



# Health system sponsored physician employment: keys to success

*Part 1: Why health systems employ physicians*

# Introduction and overview:

## Why health systems employ physicians

A perfect storm of health care trends is driving health systems to employ physicians in growing numbers. Many health systems engaged in acquiring and recruiting employed physicians in the mid-1990s only to experience huge, unsustainable financial operating losses. Today, however, a confluence of economic and regulatory factors has dramatically altered the strategic imperative for hospital/physician alignment and is driving hospitals to employ physicians in record numbers. Following lessons learned from the past, a new, more sustainable generation of health system sponsored physician employment is underway.

With properly aligned financial incentives and governance, a highly functional, dedicated physician practice management infrastructure and supporting information technology, the physician employment enterprise can exist as a physician led, professionally managed enterprise that enables the health system to meet the challenges of the new millennium. Understanding the complexities of physician employment and managing these elements proactively will ensure long-term success.

This document explores both the converging forces that are driving health systems to employ physicians in record numbers and the keys to success for health systems to build a financially sustainable physician employment enterprise.

## About the author

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# Converging forces driving health systems to employ physicians

There are many potent forces driving health systems to employ physicians. In this discussion, we identify and illuminate twelve such forces.

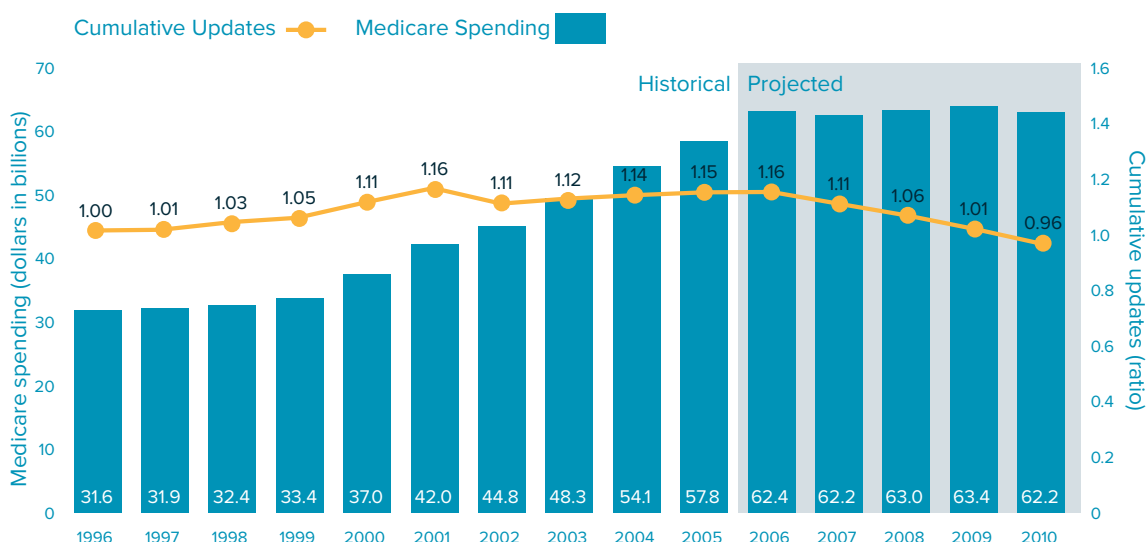
## Declining reimbursement by governmental and commercial third party payers

Reimbursement pressure from changes in Medicare is driving down reimbursement for both professional fees and physician practice based ancillary services. Total Medicare reimbursement is subject to the “sustainable growth rate,” a limit on total Medicare reimbursement for physician services. Currently at 3% the sustainable growth rate (SGR) attempts to cap total payments at a financially sustainable level for the Medicare program. In fact, given the aging baby boomer population, new technology and the

increasing frequency of physician generated fee-for-service charges, the total demand for Medicare payment is increasing at significantly higher rates each year.

In July 2008, last minute action by Congress abated a 10% reduction in fee-for-service payments in favor of a 1.5% increase, leaving for the following year a projected reduction of over 20%.<sup>1</sup> With physician practice operating costs escalating at 3%-5% per year, even a 1.5% increase in Medicare reimbursement represents a pay cut to physicians in real terms since practice expenses are increasing at a higher rate.

**Table 1: Fee-for-service Medicare spending and payment updates for physician services, 1996-2010**



Note: Dollars are Medicare spending and do not include beneficiary coinsurance.  
Source: 2006 annual report of the Board of Trustees of the Medicare trust funds.

