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Partnering With Orthopedists: Understanding the Options

The private physician practice business model is facing pressures, including reimbursement changes, increased practice expenses, movement toward accountable care organizations (ACOs), and the growth of hospital-employed physician networks. Until recently, primary care and hospital-based physicians comprised the vast majority of employment relationships. However, in the past few years, the employment of specialists from private practices has gained significant traction. Cardiology is the most obvious example, and, given the large volume and high reimbursement for technical components associated with orthopedic surgery, it is not surprising that many hospitals are pursuing employment of orthopedists. This Diagnostic *will discuss when employment relationships with orthopedic surgeons may be appropriate and when alternatives to employment should be considered in order to build strong, sustainable partnerships with independent orthopedists.*

KEY TAKEAWAYS:

- *Hospitals continue to employ specialists in ever-growing numbers, and orthopedic surgery remains a top employment priority for many hospital executives.*
- *The culture and economics of the orthopedic surgery practice, however, continue to favor independence, as surgeons' incomes are rising, ASC reimbursement is still favorable, and orthopedic surgeons are highly entrepreneurial and independent by nature.*
- *Hospital executives should strongly consider non-employment alternatives to provide the foundation for more integrated relationships in the long run.*

Culture and Economics Favor Independence

Physicians in any specialty will consider hospital employment if the combination of compensation, practice environment, lifestyle, and stability offered is attractive in comparison to their current situation. For cardiology, the dramatic differences between CMS payments

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for office- and hospital-based ancillaries are driving cardiologists into employment relationships in significant numbers. Orthopedists, on the other hand, are generally financially stable and continue to prize their autonomy and independence. It is important to understand the perspective and preferences of practicing orthopedists in order to determine the types of potential hospital relationships that might be feasible and appropriate. In general, the three critical factors for orthopedists are practice income, ambulatory surgery center (ASC) revenue, and independence.

Income

Even with generally flat Medicare reimbursement, orthopedic compensation has been steadily trending upward over the past 4 years. With median compensation now between $450,000 and $600,000, hospital employment is generally not viewed as a way to improve income for most orthopedists.

ORTHOPEDIC COMPENSATION TRENDS

MGMA Survey Data[1]					
Specialty - Median Compensation	2007	2008	2009	2010	Percentage Increase
Orthopedics - General	$446,303	$455,762	$473,770	$497,088	11.4%
Sports	$553,344	$570,503	$599,759	$583,443	5.4%
Hip and Joint	$548,863	$552,663	$564,139	$589,272	7.4%
ECG Proprietary Survey Data[2]					
Total Compensation	2007	2008	2009	2010	Percentage Increase
All Orthopedic Surgeons	$430,036	$440,049	$442,612	$453,562	5.5%

NOTE: Figures may not be exact due to rounding.

While private orthopedists are generally well compensated, some markets are oversupplied and/or have unfavorable reimbursement from payors. In these regions (San Diego is an example), orthopedists may be receptive to employment relationships that provide stable, competitive compensation. In addition, as orthopedic surgeons retire from practices with a buy-out provision as part of the ownership model, the remaining owners may look to selling the practice to a hospital rather than funding the cost of the buy-out.

ASC Revenue

Ownership of ASCs by orthopedists is widespread, and these profits contribute significantly to income. In recent years, the ASC reimbursement methodology from Medicare has changed to be targeted at a percent of Hospital Outpatient Departments (HOPDs) for the same procedure. While the ASC payment environment is difficult in most specialties, orthopedic ASC reimbursement has grown considerably, as shown with the sample of procedures in the table on page 3. While Medicare payments are still much larger for the same procedures when hospital-based, the orthopedist-owners of ASCs have enjoyed increases in profitability and most often see little reason to forgo that revenue stream by becoming hospital employees.

[1] Source: 2008 to 2011 MGMA *Physician Compensation and Production Surveys* (based on 2007 to 2010 data).
[2] Source: 2008 to 2011 ECG Management Consultants, Inc., *Provider Compensation, Production, and Benefits Surveys* (based on 2007 to 2010 data).

ORTHOPEDIC ASC REIMBURSEMENT TRENDS				
CPT Code	Description	2007 Rate	2008 Rate	2011 Rate
29827	Shoulder arthroscopy with rotator cuff repair	$717.00	$1,010.83	$2,303.84
29881	Knee arthroscopy with meniscectomy	$630.00	$770.31	$1,201.33
29888	ACL	$510.00	$855.58	$3,585.09
64721	Neuroplasty median nerve at carpal tunnel	$446.00	$521.34	$762.31

The future for orthopedic ASCs looks bright as more procedures shift from inpatient to outpatient and high-margin cases once performed only in the hospital (such as arthroscopies and ACL reconstructions) move to ASCs. Continued expansion of arthroscopic technologies and refinement of semi-invasive surgical techniques in specialties such as spine and total joint will further enhance ASC profitability.

However, not all orthopedists are benefiting from ASC profitability. Some are not invested in ASCs at all, and others may be partners in an ASC that is struggling or dominated by other surgical specialties with declining reimbursement, such as gastroenterology (GI) and urology. Further, as orthopedic subspecialization grows, inpatient-based orthopedic subspecialties (e.g., joints and spine) will likely explore closer alignment with hospitals, while outpatient-based specialties (e.g. hand, sports medicine) may prefer to continue with the private practice model. Understanding the ownership and profitability of ASCs in your market is important to determining the best potential relationship between the hospital and orthopedists.

