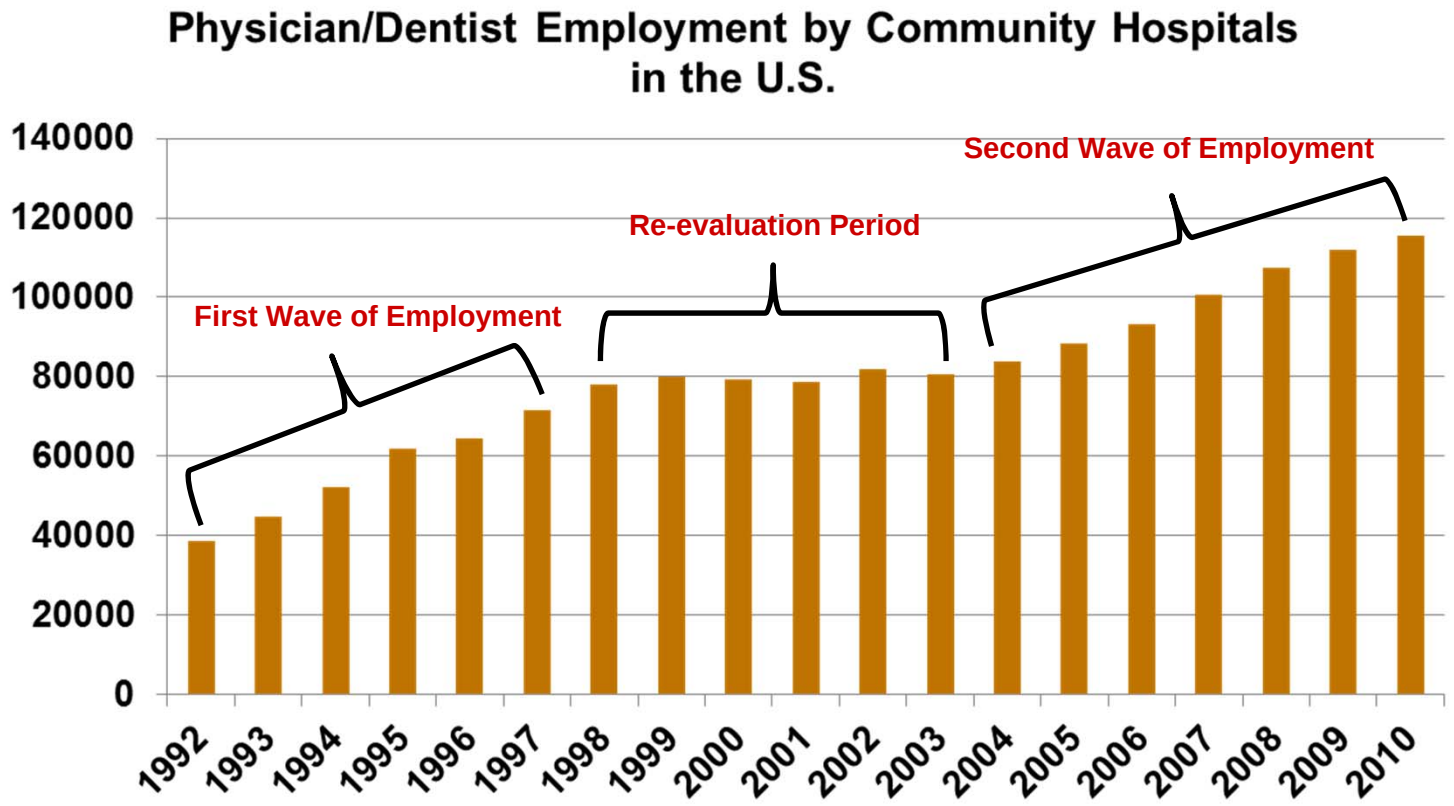
Key Market Trends/Influences

Key Market Trends/Influences

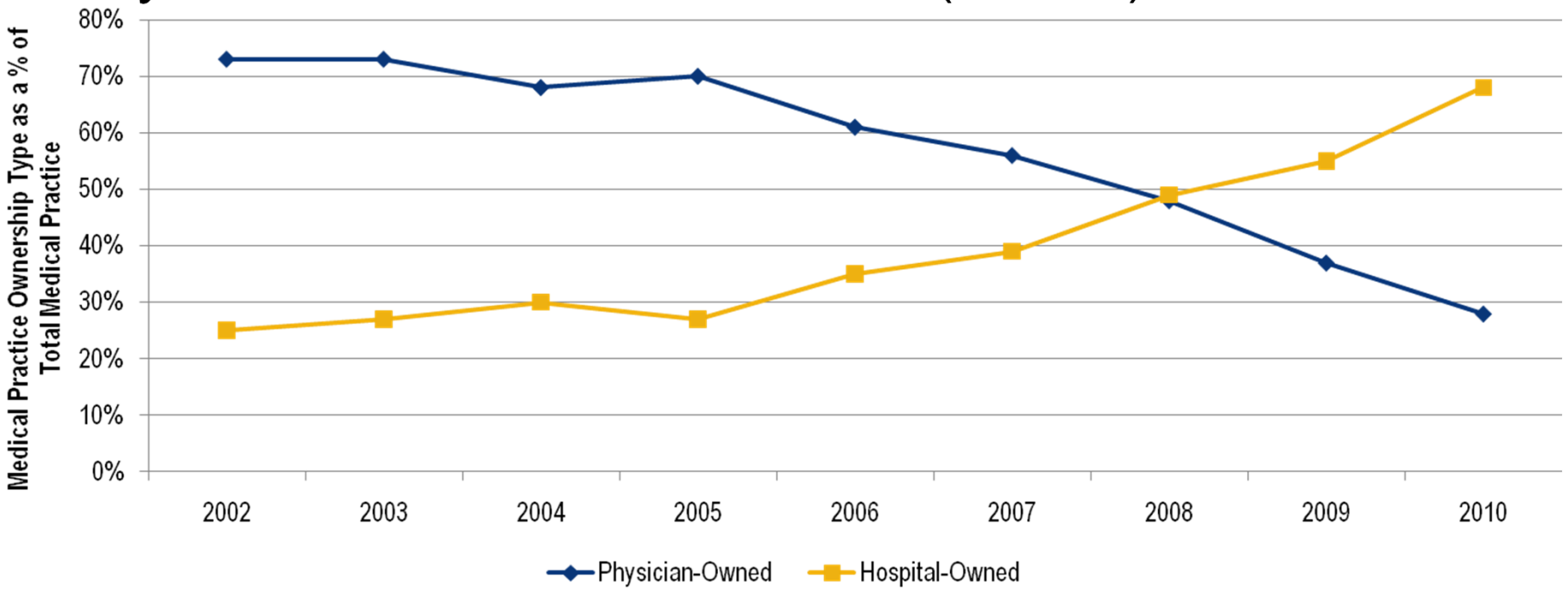
- Physician employment – round #2
- Historically, separatism and/or competition between hospitals and physicians
- Now, desire of physicians for security
- Ultra competitive to recruit PCPs and certain specialists
- Regulations constrain the options for formal business relationships other than employment

Key Market Trends/Influences (cont'd)



Source: 2010 Merritt Hawkins review of physician recruiting incentives survey; Health Forum, American Hospital Association Annual Survey of Hospitals, January 2012.

Key Market Trends/Influences (cont'd)



- In 2010, MGMA found that the share of hospital-owned practices reached 68% vs. 30% in 2004.
- Hospitals have been increasingly employing physicians, in part to position themselves to become accountable care organizations.
- Physicians are increasingly seeking employment in order to "lock-in incomes" in a declining reimbursement environment, shifting this risk from their practices to the hospital.

Source: MGMA Physician Compensation and Production Survey Report ; Organization Ownership 2011 based on 2010 data; Wall Street Journal, "Shingle Fades as More Doctors Go To Work for Hospitals," November 8, 2010

Key Market Trends/Influences (cont'd)

U.S. Physicians (2006)

