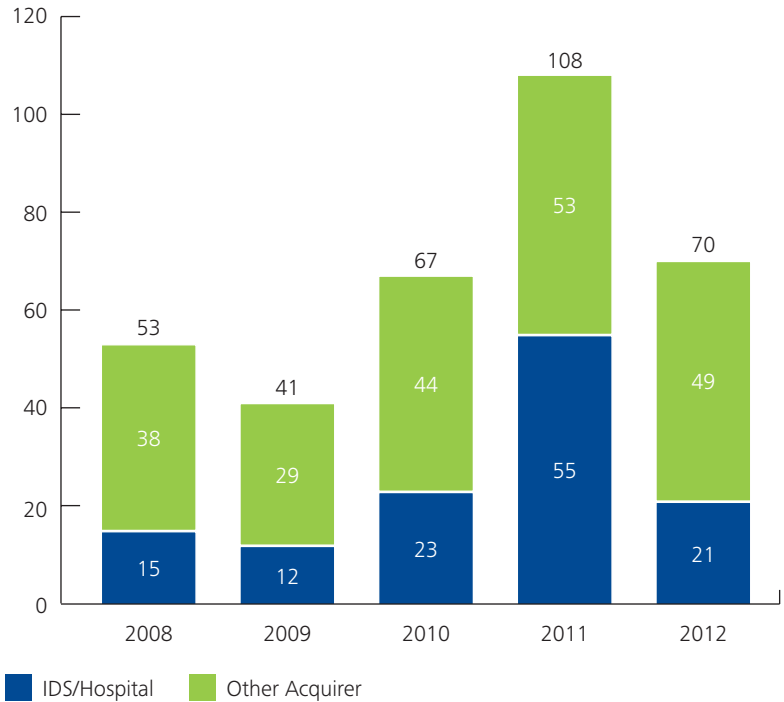
Medical groups are a growing acquisition target for hospitals and Integrated Delivery Systems (IDS). Recent activity shows (Figure 1):

- Medical group acquisition deals by all acquirers grew 32 percent from 2008-2012.¹
- Medical group acquisition deals by hospitals and IDS grew 139 percent from 2010-2011.¹
- Hospitals and IDS represented 51 percent of medical group acquirers in 2011.¹
- Medical group acquisitions declined 37 percent from 4Q12 (19 deals) to 1Q13 (12 deals), although deals declined in all health care sectors during this traditionally slow M&A time period (quarterly data not shown in Figure 1).⁸

In addition to acquisitions that help hospitals address their ongoing need to expand primary care physician relationships, current strategies focus on acquisitions of specialty physician practices, which offer lucrative returns, or primary care capabilities that position hospitals for future service delivery models such as Accountable Care Organizations (ACOs). Popularly targeted specialties include (Figure 2):⁹

- Cardiology, which traditionally is financially attractive but has seen income decline, driving physicians’ desire for employment.
- Hospitalist and internal medicine, which are core components of ACOs.

Figure 1: Medical group acquisitions by acquirer

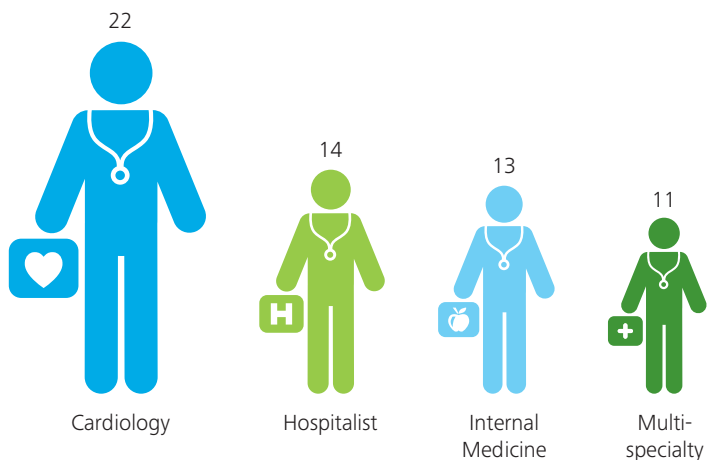


Number of transactions

Source: The Health Care Services Acquisition Report, Nineteenth Edition, Irving Levin Associates, Inc. March 2013¹

Note: Only includes deals > \$1M. Other acquirers include medical groups, health plans, etc.

