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NEWS & INSIGHTS ON HEALTHCARE REFORM

A Fresh Look at Physician Employment by Hospitals

CONTACT »

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Last week, Anthem announced it reached terms to acquire rival Cigna in a $54 billion acquisition. And in tandem, Aetna is pursuing Humana in a $37 billion transaction. Combined with United, the Big Three will have 2015 premium revenue of $386 billion and cover 122.5 million American enrollees. That's 40% of total premiums and 45% of the insured population including those with private, Medicare, Medicaid, and military health coverage. Wow.

No wonder physicians are seeking security in hospital employed medical groups, and hospitals are consolidating to achieve scale. It's healthcare's version of Darwinism—the survival of the fittest requires adaptation.

Per Medscape's 2014 analysis, physicians are adapting by becoming hospital employees in growing numbers due to the increasingly uncertain environment and burdensome administrative requirements in private practice. They're not naïve: they acknowledge they're trading autonomy for security, and in most cases, they're cognizant that their income may be less in time. Nonetheless, more than 200,000 physicians in the U.S. are now employees, and three in four medical residents will start their career as employees of a medical group, hospital or faculty plan.

This trend toward physician employment in hospitals is accelerating at a time when the stakes for hospitals are at an all-time high. The headwinds facing hospitals are gargantuan—declining margins in the inpatient business, increased complexity in patient populations, escalating medical inflation costs for technologies, labor, drugs and supplies, increased competition from niche players carving away profitable service lines, heightened regulatory scrutiny around fraud and more. Add physician employment to the mix.

Here's the challenge for hospitals: employing physicians is not a slam dunk, even if the market is benign about shared risk arrangements with payers. Physicians want clinical autonomy whether employed or not. Physicians want the technologies and tools that are required to ply their trade and they expect them to help, not hinder their work. Physicians want to be heard on matters of consequence to the entire organization, not just clinical issues de jour. Physicians want to be "in the room," not outside looking in. Physicians want to be compensated for their experience and aptitude, not just their production. And they want to be aligned with a winning organization that's recognized for quality and well-positioned long term.

In tandem with the Healthcare Financial Management Association, we gathered impressions from the administrators of 44 hospital sponsored group practices to see how their marriage with

the hospital is working. Among items in the survey, we asked "what keeps you awake at night?" They're losing sleep over 3 concerns:

Operations: "We worry about how to operate the group efficiently as payments shift from volume to value, margins shrink, and costs for information technology and labor increase. It's a tough job, and it's a different job than running the hospital."

Compensation: "We worry about how to compensate doctors as the change from production to performance accelerates. Doctors like to "eat what they kill" and they expect to get paid well. Something's gotta give."

Recruitment: "We worry about how we will recruit new physicians to join the group and sustain its growth."

These concerns are understandable. And they also said the hospital is not addressing them as well as they desire.

According to B.E. Smith, the turnover rate for hospital CEOs is averaging nearly 20% annually. A contributing factor is physician relationships: they're tense even in the best of situations. But the risks for CEOs goes well beyond physician employment, medical staff development, credentialing, shared risk arrangements, accountable care organizations, clinically integrated networks and operating losses resulting from practice operating deficits. The biggest risk is failure to build a viable physician enterprise that's capable of competing on the basis of its demonstrated value—the best consumer experiences, the best prices, the best set of services and programs with the best outcomes.

The physician enterprise is substantially more than a collection of physicians who share a structure for participating in risk sharing arrangements with payers. It's a big tent inclusive of behavioral and physical medicine, pharmacists, dentists, optometrists, nutritionists and nurse practitioners who play active roles. It's the formal platform through which care coordination is managed and enterprise growth is leveraged. Its scope extends beyond third-party reimbursable services wherein retail and alternative health are key. And it's organized and governed as a winning team rather than as a collection of experts and departmental silos.