"Matures"
Age: > 62

- Dedication, sacrifice, hard workers
- Respect authority, conformity

"Boomers"
Age: 43 – 61

- Value personal growth
- Expect financial rewards

Generational Clash

"Gen X"
Age: 28 – 42

- Indifferent to authority, loyal to people
- Entrepreneurial, self-reliant

"Millennials"
Age: < 28

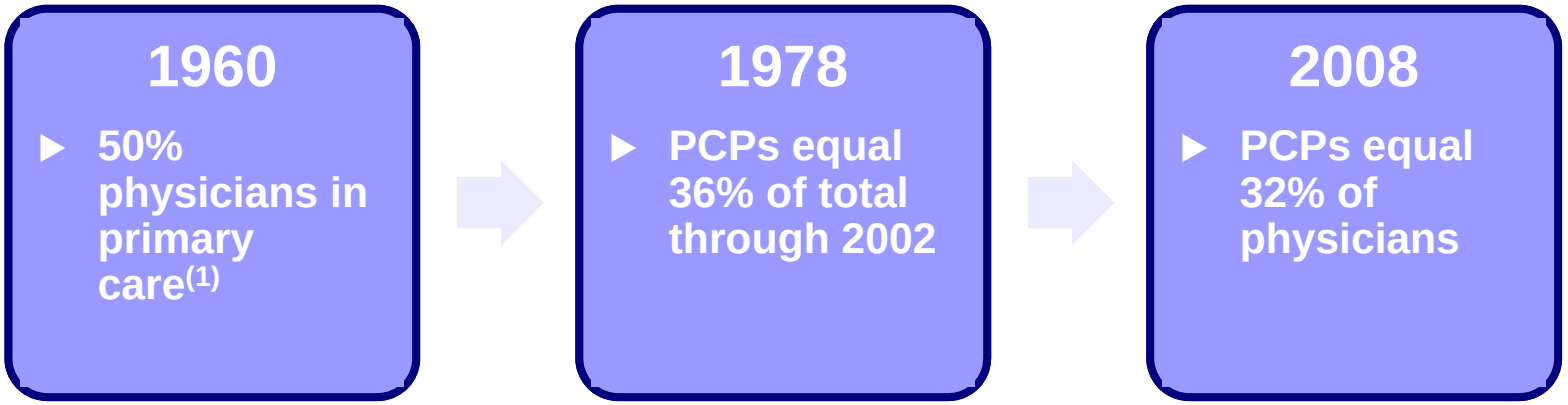
- Want work/life balance
- Expect high compensation early

The effective number of FTE physicians will fall as doctors work shorter hours and seek a better life/work balance

Sources: Marston, *Recruiting and Retention Trends*, SHRM Conference (2006); Laumyer, J., *Generations X & Y: An H.R. Challenge*, SHRM Conference (2006). *Physician Characteristics and Distribution in the U.S.*, AMA (2008). Carol Westfall, President, Cejka Search.

Key Market Trends/Influences (cont'd)

Employment particularly challenging for primary care specialties:



- **Since 2008, medical student interest in primary care has ranged from 14% to 20%; recent uptick**
- **If uninsured population becomes insured, an additional 122,000 PCPs are needed**

(1) Primary care includes general practice, family practice, general internists, and general pediatricians.
Source: COGME 20th Report: Advancing Primary Care, January 2011.

Key Market Trends/Influences (cont'd)

- ACO development and payor initiatives – slow to materialize
- Ultra competitive for certain specialists
- In some markets, virtually all physicians are employed by hospitals or large practices
- Most large employed physician networks are able to negotiate premium reimbursement rates
- While industry average subsidy is >$150,000 annually, best practice is $35,000 to $40,000

Key Market Trends/Influences (cont'd)

- Reimbursement pressures:
  - Cuts in rates
  - Bundling
  - SGR fix looming
  - Payor power v. smaller groups
  - Out-of-network initiatives being quashed

Trends in Compensation Models

Employment Through the Years

1990's

- **Salary guarantees**
- **Primary care physicians (PCP's)**
- **Long-term contracts**
- **High goodwill payments**
- **Unrealistic business plans**
- **Practice management companies**