Figure 2: Medical group acquisitions by top specialties, 2011



Source: The Health Care Services Acquisition Report, Eighteenth Edition, Irving Levin Associates, Inc. March 2012⁹

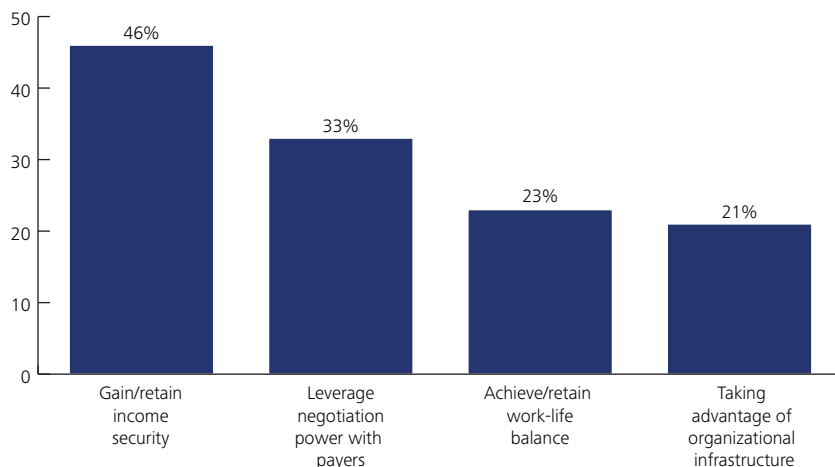
Note: Only includes deals > \$1M. Acquisitions are by all acquirers. All specialties/deals are not listed.

Physicians themselves expect consolidation with hospitals to increase:³

- 66 percent expect more physician-hospital integration in the next one-to-three years.
- 31 percent have consolidated/considered consolidation in the past one-to-two years.

Multiple reasons for consolidation were noted, but most physicians sought to gain/retain income security (Figure 3).

Figure 3: Top physician reasons for consolidation



Source: "Deloitte 2013 Survey of U.S. Physicians: Physician perspectives about health care reform and the future of the medical profession", Deloitte Center for Health Solutions. March 2013³

Note: Respondents were allowed to select multiple reasons.



Direct employment trends

Although a majority of U.S. physicians remain in physician-owned medical groups, the growth rate in this employment category is slowing, particularly compared to hospital-owned groups (Figure 4).

Among direct employment trends:

- Hospital-owned medical groups saw 65 percent growth in physician employment from 2003-2010.¹⁰
- The number of physicians directly employed by hospitals increased 45 percent from 2000-2010 (Not shown in table).²

Figure 4: Physicians by employer

Employer	2003 % of Physicians	2010 % of Physicians	Growth
 Physician-owned medical groups	43.6%	44.6%	2.3%
 Hospital-owned medical groups	17.0%	28.1%	65.3%
Other*	39.3%	27.3%	-30.5%

Source: *Employing Physicians: The Future is Now*, Medical Group Management Association 2011¹⁰

*Health plans, universities, and government entities

Tactics such as employing physicians directly out of residency or employment by hospital-owned medical groups can help hospitals achieve organizational strategies, such as targeting select specialties to develop integrated care models. In fact, important stakeholders expect physician employment by hospitals to increase in the coming years.

Final-year medical residents:

- Prefer to be employed by a hospital rather than other practice settings¹¹
 - 2011: 32 percent
 - 2001: 3 percent
- Say they are unprepared to handle the business side of medicine¹¹
 - 2011: 48 percent
 - 2006: 16 percent

Hospitals/IDS:

- Expect physician employment to increase in the next two-to-three years: 71 percent¹²

Our view: Continued physician-hospital employment

Hospitals should pay close attention to trends in physician-hospital employment, as the impetus for the current uptick in activity may reflect a broader health care system transformation focused on improving quality and lowering costs. Changing practice patterns, new service delivery models, and personal preferences for employment setting, geographic location, and work hours underpin a shift in physician demographics and attitudes about hospital employment. Among drivers of the current wave of physician-hospital employment:

Hospital/IDS drivers	Physician drivers
<ul style="list-style-type: none"> • Volume: Capture referral channels, gain market share and/or competitive advantage; mitigate reimbursement decline.^{4, 12, 13} • Financial: Contain costs; take on financial risk with payers.^{13, 14} • “Building blocks”: Assemble components for ACOs and other integrated care models.^{9, 15} 	<ul style="list-style-type: none"> • Financial: Obtain capital for HIT and other investments; offset decreasing reimbursement/income and increasing expenses; share financial risk with payers. • Administrative/regulatory: Manage heightened scrutiny and complexity. • Changing demographics: Address preference for work-life balance among younger physicians and female physicians.^{3, 5, 10}

Of particular note, pending shifts in care models and reimbursement practices are likely to drive hospitals and physicians to work more closely together, in an effort to effectively address:

- Value-based purchasing, ACOs, and bundled payments
- Avoidable re-admissions penalties
- Pending Medicare reimbursement cuts
- Meaningful Use bonus payments or penalties
- Medicare focus on redressing payment differences across care sites (outpatient departments vs. physician offices)
- Physician Sustainable Growth Model (SGR) fixes

Financial, supply-and-demand issues

The current wave of physician-hospital consolidation and employment is not without issues. Recent experience shows, for example, some resultant financial challenges for hospitals.