## Commercial reimbursement at less than Medicare rates

Consolidating commercial insurance carriers have pegged their physician reimbursement to a percentage of the Medicare fee schedule – locally adjusted – which has compounded physicians’ reimbursement woes. Unlike most health systems that have succeeded in achieving inpatient and outpatient commercial reimbursement at significantly higher levels to offset less than cost governmental payments, physicians in private practice in many markets are experiencing commercial insurance reimbursement at less than Medicare rates or based upon Medicare fee schedules that are several years old. The result is an unsustainable financial future for private practicing physicians.

## Physicians seeking alternative revenue sources

Physicians in some markets have been successful at investing in diagnostic imaging, ambulatory surgery and other ancillary businesses in order to augment their income. In most cases, this results in business being transitioned from the health system to the new, physician sponsored enterprise, challenging the ability of health systems to meet their financial operating targets. Much like the proverbial “whack-a-mole” game at the amusement park where when one problem mole is whacked only to find another pop up in a different spot, payers are reducing reimbursement for such services one by one, and effectively closing the door on outpatient ancillary services as a long-term strategy for physician survival.

**Table 2: Medicare reimbursement – declining physician fee schedule**  
Proposed payment changes for 10 highest volume ambulatory surgery center procedures

CPT®/ HCPCS Code	Specialty	ASC Volume from 2004 PSPS File	2007 ASC Payment	Fully-implemented 2008 rate at 62%	Percent change
66984	Ophthalmology	1,094,801	\$973.00	\$935.31	-4%
43239	Gastrointestinal	348,738	\$446.00	\$329.69	-26%
45378	Gastrointestinal	333,676	\$446.00	\$349.82	-22%
66821	Ophthalmology	314,059	\$315.55	\$203.46	-36%
45385	Gastrointestinal	232,553	\$446.00	\$349.82	-22%
62311	Pain management/ neurology	231,665	\$333.00	\$253.16	-24%
45380	Gastrointestinal	212,475	\$446.00	\$349.82	-22%
64476	Pain management/ neurology	113,196	\$333.00	\$220.03	-34%
64483	Pain management/ neurology	110,573	\$333.00	\$253.16	-24%
45384	Gastrointestinal	106,771	\$446.00	\$349.82	-22%

Source: [www.aaasc.org](http://www.aaasc.org)

As a case in point, the American Association of Ambulatory Care Centers reported that in 2007, payments for the ten most frequent ambulatory surgery procedures were reduced between 4% and 36%, with most reduced by 22% or more.<sup>2</sup>

Many physicians are forming large, single-specialty group practices in order to achieve both economies of scale in the ancillary service enterprise and managed care contracting clout. “Groups without walls,” inferring smaller legacy practices linked together under a single federal tax identification number and a common information technology and centralized management platform qualify under the “group practice exemption” to share in ancillary services profits. Third-party payers often recognize the market power of such groups with 20%-30% improvements in reimbursement rates.

## Physician incomes (adjusted for inflation) are down

In fact, over time physician earnings adjusted for inflation have actually decreased. One study identified that over eight years ending in 2003, inflation adjusted physician earnings were reduced 4%, 8% and 11% for medical specialists, surgical specialists and primary care physicians respectively.<sup>3</sup> During the same time period, laboratory and radiology technicians in hospitals saw 7%-8% increases in compensation, even after adjusting for inflation.

These findings affirm that private practicing physicians are akin to a frog being slowly boiled in hot water where the frog doesn't think to jump out of the water because the process of boiling is so gradual. Physicians in solo or small private practice are at risk for extinction, albeit at a rate that may not be noticeable on a day-to-day basis. The crisis is cumulative as opposed to “in the moment.” Even so, the growing number of primary care practices looking to local hospitals for employment options, indicates an awareness of the increasing heat in the pot.

## Physician shortage projected to increase

The physician shortage is projected to steadily increase as the boomers age, with a gap of 130,000 specialists<sup>4</sup> and over 60,000 primary care providers<sup>5</sup> predicted by 2020. This gap has led the Association of American Medical Colleges to call for a 30% increase in medical school enrollments.<sup>6</sup>

Physician shortages are projected to be most severe in the following specialties:

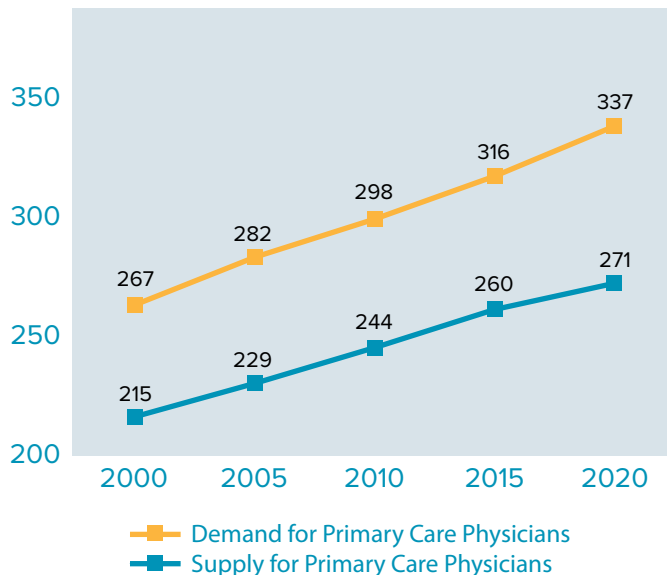
- Cardiology
- Endocrinology
- General surgery
- Geriatrics
- Orthopedics
- Primary care
- Rheumatology
- Other medical subspecialties treating chronic conditions.<sup>7</sup>

The above forces have so significantly affected primary care that residents are electing more lucrative subspecialties and adding to a growing primary care access issue. For example, Only 2% of 1,177 respondents to a survey at 11 U.S. medical schools said they planned to go into general internal medicine.

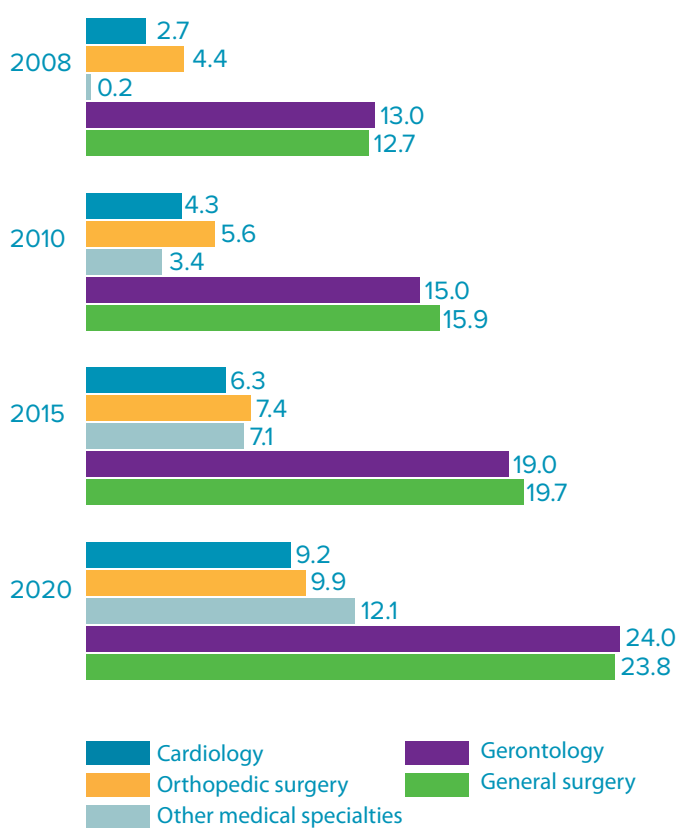
Similarly, compounding the challenge of physician supply for general surgeons is that substandard reimbursement and lifestyle considerations are driving general surgeons to subspecialize in their practices or through fellowship study as colorectal surgeons and breast surgeons which have both a superior reimbursement profile and reduced “in the middle of the night” call demands.

**Table 3-4: Physician shortage is becoming severe**

Primary care physician supply vs. demand (in thousands)



Physician shortages in selected specialties (in thousands)



## Regulatory changes closing the door on alignment alternatives

Since the early 1990s, physicians and hospitals have developed alternative models of alignment to share in the revenue stream of services that were traditionally provided by the hospital. These include hospital/physician ambulatory surgery center and diagnostic imaging joint ventures, hospital service line co-management agreements and innovative facility and equipment leasing arrangements.

Recent changes to the Stark Law and other regulations such as the anti-kickback legislation of 1972 have required that many of these arrangements be either restructured or terminated.<sup>8</sup> One such common arrangement is known as an “under arrangement joint venture.” In this arrangement, a hospital-based outpatient service contracts with a management company (which may include physician investors) to provide outpatient services to registered hospital outpatients. Using this model, the hospital is able to bill for the services rendered to the patients and be reimbursed via hospital-based third-party contracts.