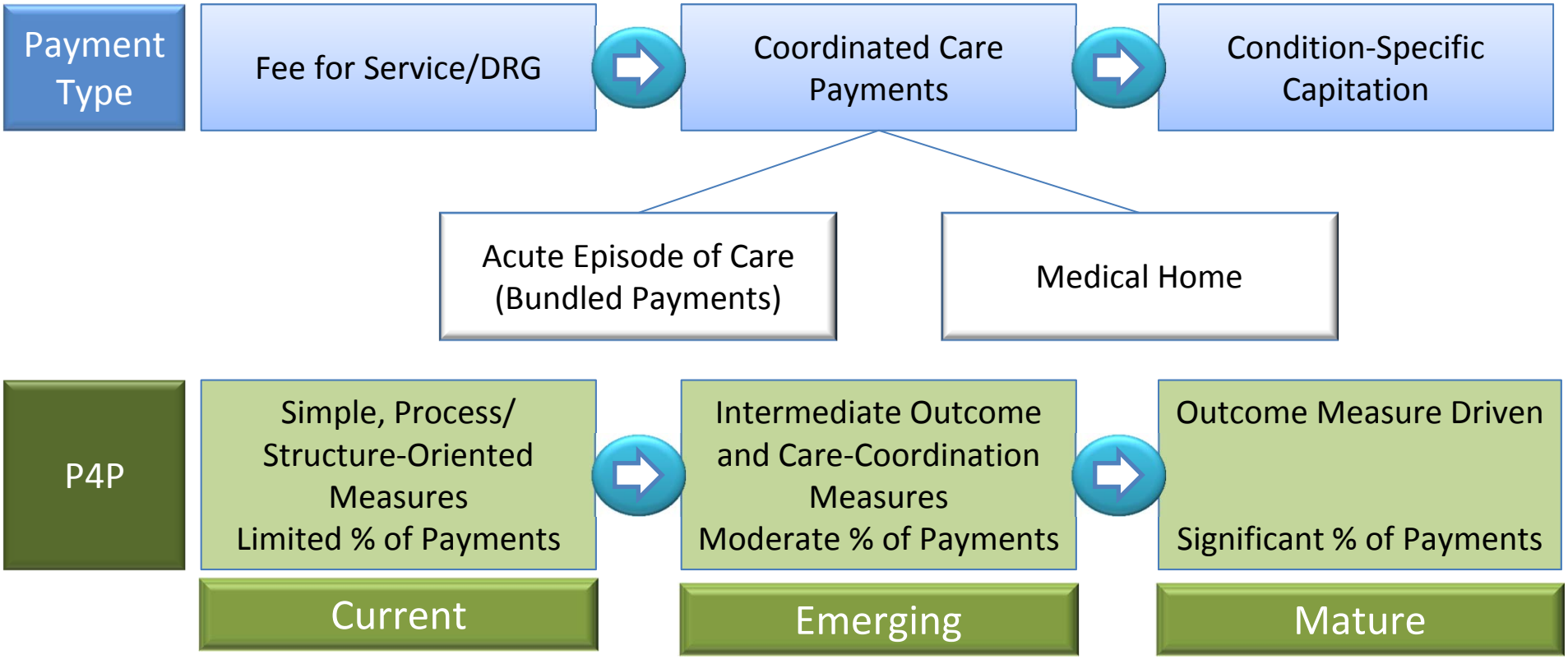
Today

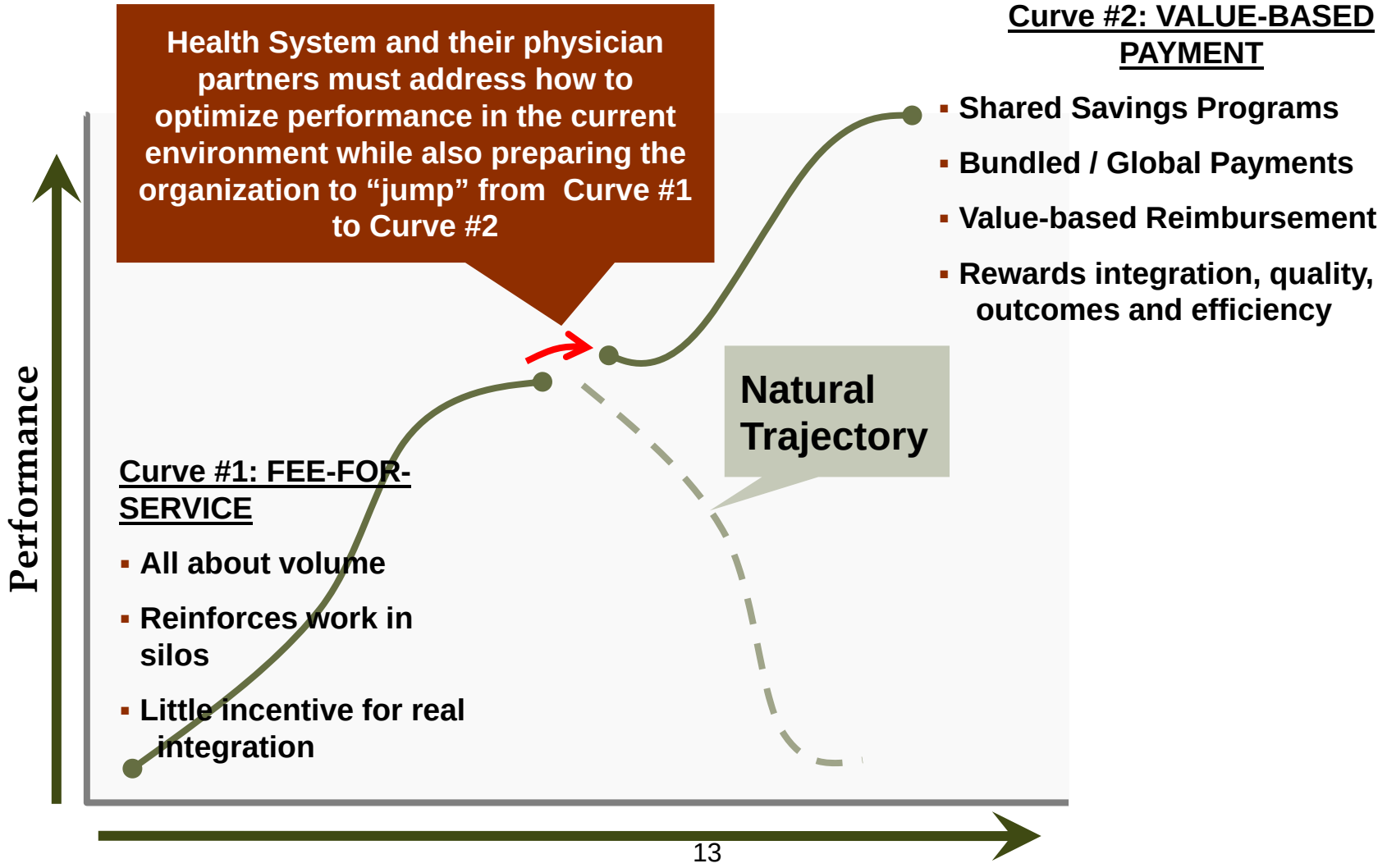
- **Incentive based contracts**
- **PCP's + other categories**
- **Short-term contracts**
- **More asset-based deals, but . . .**
- **Focus on compensation, such as quality, retention bonuses, deferred comp, etc.**