In the physician enterprise, physician employment plays a key role, but the enterprise is much more. It's incumbent, therefore, for hospital boards and management to contemplate answers to these questions if the intent is to win, not just survive:

- Why would a physician want to work for our hospital and join our physician enterprise? How are we positioned vis-a-vis value-based purchasing, avoidable readmissions, safety, outcomes and cost efficiency performance? Is our "reputation" and proximity the only thing we have going for us? And how many and what types of clinicians do we need?
- Do we have tools in place—the information systems, analytics, care coordination processes, post-acute and retail health partnerships, and appropriate positioning with employers and insurers to be a secure place of employment? And how will the physician enterprise deny entry by peers prone to unnecessary care associated with overuse?
- How well will our clinical enterprise integrate alternative health into our traditional allopathic models of care? How responsive is our enterprise to consumer demand for Curve 2 health that's person centered and evidence-based?
- Are our capital and operational decisions reflective of where the puck is going, or where it was? If the physician enterprise is central to sustainable growth, and capital is not unlimited, do our capital priorities reflect commitment to the physician enterprise over bricks and sticks in the hospital?
- How will our physicians be compensated as a key employee of the enterprise team? And how does our "package" compare to the options each physician has to work elsewhere, or for CVS, an employer, insurer, large independent medical group or the competing health system?
- How is governance and accountability structured in our physician enterprise? Are leaders trusted? And are physician leaders prepared to lead effectively?

The issue is not physician employment nor associated operating losses from practice operations. The performance, brand and positioning of the physician enterprise will likely rival or eclipse the reputation of the sponsoring hospital. That's why Darwin's 'survival of the fittest' premise circa 1869 is an apt metaphor for where we are in healthcare. The conjoining of physicians and hospitals is an adaptation to the reality that the future of medicine is not a repeat of its past and hospital employment only a part of the evolution to significant physician enterprises.

It's time we had adult conversations in healthcare about how physicians and hospitals can and should work together not for the purpose of creating barriers to change but to define it. Others

perhaps less sensitive to community and mission but more adept at bringing tools and approaches to health are employing physicians and building physician enterprises equipped for Curve 2.

Employing physicians is not an end in itself. It's a means toward building a physician enterprise that's scalable, impactful and the centerpiece of a hospital's transformation. Hospital leaders need to take a fresh look.

Paul

INDUSTRY PULSE

Louisiana health co-op shut down. Louisiana Health Cooperative Inc., a nonprofit health insurer created with a $65.8 million in federal funding under the Affordable Care Act is shutting its doors at the end of the year because of financial struggles. The Louisiana co-op is not alone in folding due to the accumulation of heavy losses. Iowa's CoOportunity Health was liquidated earlier this year. "They were created with the best of intentions to offer more competition and more options. More competition was needed because in many states, Blue Cross and Blue Shield affiliates have a monopoly on market share," Louisiana Insurance Commissioner Jim Donelon. *Timothy Boone, "Louisiana Health Cooperative discontinuing insurance operations after being created with federal funds under Obamacare," The Advocate, July 25, 2015*

High cost of cancer drugs targeted by oncologists. Leading cancer experts from across the country have outlined steps that will lower the rising cost of cancer drugs. "In Support of a Patient-Driven Initiative and Petition to Lower the High Price of Cancer Drugs" included in the Mayo Clinic Proceedings journal, was signed by 118 specialists. Among the steps noted to curb drug costs include creating a post-FDA drug approval review panel to assess the value of the drug and propose a fair price for the new treatment; and allowing Medicare to negotiate drug prices, which is currently not legal. *Lenny Bernstein, "Cancer experts call for curbs on rising drug prices," Washington Post, July 23, 2015*

"We're not against drug companies… We are saying there is a problem and the stakeholders have to change their practices." "The status quo is not going to work." Ayalew Tefferi, lead writer in the commentary and a professor of medicine and consultant in hematology at the Mayo Clinic in Rochester, Minn.