The Centers for Medicare and Medicaid Services is concerned that “under arrangements” create incentives for overutilization of outpatient services because they are reimbursed on a per-service basis; and that because the services are provided through a hospital facility the cost is higher to Medicare beneficiaries. CMS states that “the use of these arrangements may be little more than a method to share hospital revenues with referring physicians in spite of unnecessary costs to the program and beneficiaries.”<sup>9</sup>

With the election of a Democratic Congress and president, the executive and legislative branches may be aligned and the handwriting on the wall that regulators will increasingly limit such revenue and profit-sharing arrangements between hospitals and physicians. Unless hospitals and physicians consolidate into a single enterprise through physician employment to begin working in a more integrated manner to focus on quality and efficiency in a manner that preserves and perhaps more effectively manages health care costs, they will continue to compete for an ever shrinking ancillary income stream.

## Traditional physician recruitment income guarantees are less viable

Regulatory changes are also impacting the hospital’s ability to facilitate private practice physician recruitment. A common form of physician recruitment assistance offered by hospitals is the “income guarantee.” While still permissible if there is demonstrated community need, in this arrangement there are two factors that impact its viability in the current environment.

The first is that the newly recruited physician must sign a promissory note that provides for repayment of any net deficit associated with the arrangement in the event the physician chooses to leave the community during the initial term of the arrangement, usually three years. Why would physicians in a physician shortage environment and with several employment offers in hand agree to sign a promissory note?

The second factor is a regulatory limitation on any payments from the hospital to a pre-existing private practice that may be willing to host the new physician. This rule prohibits the hospital from paying for fixed overhead expenses that exceed incremental practice expenses attributable to the new physician’s costs. Thus, a private host practice would not be reimbursed for its fixed costs which likely include office space, support staff, management expenses and additional technology software, hardware and training expenses.

Temporary employment arrangements whereby the hospital directly employs a new physician and embeds the physician in a private practice can overcome the incremental practice expense limitation above, but are exceedingly complex and challenging to administer.

## Other recruitment assistance limited to markets with “demonstrated community need”

Any other form of tangible recruitment assistance such as physician search fees, reimbursement of interviewing expenses, signing bonuses, relocation reimbursement, medical school loan repayment and the like are contingent upon demonstrated community need. In cases where the hospital may have a strategic need to recruit a specialist to a market where there already may be an adequate number of providers, such recruitment assistance is not an option.

## New generation physicians are seeking employment arrangements

The new generation of physicians is unlike the physicians of the past. The historical model of small group and solo practicing physicians working 60 hours to 80 hours per week in the tradition of Marcus Welby no longer exists. Today’s new physician is seeking a work/life balance. Male or female, these young physicians want to be home for dinner (or home earlier to make dinner) in order to spend quality time with their children and spouse. While half of physicians in training are women, regardless of gender they typically view the practice of medicine in the context of but one component of a well-balanced life.

Increased indebtedness is also influencing medical student specialty choice. The average debt load per student, is now almost \$142,000 and almost 18% had educational loans of \$200,000 or more by medical school graduation.<sup>10</sup> This debt load also makes med students and residents “risk averse” about taking on more capital debt load to start a practice or buy equipment especially in this capital starved time. So it becomes another driver in the desire for an employment model.

## Defense against “unfriendly aggregators”

Many health systems are employing physicians to defend against physicians organizing to compete for the provision of services traditionally performed by the hospital. Whether it be the heart hospital, orthopedic hospital, ambulatory surgery or endoscopy center, radiation therapy center or diagnostic imaging center, physicians in private practice have access to capital through for-profit firms that will joint venture such services.

The strategy of physician employment as a defense against unfriendly aggregators can take two forms. The first is to employ primary care physicians in order to reduce referrals to competing entities. The second is to employ specialty physicians to compete with specialists on the medical staff that are sending their patients to physician-sponsored arrangements.

## Where is the “glue?”

In the new world of hospital medicine primary care physicians rarely leave their offices to follow patients in the hospital. They refer to hospital employed hospitalists to care for their patients in order to optimize more lucrative office visit productivity. Whereas in the past, a hospital CEO could touch base with most of the community’s primary care physicians in the doctor’s lounge at 7 a.m. or at monthly medical staff dinner and committee meetings, today these physicians are nowhere to be found in the hospital.

In this environment, where is the emotional connection between primary care providers and the health system? Increasingly, primary care referral patterns are at risk for wholesale changes based on competing service offerings or, worse, employment of the physician by a competing institution.