Compensation Models Through the Years

- Early to mid 1990s: salaries and guarantees
- Late 1990s: base plus productivity incentives
- Early 2000s: revenue less expenses pools
- Mid to late 2000s: pure productivity
  - Percentage of collections/charges
  - wRVUs
  - Tiered wRVUs
- Today: productivity plus incentives – typically:
  - wRVU-based system
  - Guaranty or floor only for:
    - Transition period
    - New hires
  - Small quality/efficiency/outcomes incentive (10-15%)
  - Administrative/non-clinical or revenue producing time credit

Looking Forward – Shift in Focus




Health System and their physician partners must address how to optimize performance in the current environment while also preparing the organization to "jump" from Curve #1 to Curve #2
Curve #2: VALUE-BASED PAYMENT
▪ Shared Savings Programs
▪ Bundled / Global Payments
▪ Value-based Reimbursement
▪ Rewards integration, quality, outcomes and efficiency
Natural Trajectory
Performance
Curve #1: FEE-FOR-SERVICE
▪ All about volume
▪ Reinforces work in silos
▪ Little incentive for real integration

Regulatory and Compliance Considerations

Key Issues

- Stark Law
- Anti-kickback statute
- Tax-exemption considerations

Stark Law

Terms of exception	Group practice physicians [1877(h)(4); §411.352]	Bona fide employment [1877(e)(2); §411.357(c)]	Personal services arrangements [1877(e)(3); §411.357(d)]	Fair Market Value [§411.357(1)]
Must compensation be "fair market value"?	No.	Yes – 1877(e)(2)(B)(i).	Yes – 1877(e)(3)(A)(v).	Yes – §411.357(1)(3).
Must be "commercially reasonable"?	No.	Yes (remuneration) – 1877(e)(2)(C).	Yes (aggregate services reasonable and necessary) – 1877(e)(3)(A)(iii).	Yes (arrangement) - §411.357(1)(4).
Must compensation be "set in advance"?	No	No.	Yes – 1877(e)(3)(A)(v).	Yes - §411.357(1)(3).
Scope of "volume or value" restriction.	DHS referrals – 1877(h)(4)(A)(iv).	DHS referrals – 1877(e)(2)(B)(ii).	DHS referrals or other business – 1877(e)(3)(A)(v).	DHS referrals or other business - §411.357(1)(3).
Scope of productivity bonuses allowed.	Personally performed services and "incident to" plus indirect – 1877(h)(4)(B)(i).	Personally performed services – 1877(e)(2).	Personally performed services - §411.351 ("referral") and §411.357(d)(3).	Personally performed services - §411.351 ("referral") and §411.357(d)(3).
Are overall profit shares allowed?	Yes – 1877(h)(4)(B)(i).	No.	No.	No.
Written agreement required?	No.	No.	Yes, minimum 1-year term.	Yes (except for employment), no minimum term.
Physician incentive plan (PIP) exception for services to plan enrollees?	No, but risk-sharing arrangement exception at §411.357(n) may apply.	No, but risk-sharing arrangement exception at §411.357(n) may apply.	Yes, and risk sharing arrangement exception at §411.357 may also apply.	No, but risk-sharing arrangement `at §411.357(n) may apply.