Related: States begin to take steps to curb oncology drug prices. State legislatures, in six states thus far, have introduced pharmaceutical cost transparency bills that would require drug companies to substantiate the cost of new drug treatments. "If a prescription drug demands an outrageous price tag, the public, insurers and federal, state and local governments should have access to the information that supposedly justifies the cost," says the preamble of a bill introduced in the New York State Senate in May. *Andrew Pollack, "Drug Prices Soar, Prompting Calls for Justification," New York Times, July 23, 2015*

Deals:

» Anthem to buy Cigna for $54.2 billion. The Anthem-Cigna deal would create the largest health insurer in the United States in terms of membership – covering about 53 million lives. The deal is expected to face "intense regulatory scrutiny." This mega-deal will "create a juggernaut with the ability to drive up premiums for policyholders and force hospitals into charging lower prices, but only in the limited markets where the pair are already the dominant insurers," according to industry experts. The deal announced Friday is valued at $54.2 billion including debt. Shareholders of Cigna, based in Bloomfield, Connecticut, will receive $103.40 per share in cash and 0.5152 shares of Anthem stock for each of their shares. The companies put the total value at $188 per share. *Tom Murphy; Michelle Chapman; and Matthew Perrone, "Mega-Health Deals Bloom in July, Anthem Bids $48B for Cigna," Associated Press, July 24, 2015*

Related: Hearings around Consolidation scheduled. The House and Senate Judiciary Committees will hold hearings in September on the Anthem-Cigna and Aetna-Humana mergers. Republicans and Democrats have expressed concerns. The Department of Justice has not commented on whether it will investigate either proposed merger for an antitrust violation. *Paul Demko, "Antitrust scrutiny likely for insurance mergers," PoliticoPro, July 24, 2015*

» Ascension to buy Capella hospitals. Ascension, has signed a definitive agreement with Capella Healthcare to take full ownership for four hospitals, previously owned through a joint venture between the entities since 2012. The four hospitals included in the deal are River Park Hospital in McMinnville, Highlands Medical Center in Sparta, DeKalb Community Hospital in Smithville and Stones River Hospital in Woodbury.

> The deal terms called for a $1 million renovation of Highlands, as well as investments in developing cardiac-care centers at three of the hospitals. Capella remained the majority partner, with Nashville-based St. Thomas holding an equity interest. *Eric Snyder, "Saint Thomas parent to buy out Capella's interest in several Middle Tennessee hospitals," Nashville Business Journal, July 24, 2015; and Beth Kutscher, "Ascension buys Capella out of mid-Tennessee joint venture," Modern Healthcare, July 24, 2015*

*Geisinger Community Medical Center v. U.S. Department of Health and Human Services et a*l. In a precedential ruling last week the Third Circuit panel majority found that the U.S. Department of Health and Human Services "cannot bar a Pennsylvania hospital from seeking a higher annual Medicare reimbursement by using its recently acquired geographic designation as leverage to be reclassified into a more desirable zone." According to the opinion, Geisinger successfully sought reclassification as a Section 401 rural hospital in 2014 as part of a larger bid to become associated with the Allentown-Bethlehem-Easton urban area, which would increase its annual Medicare reimbursement by $2.6 million. The majority panel disagreed with the lower court and HHS that the health system couldn't be reclassified for that area because it is located nearly 30 miles away from Scranton. *Alex Wolf, "3rd Circ. Invalidates HHS Medicare Zoning Policy," Law360, July 23, 2015*

Majority of people favor Medicare as is. Kaiser Family Foundation examined attitudes toward Medicare and Medicaid programs in a recent poll finding that "among Medicare changes the strongest support is for negotiating drug prices" and that "people with Medicare, Medicaid and employer plans give their coverage similar ratings," but some of the issues reported relate to affordability and access. A majority (70%) of respondents say that Medicare should continue to ensure all seniors get the same defined set of benefits, while much fewer (26%) say that the program should be changed to instead guarantee each senior a fixed contribution to the cost of their health insurance – a system known as premium support that has been proposed to address Medicare's long-term financing challenges. *"With Medicare and Medicaid Getting High Marks from the Public and Beneficiaries, Majorities Favor Status Quo over Major Structural Changes Such As Premium Supports or Block Grants," Kaiser Family Foundation Poll, July 17, 2015*