Many health systems are finding that a robust network of employed primary care physicians both secures and enhances the referral base while positioning the system to benefit from integration, including the opportunity to operate as a comprehensive health system on a common information technology platform under a unified vision and strategy.

## Foundational model for quality

Forward thinking health system executives view employment of physicians as the foundation or platform for measuring, monitoring and demonstrating health care quality. As best practice guidelines are becoming standardized, those systems that are able to operate on a common clinical and business information technology platform with their physicians are well positioned. With aligned financial incentives through the employed physician compensation plan those systems are demonstrating superior quality outcomes and effecting substantial cost improvements.

President Obama indicates he favors an American health care system that is outcomes oriented:

*“We must align incentives for excellence. Both private and public insurers tend to pay providers based upon the volume of services provided, **rather than the quality or effectiveness of care.** Providers (will be) rewarded for achieving performance thresholds on outcome measures.”<sup>11</sup>*

Mr. Obama proposes to base Medicare and Medicaid reimbursements on patient outcomes in a coordinated effort focusing on better health and not just the provision of care.<sup>12</sup>

# Physician employment demonstrates profitability

It is well known that the vast majority of health system sponsored physician employment arrangements experience a significant financial operating loss when only considering the professional fee revenue stream and physician enterprise operating expenses. In 2007 the Medical Group Management Association reported that the median annual financial operating loss per physician for health system sponsored multi-specialty physician practices was \$86,000.<sup>13</sup>

Yet this does not represent the whole story. Surveys indicate that the average primary care physician generates approximately \$2 million in annual hospital revenue from the physician's patient base.<sup>14</sup> Depending upon the circumstances, most health systems can make good financial sense out of investing \$35,000-\$75,000 per primary care physician per year to retain and grow the total health system revenue stream, build a platform for demonstrating and continuously improving health care quality and ensuring community physician capacity needs are met in a time of shortage.

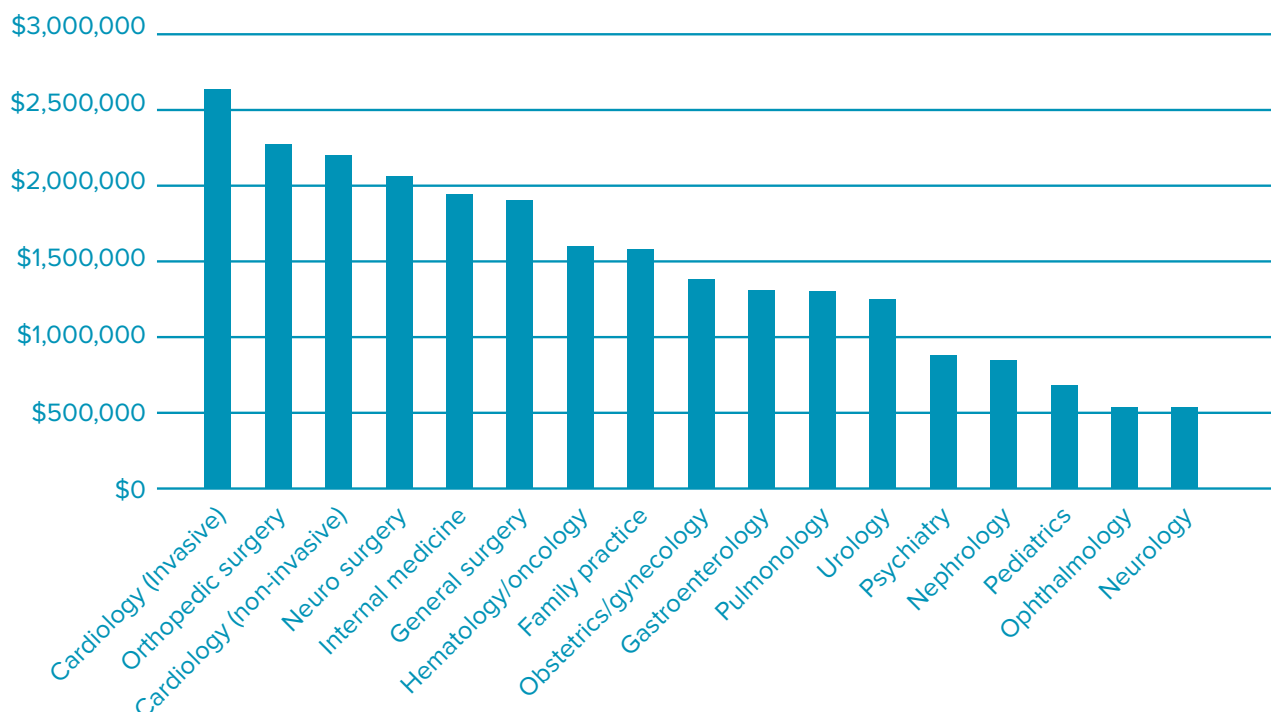
**Table 5: Financial loss per physician**