Stark and FMV (42 CFR 411.351)

- FMV means
  - Value in arm's length transactions, consistent with the ***general market value***
  - ***General market value*** means the compensation that would be included in a service agreement as the result of ***bona fide bargaining between well-informed parties*** to the agreement who are ***not otherwise in a position to generate business for the other party***, at the time of the service agreement.
  - Fair market price is generally based on **bona fide comparable services agreements, where the compensation has not taken into account the volume or value of anticipated or actual referrals**

Stark and FMV (42 CFR 411.351)

- FMV History
  - Stark II Phase II
    - Clarified CMS will consider ***range of methods*** to determine
    - Appropriate ***method varies*** based on nature and location of transaction and other factors (69 Fed Reg 16054 (Mar. 26, 2004) at 16107)
    - Established voluntary safe harbors for FMV consisting of two methodologies for determining hourly rates for personal services (average hourly rates for ER physicians and average 50th% salary for specialty using 4 of 6 specified salary surveys) (69 Fed Reg at 16092)
  - Stark Phase III eliminated "FMV" safe harbors but noted "***reference to multiple objective, independently published salary surveys remains a prudent practice***" (72 Fed Reg 51012 (Sept. 5, 2007) at 51015)

Stark and Volume or Value of Referrals

- Compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals
- Consider business purposes judgment factors
  - Strategic objectives
  - Demonstrated community need for specialty or service
  - Objective to add or expand services to community or segment of patients (e.g., indigent, submarket)
  - Quality improvement goals
  - Unique skills of the physician

Anti-kickback Statute

- FMV not an express requirement:

  "any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services"

- But...Thornton letter:

  "[T]o the extent that a payment exceeds the fair market value of ...the value of the services rendered, it can be inferred that the excess amount paid over fair market value is intended as payment for the referral of program-related business." (citing United States v. Lipkis, 770 F.2d 1447 (9th Cir. 1985)).

- Scarce case law
- Advisory opinion 08-22

IRS and FMV

- IRS Definition FMV (Rev Rule 59-60)
  - Price expressed as price at which property would change hands between a ***hypothetical willing and able buyer and hypothetical willing and able seller acting at arms' length*** in an open and unrestricted market when neither is under compulsion to buy or sell and when both parties have reasonable knowledge of relevant facts

Defining Commercial Reasonableness

CMS, then HCFA, in the 1998 Stark proposed rule, interpreted "'commercially reasonable' to mean that an arrangement appears to be a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any particular referrals." Later in the preamble to the Stark interim final rule, Phase II, CMS noted that an arrangement "will be considered 'commercially reasonable' in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS referrals."

This definition is long-standing and was cited in the Federal Register: March 26, 2004 (69 Federal Register, p. 16093).

Commercial Reasonableness Considerations

- Physician employee not able to generate enough net revenue to cover cost of salary and benefits
- Compensation exceeds collections
- Business rationale
- Expected financial impact
- Evaluation of alternatives

Properly Valuing the Services to be Provided

Measuring Physician "Value…"

The organization must determine (through its pay and performance management plan) how to measure physician value and contribution. Base amount and incentive income must be linked to an internally equitable and externally competitive methodology. Options include:

- "Productivity" (revenue vs. time-based; clinical vs. non-clinical)
- Quality measures (e.g., clinical outcomes, etc.)
- Service measures (e.g., patient satisfaction, etc.)
- Teaching/Training responsibilities
- Research responsibilities
- "Call Coverage" services responsibilities
- Leadership (task related, marketing, administrative, protocol development)
- Other strategically significant contributions

Properly Valuing the Services to be Provided

… and Linking It To Market

The performance metrics used to measure physician value and contribution should then be linked (in some manner) with market data.

Options include:

- Published surveys of compensation and productivity
- Customized market surveys/reports
- Other professional organization data/surveys
- Other proprietary data