Nurses at Kaiser's LA hospital unionize. National Nurses United and the affiliated California Nurses Association won the rights to unionize nurses at Kaiser Permanente's flagship hospital in Los Angeles. The vote to unionize was won by almost 70%. The nurses will appoint a bargaining team who will hold contract talks with Kaiser. "We believe this election process was fair and we will respect the majority decision, as certified by the NLRB and we look forward to working with CNA to reach a fair and equitable contract…" John Nelson, Kaiser's vice president of government relations. *Adam Rubenfire, "NNU wins rights to unionize at Kaiser's L.A. Medical Center," Modern Healthcare, July 24, 2015*

Lawsuit against Aetna for limiting autism treatment. Aetna Inc. and a California affiliate were hit with a proposed class action in California federal court last week, alleging that the health insurance giant "wrongly caps benefits for the treatment of autism spectrum disorder, in violation of state and federal health laws." Anna M. Sanzone-Ortiz, who has employer-sponsored health insurance for herself and her family through Aetna Health of California Inc., says that her son's health provider recommended 36 hours per week of behavioral health therapy to treat his autism, but the company's policies limit the benefit to 20 hours per week. *Bonnie Eslinger, "Aetna Hit With Suit Over Cap On Autism Benefits," Law360, July 21, 2015*

Humana and Board accused of breaching fiduciary duty. A Humana Inc. investor filed a putative class action in Delaware Chancery Court last week "seeking to block the health insurer's proposed $37 billion acquisition by rival Aetna Inc., saying the deal undervalues Humana and underestimates the antitrust hurdles to come." The complaint alleges "Given Humana's recent stock price as well as its future growth prospects, the consideration stockholders will receive is inadequate and undervalues the company." *Linda Chiem, "Humana Hit With Investor Class Action Over $37B Aetna Deal," Law360, July 23, 2015*

GOVERNMENT PULSE

GAO Report: Ineligible providers in Medicare: The GAO report released last week examined the implementation of four enrollment screening procedures that the Centers for Medicare & Medicaid Services (CMS) uses to prevent and detect ineligible

or potentially fraudulent providers and suppliers from enrolling into its Provider Enrollment, Chain and Ownership System (PECOS). Findings:

» Two of CMS's procedures appear to be working to screen for providers and suppliers listed as deceased or excluded from participating in federal programs or health care–related programs.

» GAO identified the following weaknesses in the other two procedures: CMS's verification of provider practice location and physician licensure status. First, Medicare providers are required to submit the address of the actual practice location from which they offer services. GAO's examination of 2013 data found that about 23,400 of 105,234 (22%) of practice location addresses are potentially ineligible. Ex: a mailbox located within a UPS store that an applicant reported as a practice location, which CMS contractors inaccurately verified as an authentic practice location under CMS's new guidance, which allows contractors to use phone calls as the primary means for verifying provider addresses.

MEDICARE PROGRAM: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers GAO-15-762T: Published: Jul 22, 2015. Publicly Released: Jul 22, 2015

Christopher Weaver "Government Report Cites Shortfalls in Medicare's Screening Process for Doctors," Wall Street Journal, July 21, 2015

IRS: Individual mandate penalties: 7.5 million individuals paid fines totaling $1.5 billion for failing to obtain health care coverage in 2014, according to data released by the Internal Revenue Service last week. The average penalty was roughly $200, with 95% of those failing to obtain coverage paying a fine of less than $500. The ACA penalty last year was $95, or 1% of income, whichever was higher. Other findings:

» 12 million individuals, claimed an exemption instead of paying a fine for failing to obtain coverage such as the death of a spouse or loss of household utility service.

» Three quarters, simply checked a box indicating that they received health care coverage through their employer.

» 8 million individuals had to file forms indicating how much assistance they received toward paying for insurance coverage obtained through the exchanges. Of that group, roughly 3.2 million individuals have filed the tax form, accounting for roughly $10 billion in subsidies. That's nearly two thirds of the total amount paid out through the Obamacare exchanges in 2014.