Percentile	2007 Loss
75th	\$35,000
Median	\$86,000
25th	\$132,000

As a case in point, recent research of a Midwest health system conducted by the University of Minnesota revealed that the number one correlation with overall health system contribution margin was the productivity of its employed primary care physician network. Orthopedic surgeon productivity was second while cardiovascular services was third.<sup>15</sup>

**Table 6: Average annual hospital revenue generated by specialty**

50 Primary care practitioners generate \$80-95 million every year



Source: Merritt, Hawkins & Associates, 2007 Physician Inpatient/Outpatient Revenue Survey

# Looking back: what went wrong?

The consequences of a poorly planned and executed health system employment enterprise have been well documented. Annual financial operating losses exceeding \$100,000 - \$300,000 per physician were not uncommon in the mid-1990s. In the last ten years, the problems of poor performance and poor management have been better understood. The challenges are multifaceted and include the following major elements:

## Increased Overhead

When health systems began employing physicians, practice overhead dramatically increased. Small group and solo private practices were acquired by hospitals that layered on expensive management, costly technology and expensive outpatient clinic facilities without any means of mitigating such expense. A rich benefit plan for support staff, perhaps union negotiated, was incorporated into the physician enterprise, while in the previous private practice employee benefits were at best thin, if not non-existent. Today's models recognize and address these issues through differentiated cost structures of a separate physician enterprise or recognition of the need for the system to mitigate the impact of such expense in determining physician compensation.

## Physician Productivity

Initially, physician compensation plans were straight salary with no incentive for productivity, cash collections or practice expense management. Later evolutions of the physician compensation plan incorporated a base salary plus productivity incentive which led to some physicians accepting the base salary in exchange for low productivity and others earning oversized incentive payments that were not tied to the actual financial outcomes of the practice. As a result of the above, physicians became disengaged from managing the key components of a successful compensation plan, such as cash collections and expense management.

## Professional fee revenue cycle

Many hospitals failed to recognize that professional fee billing is a wholly different business from hospital billing. Faulty information technology selection, poorly executed computer conversions and a tendency to continue to operate multiple hardware and software platforms for the physician enterprise to honor commitments to physicians that “nothing will change” under an employment arrangement had disastrous results. By decoupling physician compensation from the professional fee revenue cycle, cash collections were abysmal. Decreased collections left health systems unable to support the physician productivity based compensations plans discussed above.

## Managed care contracting not prioritized

Since it is a given that any physician enterprise of size will incur additional costs for technology, management and other infrastructure, it is essential that significant improvement in managed care contracting rates be realized. Early adopters of physician employment failed to prioritize significantly higher professional fee reimbursement rates as they continued to focus on the core inpatient business reimbursement from payers. As a result, true third-party payer relationships or partnerships were not developed and the ability to share more equitably in third-party payer premiums was foregone and the practice or health system was left on its own to subsidize the additional costs associated with employment.

## Myths of “groupness,” management and governance

First generation health system sponsored physician employment adopted three classic myths:

- **Myth of the group** While hospitals assembled a group practice composed of acquisitions and organic recruitment of multiple physicians into multiple practice sites, the true group practice never came into being. Physicians entered into the relationship individually with a “what’s in it for me” attitude that hospitals reinforced with individual contracts and promises that “nothing would change”. Most disastrous for the group enterprise were compensation arrangements with poorly aligned incentives that were highly individual and not dependent upon group and system success. The lack of a group culture made it difficult to address issues in a collective manner.
- **Myth of hospital-centric practice management** The second myth propagated by early health system sponsored physician employment organizations was that the hospital would assume responsibility for practice management and that the physician would simply be responsible for seeing patients and not for leading or managing the physician enterprise. In fact, there are few successful examples of physician practices that are not physician-led and professionally managed by either the physicians themselves or, if not, experienced physician practice management executives. Being a “department of the hospital” or run by former hospital administrators is not as successful as management by seasoned medical group practice executives. Thus, the benefits associated with professional management, specifically the ability to facilitate physician engagement and support for managing a business plan including revenue and expense management was unrealized.