- **Losses during first three years of employment:**

In some cases, transition difficulties resulted in a \$150,000-\$250,000 loss per year per employed physician, according to 2011 data.¹⁰

- **Certain hospital-employed specialties lose**

dollars: There have been net income losses for some hospital-owned medical, surgical, multispecialty, and family medicine specialties, per 2010 data.¹⁶

- **Reduced productivity for hospital-employed**

physicians: Physicians in multi-specialty groups owned by IDS have 14 percent lower productivity, based upon Relative Value Units (RVUs), compared to physicians in privately owned, multi-specialty practices, according to 2012 data.¹⁷

As physician employment by hospitals grows, supply and demand issues involving the highly skilled medical labor force may limit hospitals' options to find the right partners. Many physicians remain independent or employed by physician-owned groups, so there is opportunity for hospitals to further increase physician employment. However, hospitals are not only competing for talent against other health systems in their markets; additional, nontraditional market entrants, such as health plans, are making the race to employ or acquire physicians even tougher.

Implications for stakeholders

Hospitals

Employing physicians or acquiring physician-owned groups can help hospitals capture specialty skills, gain market share and competitive advantage, prepare for integrated care models, and control the governance and infrastructure necessary for future growth. Yet, integrating groups of incoming physicians into a hospital can be difficult. One of the overriding challenges is balancing relationships with employed and community-based affiliated physicians. For the employed group, in particular, addressing culture, costs, shared goals and decision making, and regulatory risks may present issues and concerns. Hospitals seeking to employ physicians, either directly or through acquisitions, should consider whether there is a need to:

- Develop physician compensation models that align with organizational, quality/outcomes, and financial goals, as well as reward collaborative behaviors
- Create physician-led committees focused on quality and cost
- Mitigate regulatory risks surrounding physician-hospital relationships and compensation
- Meet Meaningful Use requirements and enable physician attestation
- Align with physicians using new relationship models (beyond employment)
- Ready their organization to assume financial risk for patient care

The ability to "make it stick" and sustain newly integrated relationships will depend, in part, on hospitals' ability to look beyond physician employment and performance metrics to include methods to achieve shared success. Such success can be defined and supported via methods such as a transparent decision-rights framework and evidence that physicians are valued by the hospital for the multiple ways in which they contribute to effective care delivery.

Physicians

As more physicians seek employment by hospitals, particularly due to financial challenges and shifting attitudes regarding work-life balance, they may need to:

- Recognize and bridge drivers and goals that may differ from their own. For example, hospitals likely will look to physicians to lead quality and cost initiatives and serve as channels to increase patient volumes.
- Evolve their approach to employment beyond traditional relationship models and performance metrics.

Some physicians may decide to remain independently employed; however, they still will have to work more closely with hospitals to achieve goals set forth by legislative and structural changes to the U.S. health care system, such as shifts in care models and reimbursement practices. Having shared goals will help to enable success.

Health plans

Continued physician-hospital employment is expected to challenge health plans, which will have to contract with fewer, more powerful provider organizations and collaborate with them on quality and cost-saving initiatives. When working with providers, health plans should consider:

- How best to align hospital/employed physician focus areas with populations that the health plans are trying to serve
- Whether hospitals with employed physicians will produce lower costs and higher quality that meet health plan goals
- Ways in which hospitals can work with health plans to understand and improve performance

Life sciences

As hospitals increasingly employ physicians, the life sciences sector – pharmaceutical, biotech, and medical technology companies – may face multiple challenges from providers who have:

- Consolidated buying power: Deeper rebate requests from more powerful provider organizations are anticipated; they are likely to impact life sciences company margins.
- Consolidated evidence: By leveraging their own consolidated, “real world” clinical data, providers will be able to question clinical trial data and efficiency statements, potentially impacting future development and cutting into both market share and margins for life sciences companies.

Life sciences companies should consider transforming their commercial model into one that is based on targeted, evidence-based sales and marketing programs and directed towards corporate decision-makers in provider organizations. In addition, companies should consider whether there is a need to accelerate expanding their range of services to enhance IDS views of their organization as a partner in health care outcomes.

Final thoughts

Physician-hospital employment – particularly hospital acquisitions of medical groups and direct employment of physicians – is on the upswing, driven, in large measure, by structural changes in the U.S. health care system and changes in physician attitudes. Earlier waves of physician-hospital consolidation ended for many with divestiture, as hospitals failed to effectively integrate physicians into their organization. This time things are different and hospitals cannot afford to fail, as integrating properly will enable successful navigation of health care transformation. Participating organizations will need to identify, employ, and align with the right physicians to master the heightened financial, regulatory, and quality-of-care expectations of a transformed marketplace.



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