» The average tax credit was approximately $3,400, according to the report.

Paul Demko, "IRS: Obamacare mandate fines totaled $1.5 billion"

Medicare Hospital Insurance Trust Fund Solvent thru 2030; Part B Premiums to Increase. The Boards of Trustees for Medicare released the 2015 Medicare Trustees Report, which annually details the Medicare financial operations and actuarial status, and concluded that the Medicare hospital insurance trust fund will remain solvent until 2030. That is the same projected date as last year and 13 years longer than the 2009 projection. Affordable Care Act reforms and an improving economy are credited with the stabilization, but the aging US population (Medicare gets 10,000 new beneficiaries a day due the Baby Boom Generation) and slowing the growth of health care costs remain challenges. In 2014 Medicare spent $613 billion for 53.8 million beneficiaries. The Trustees project Medicare spending to grow to 5.4 percent of GDP in 2035, up from 3.5 percent in 2014. Approximately 30 percent of Medicare Part B beneficiaries (17 million) will have monthly premiums increase from $104.90 to $159.30 (52 percent) in 2014 due rising healthcare costs and a premium formula which limits an increase for 70 percent of beneficiaries. The Social Security Administration could institute a change so that the Part B increase would be applied universally, but it is not likely. *Phil Galewitz, "Good News, Bad News In Medicare Trustees Report," Kaiser Health News, July 23, 2015*

Senators Push For Delay of Meaningful Use Stage 3. Senator Lamar Alexander, Chairman of the Senate Committee on Health, Education, Labor & Pensions, announced that the Committee intends to recommend that HHS delay implementation of Meaningful Use Stage 3. Under a March 2015 proposed rule, providers would have to attest to Stage 3 requirements in 2018 with voluntary participation in 2017. Sen. Alexander did not provide an alternative implementation date, but expressed concern with Stage 3's reliance on provider data exchange requirements and the lack of Stage 2 compliance. The Committee is also likely to recommend: standards clarifying that patients own their health

data, a greater need for interoperability, heightened security requirements for patient data, and more user-friendly EHR systems. *Virgil Dickson, "Senate panel will push HHS to delay Stage 3 MU rules," Modern Healthcare, July 23, 2015*

Negotiating Part D Prices Could Save $16 Billion Annually. A Carleton University professor and a researcher at Public Citizen released a paper concluding the government could save $15.2 – 16 billion annually if HHS negotiated Medicare Part D drug prices and obtained the prices paid by Medicaid or the Veterans Health Administration. By design Medicare does not negotiate Part D drug prices, but Part D plan sponsors receive rebates that theoretically are passed along to consumers through lower premiums. An OIG investigation concluded that 69% of plan sponsors neglected to include beneficiary rebates in 2008 bids. In 2013, Medicare spent $69.3 billion on Part D prescription drugs. *Ed Silverman, "U.S. Could Save up to $16B if Medicare Part D Prices are Negotiated: Paper," Wall Street Journal, July 23, 2015*

"Fast Track" Review for Section 1115 Waiver Medicaid Extensions CMS announced new "Fast Track" review process for Medicaid and CHIP section 1115 demonstration extensions. The streamlined process will include an easier State application, a more efficient federal review timeframe (comparable to a Medicaid 19115 waiver or state plan amendment review), and extensions will be for 5 years. To be eligible, states must: 1) have an established demonstration programs (at least one full extension cycle without substantial program changes); 2) be in compliance with reporting and have positive monitoring and evaluation results; 3) not be proposing major or complex changes; and 4) use the new extension template. In a pilot, CMS approved an 1115 extension for a Colorado waiver in 98 days. *Centers for Medicare and Medicaid Services, "Implementation of a "Fast Track" Federal Review Process for Section 1115 Medicaid and CHIP Demonstration Extensions," July 24, 2015*