- **Myth of hospital control** In establishing the physician employment enterprise, initially hospitals were seeking control over governance, management and business decision-making. In some cases this was seen as an attractive alternative to the “hard work” of dealing with the traditional conflicts between hospital administration and physicians on the private medical staff. Thus, the governing board of the physician enterprise was dominated by hospital executives and/or hospital board members, management reporting relationships were straight to the hospital CEO and the general understanding on the part of both parties was that the hospital was in control. Hospital executives proved to be poor practice managers. Disengaged physicians stood by while poor decisions were made. Since it did not impact their compensation or incentives they were reluctant to “rock the boat” with their new employer.

In hindsight, the physician enterprise model was flawed in several key structure aspects. Relationships were formed based upon incorrect strategic assumptions and both hospital management and physicians operated in an environment where for too long financial results were unsustainable unless major changes in the operating model were adopted. This would require a new way of thinking by both parties.

## Ancillary services gap

When acquiring practices and recruiting physicians, hospitals were eager to transfer ancillary service operations to the hospital environment. In multi-facility health systems, individual hospital CEOs were incentivized to optimize hospital operating margins without respect to the financial operating losses associated with the physician enterprise. In this environment, it made good sense, for example, for the hospital CEO to acquire a cardiology group, transfer all in-office nuclear imaging and echocardiography to the hospital and ignore that the significant physician losses were in large part due to this disaggregation of services. The failure to view the hospital and physician practice on a consolidated basis created physician “losses” partially due to the shift in ancillary revenue streams to the hospital.

## Inadequate financial reporting

Hospital financial accounting systems are poorly designed to account for the financial and operating results of the physician enterprise. To do so successfully requires a unique tracking of accounts and a general ledger accounting system that provides for consistent, accurate, timely and relevant financial reporting for the individual physician, the practice site manager as well as for the health system executives. With practice management a responsibility of the hospital administrator, often the metrics chosen were not relevant to the physician enterprise and confusion regarding the root cause of financial operating losses ensued. Further, physicians were often left in a vacuum with regard to understanding the economics of their practice and therefore not in a position to meaningfully participate in its management.

## Challenges met

Over the past decade or more, successful health system sponsored physician practices have found solutions to the challenges described above. The framework for leadership, governance, management and physician incentive alignment has been re-defined and institutions are demonstrating consistent results in financially sustainable physician enterprises. In addition, health systems are better integrating employed physicians into their leadership or management of service line quality and efficiency that allows for more sustainable long-term investment and working relationships and partnerships.

# Thinking about employment differently

When most people think of “physician employment,” they think of salary-based compensation arrangements and hierarchical reporting relationships where the physician is no longer responsible for practice management and financial performance. The common concept held that the physician is free to simply focus on seeing patients and following the instructions of his or her employer regarding any financial, operational or other non-patient care matters.

## Physician led, professionally managed

For all of the challenges and common mistakes described above, successful physician employment arrangements are based on a physician led, professionally managed approach whereby the physician retains a significant stake in both the clinical and business performance of the enterprise. Employment of physicians by hospitals is primarily, an arrangement that provides a safe harbor for physician/hospital alignment in a sea of growing regulation and financial penalties. The safe harbor includes both alignment of financial incentives (within certain parameters) as well as the ability for the hospital to underwrite the physician enterprise free from most of the regulatory restrictions facing hospitals trying to advantage the practices of independent physicians.

# Keys to success

The good news is that the keys to success in designing, implementing and operating the health system sponsored physician employment enterprise are no longer a mystery. This series will explore the keys to success.

## Health system sponsored physician employment: keys to success

### **Part 1 Why health systems employ physicians**

Part 2 Aligning incentives through physician compensation

Part 3 Organizational structure, governance and management

Part 4 Optimizing the physician revenue cycle

Part 5 Metrics and reporting for the physician enterprise

Part 6 Getting started: building the enterprise through acquisition and recruitment

Part 7 Putting it all together

## Case study

# Health system sponsored physician employment: keys to success

**Memorial Health System  
South Bend, Indiana**

**Mike O'Neil, SVP and COO, Memorial Health System, explained there are currently 107 employed physicians and by 2014, he expects they will have 158. These physicians include those in primary care, office and hospital based pediatricians, hospital based adult medicine physicians and office based specialists.**

**Memorial**  
Health System<sup>SM</sup>



**Michael J. O'Neil**  
Senior Vice President and  
Chief Operating Officer,  
Memorial Health System Inc.

## History

The first family practice group was purchased in 1994. At that time the drive was to “control gatekeepers” and in fact there was almost a “feeding frenzy” of acquisition of physician practices. Essentially all family practice groups in their region became affiliated with one hospital or another. The goal was to secure a large geographic footprint for the health system. This endeavor was characterized by a significantly large sized administrative infrastructure and a lack of IT support infrastructure. The highest number of employed physicians was 71 in 1999. And the largest financial loss of the effort was in excess of \$10 million, mostly in salaries. The board of directors demanded action. Mr. O'Neil noted the physicians were like “nomads” in the system without a strategic aggregation, management or governance plan.

## Lessons learned

The key for success is a truly physician led governance structure with professional organizational management. Professional physician practice management experience is critical for the administrators. In the current Memorial Health System, there are four physicians and two administrators who lead the physician group. Each site has a medical director and an administrative person who work together as an operating committee.

Contracts with physicians are a platform for understanding partnership rather than to create a perception of being an “employee”. The platform for success is built by establishing the culture and performance expectations of the group. The compensation philosophy and plans drive the desired and necessary performance. For the primary care physicians there is a tiered compensation program based on collections. For the specialists, compensation is based on work relative value units and payer mix risk is removed.

Physician leaders are accountable for results, with their compensation including a bonus plan component based on clinical results and a component based on expense management. Developing such physician leaders is an important task according to Mr. O’Neil. He observed that financially, the perception should not be “loss per physician” but rather as an investment to be managed to the necessary return, part of the “cost of doing business.”

## Strategically positioned

Employment is an offering that responds to challenges currently facing independent physicians and the hospitals with which they are affiliated. It helps align incentives and drive quality. A large aligned group of primary care physicians is a good way to have partner opportunities with specialists. Employment provides opportunities to recruit and retain physicians to support key service lines. Mr. O’ Neil predicts that the pace of physician and hospital integration will accelerate given payment changes such as “payment for performance” and bundling as well as financial pressures increasing for physicians including specialists. Other pressures include the increasing complexity of operating independent practices as well as limitations and further potential limits prohibiting physicians from capturing technical component revenue.

This case study is summarized from comments by Mike O’Neil on March 31, 2009 as part of the 2009 VHA CEO Affinity Group Teleconference series.



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Memorial Health System		Current employed physicians	Employed physicians by 2014
Physician Leadership Governance	Hospital-based adult medicine	6	12
	Hospital-based pediatric specialists	10	12
	Office-based pediatric specialists	5	8
	Office-based specialists	17	42
	Primary care	50	60
	Retail clinics	9	12
	Urgent care	10	12

Number of current employed physicians: 107

**Number of employed physicians by 2014: 158**

# End notes

1. Modern Healthcare, July 2, 2007.
2. [www.aaacc.org](http://www.aaacc.org)
3. Community Tracing Study Physician Survey & Bureau of Labor Statistics (BLS).
4. Physician Supply and Demand: Projections to 2020, HRSA, October 2006; "Research Shows Rapid Decline in Geriatric Medicine Students," Press Release, University of Cincinnati, April 4, 2007; and "Aging Boomers Face a Doctor Shortage," CBS News, March 4, 2003.
5. Projections based on HRSA, Physician Supply and Demand: Projections to 2020, October 2006. Similar estimates of a shortage of over 150,000 physicians by 2025 are published by the Association of American Medical Colleges (AAMC).
6. AAMC Statement on the Physician Workforce, Association of American Medical Colleges, June 2006.
7. "When I'm 64: How Boomers Will Change Healthcare," American Hospital Association, May 2007.
8. Neither Southwind Health Partners or VHA provides legal advice. The legal concepts presented here reflect generally known legal requirements and fundamental legal principles relating to the design of a physician compensation plan for physician practices sponsored by not-for-profit, tax exempt institutions. The authors recommend that institutions seek legal advice from qualified legal counsel when establishing or restructuring a health system sponsored physician practice.
9. Federal Register. Part III. Department of Health and Human Services. Center for Medicare and Medicaid Services. March 26, 2004. 42 CFR Part §411.357(h).
10. 2008 AAMC Graduate questionnaire, AAMC.org.
11. Barrack Obama for President website.
12. C. Cutler, Advisor to Barrack Obama.
13. Medical Group Management Association (MGMA), 2008 Report Based on 2007 Data.
14. Merritt, Hawkins & Associates, 2007 Physician Inpatient/Outpatient Revenue Survey.
15. "The Vanguard Program," American College of Physician Executives, April 27, 2009, Chicago, Illinois.