ACA Repeal Effort by McConnell. Senate Majority Leader Mitch McConnell will offer an amendment to repeal the Affordable Care Act during ongoing efforts to pass a $47 billion Highway Trust Fund bill. The amendment is expected to fail since Republicans need 6 Democrats to support to reach the 60 vote threshold. ACA repeal was one of McConnell and other Republicans' 2014 campaign promises. Senator Cruz criticized McConnell of using the ACA repeal as a distraction from McConnell support for the reauthorization of the Export-Import Bank. *Dylan Scott, "McConnell Adds Obamacare Repeal to Highway-Bill Drama," National Journal, July 24, 2015*

HHS Encourages Scrutiny of Exchange Premium Increases. Kevin Counihan, the CEO of Healthcare.gov and Director of CMS' Center for Consumer Information & Insurance Oversight, sent a letter to every state and DC's insurance commissioner encouraging scrutiny of rate increase requests. The letter encouraged commissioners to consider several factors when approving rates: 1) Recent claims data show healthier consumers; 2) Recent data show a continued moderate medical cost trend; 3) CMS will use a one hundred percent coinsurance rate for the 2014 reinsurance program; 4) CMS remains committed to the risk corridor program; and 5) Public hearings are helpful. *Julie Rovner, "HHS Pushes States To Negotiate Lower Obamacare Rates," Kaiser Health News, July 22, 2015*

Contraception Accommodation to be Appealed to Supreme Court. Little Sisters of the Poor and four Oklahoma Christian colleges will ask the Supreme Court to hear their case contesting the process of requesting an exemption from the contraceptive coverage mandate. The organizations contend that that the third party will still provide contraceptive coverage to the organizations' employees, violating the organizations religious beliefs. Nonprofits in Pennsylvania, Texas, and Washington have made similar petitions to the Supreme Court. *Associated Press, "Colorado Nuns Appeal Birth Control Ruling to Supreme Court," New York Times, July 23, 2015*

Planned Parenthood's Funding in Jeopardy. After videos surfaced of Planned Parenthood representatives making controversial comments about selling fetal tissue, critics are asking Congress to suspend federal funding and ties. Planned Parenthood received $528.4 million (41% of total revenue) in 2014 from federal and state governments for family planning programs, serving Medicaid beneficiaries, and Exchange enrollment efforts. (Note there is a restriction on federal financing of abortions, except in limited cases.) Limits on federal funding for Planned Parenthood are likely to be raised during the FY 2016 appropriations process.

Louise Radnofsky and Kristina Peterson, "Planned Parenthood Federal Funds Challenged by Surreptitious Videos," Wall Street Journal, July 23, 2015

Contractor for Maryland's Failed Exchange to Repay $45 million. Nordian Healthcare Solutions, the prime contractor for Maryland's failed online health exchange, agreed to refund Maryland and the Federal government $45 million (61% of the total contract). $20 million will be paid upfront and then $5 million per year for five years. The settlement avoids a potentially lengthy litigation. Maryland continues to investigate claims against other contractors. *Josh Hicks, "Noridian to pay $45 million to state, U.S. government for flawed exchange," Washington Post, July 21, 2015*

VA Employee Indicted for Veteran Medical Record Falsification. Cathedral Henderson, a revenue and billing manager at a Georgia Veterans Affairs medical center, has been indicted on 50 counts of ordering his staff to falsify medical records of veterans waiting for medical care. It is alleged that Henderson ordered his staff to falsify the waiting patients' medical records to show that the veterans had either completed or refused services. This is the first criminal case resulting from the 2014 VA wait times scandal. If convicted, he faces a maximum sentence of five years in prison and a $250,000 fine. *Lisa Rein, "VA manager indicted on 50 counts of falsifying records of veterans waiting for medical care," Washington Post, July 20, 2015*

FACT FILE: HOSPITAL EMPLOYED PHYSICIANS

Special thanks to Juan Qian and Sydney Weis, Navigant Center for Healthcare Research and Policy Analysis

Prevalence of employment agreements in hospitals: Unknown. The data upon which a determination can be made is incomplete. An AHA report estimated 1186 hospitals use an integrated salary model with physicians, but it's unclear how many of these are contracts for hospital-based services only (i.e. radiology, anesthesia, intensivists, and others). And many employed physicians working in hospitals work for outsourcing companies like Team Health and others. *American Hospital Association, AHA Hospital Statistics 2014 Version*

Physician employment stats: Likewise, accurate statistics about the numbers and types of hospital employed physicians is difficult to find. Sources that quantify the total number of hospital-employed physicians vary widely. Data sources that comprise hospital-employed radiologists, anesthesiologists and pathologists ("RAP") in addition to other specialists, will report a larger total, whereas other sources report the physicians who are now employed by a hospital either as a result of leaving private practice or pursuing employment rather than enter the private sector.

In 2010 the total number of hospital-employed physicians reported was 212,418, a 34% increase compared with 158,057 in 2000. American Hospital Association. "AHA Hospital Statistics," Version 2012

"Although 55.1% of physicians are not employed or under contract with hospitals, the report reveals that 20.3% are covered by a group contract, 17.3% are directly employed, and 7.2% have individual contracts." *Alicia Caramenico, "Hospitals employing 32% more physicians," FierceHealthcare, January 9, 2012*

The number of hospital-employed primary care physicians increased from 10% in 2012 to 20% in 2014. And the number of primary care physicians with an ownership stake in a single-specialty practice decreased from 12% in 2012 to 7% in 2014. *Sheri Sorrell and Keith Jennings, "A Profile of Physicians' Practice Environments: 2014 Physician Outlook and Practice Trends," Jackson Healthcare, National Survey May 2014*

Between 2012 and 2013, hospital-employed physicians increased from 20 to 26%; 39% of physicians younger than 45 years of age have never worked in private practice. *"Filling the Void: 2013 Physician Outlook & Practice Trends," Jackson Healthcare, National Survey, May 2013*

Private practice vs employment: 63% of physicians are now employed vs 32% in private practice. Younger clinicians, especially women, are more inclined to be employed and older males less so. *Medscape Physician Compensation Report 2015 – interactive report*

Compensation: Employed specialists earn 21.6% less than their private counterparts ($329,000 vs. $258,000) and employed primary care clinicians earn 10.8% less ($212,000 vs $189,000). *Medscape Physician Compensation Report 2015*

Top 2 Reasons for hospital employment decision: Freedom from administrative burden (58%) and freedom from dealing with insurance companies (45%). *Medscape Physician Compensation Report 2015*

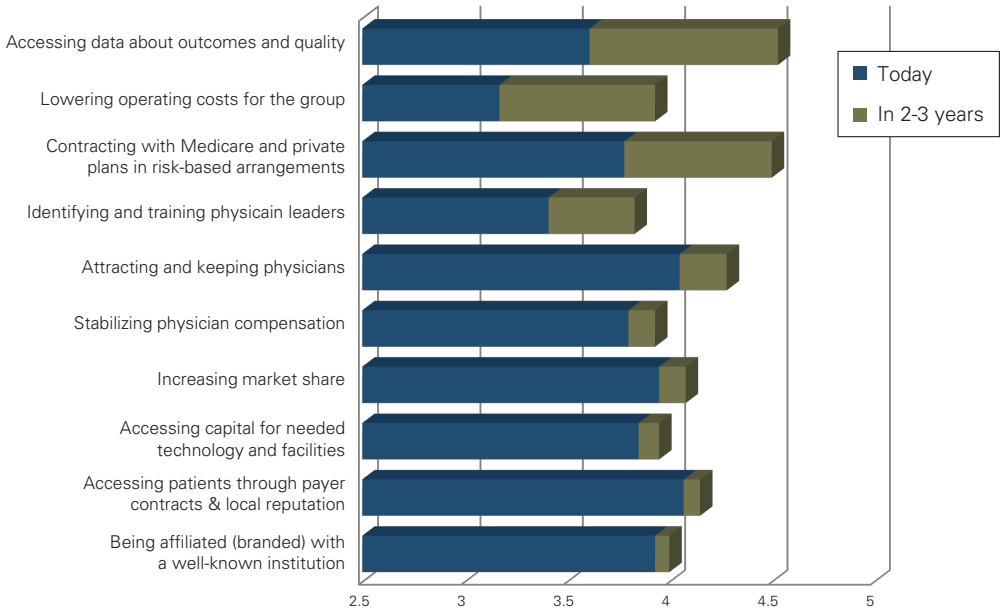
PHYSICIAN PARTICIPATION IN EMERGING MODELS:

	2011 (%)	2012 (%)	2013 (%)	2014 (%)
Concierge	1	2	3	3
Cash only	3	4	6	5
ACO Participation	3	16	24	30

Source: Medscape Physician Compensation Report 2015 - interactive report – http://www.medscape.com/features/slideshow/compensation/2015/public/overview#page=10

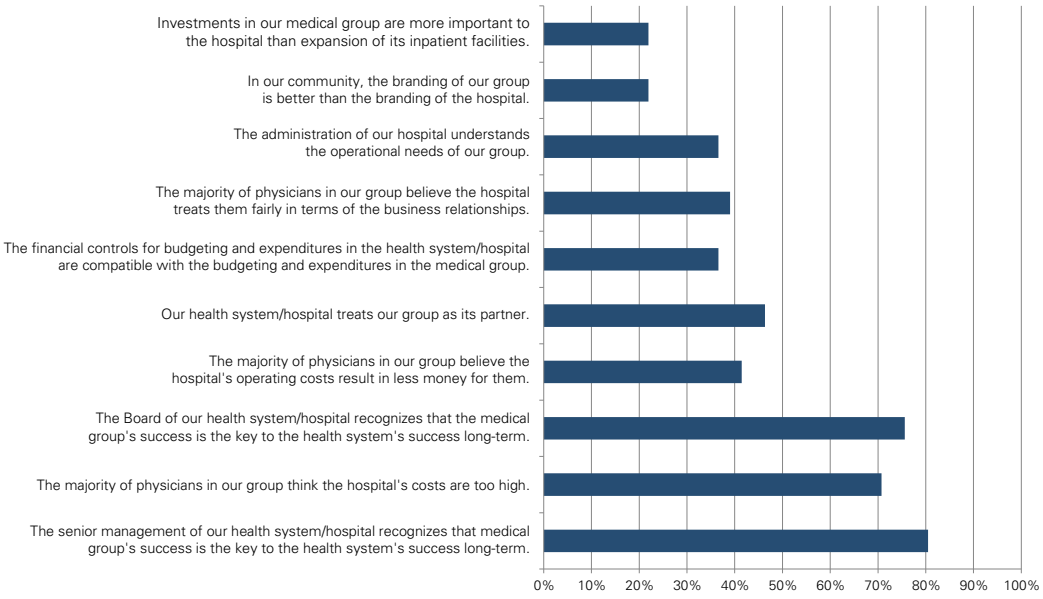
***Source**: Medscape Physician Compensation Report 2015 – interactive report*

Practice Administrator survey results: Relationship with Hospital/Health System Key Finding: CFOs find the relationship with the hospital/health system will be increasingly important for measuring quality and outcomes, lowering operating costs, and contracting in risk-based arrangements.



HFMA Survey Question:
How does your group see its relationship with the hospital TODAY, and how the group is likely to think of the affiliation in 2-3 years?

Key Finding: While medical groups are viewed as key to the long-term success of the health system, from the perspective of CFOs in medical groups, investments by the hospital/health system in the medical group are not the hospital's highest priority.



HFMA Survey Question:
Based on your experience as the financial leader of the medical group, indicate your level of agreement for each statement.

Sources: *HFMA – Navigant Center for Healthcare Research and Policy Analysis Survey of Hospital Sponsored Medical Financial Leaders (June 2015); Doug Smith, MBA, MHA & Christine Ricci, MBA, RN, "B. E. Smith White Paper – Healthcare Trends 2015"*

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