Independence

Orthopedic surgeons are highly entrepreneurial and independent by nature and the vast majority of orthopedists remain in private practice. Orthopedics is not among the top 10 specialties currently employed by hospitals, yet 39 percent of surveyed healthcare organizations stated that they are planning to employ more orthopedic specialists in the next 12 to 36 months.[3] Discussions with orthopedists in different regions of the country and in groups of varying sizes generally reveal a high level of satisfaction with their private practice environment and current autonomy. While there is willingness to participate with hospitals in clinical coordination initiatives, hospital employment holds little interest for many orthopedists. In short, hospitals want to hire orthopedists, while orthopedists frequently see little benefit to hospital employment.

Alternatives to Employment

In the near term, the combination of increasing pay, expanding ASC profitability, and continuing preference for independence will likely limit the number of orthopedists nationally who are receptive to hospital employment, except in specific and unusual situations. Most often, hospitals' time and resources are better spent engaging with orthopedic surgeons in ways that respond to their current perceived needs and can build a foundation for more integrated structures (possibly employment) in the future.[4] Non-employment models that facilitate integration include:

ASC Acquisition

ASCs often represent a significant source of income, but orthopedists also recognize that margins are likely to fall as payment reform, decreased reimbursement, and higher costs reduce ASC profitability. Because of the payment differentials between hospital-based and freestanding facilities, the hospital may be able to offer an attractive price, as well as drive increased volume. Contracting for management and medical direction with the selling group can promote a positive and mutually supportive relationship. This option should not be ignored by the hospital, even if past interest in acquiring the ASC was rebuffed.

[3] "Physician Alignment in an Era of Change," HealthLeaders Media, September 2010.

[4] The most traditional way to align with orthopedists is by providing them a superlative clinical and operating experience in your ORs. For further details, see "Hitting Your Stride: Aligning With Surgeons to Develop Your Orthopedic Program," *Insight*, January 2009.

Innovative Recruitment/Physician Support Relationships

Orthopedic groups often want to add physicians but are increasingly nervous about the financial risks involved in a start-up. In addition to the usual recruitment support, one consideration involves hospital employment of a new orthopedist who would then be "assigned" to practice with the independent orthopedic group through a contract with the hospital. Unlike traditional start-up support such as loan forgiveness, this approach anchors the new practice to the sponsoring hospital and provides a mechanism for communicating and building trust with the group.

Bundled Payments/Joint Contracting

It is widely accepted that surgeons and hospitals will be sharing financial risk and participating in payment arrangements that require close collaboration/cooperation. Because they are concerned about the impact of such relationships, orthopedists are often interested in working with the hospital to design and negotiate shared payment contracts, as well as to participate in Medicare payment reform initiatives that will be implemented in the future. Creating an orthopedic joint-contracting task force can be a useful first step in evaluating the scenarios.

Shared Leadership Models

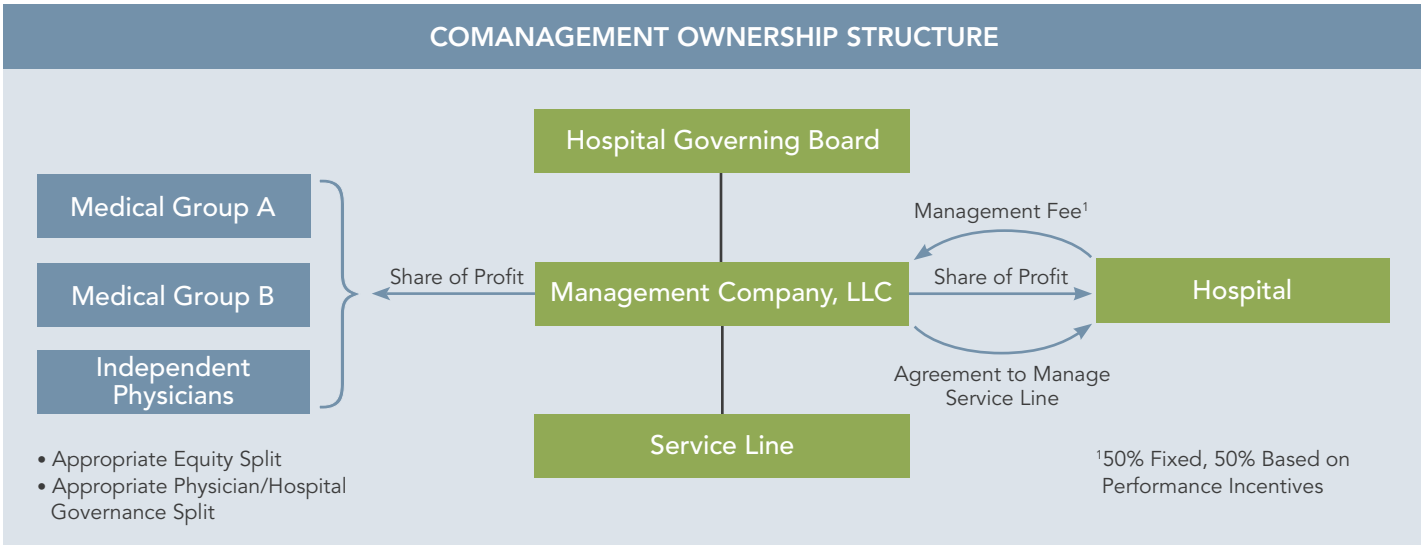
The critical component of any physician initiative is to substantively involve the physicians in the planning, operations, and governance of hospital-supported programs. Shared leadership goes a long way beyond the traditional advisory committees to unite physicians and hospital administration in common goals. In orthopedic services, there is a range of opportunities for shared leadership, including:

Service Line Comanagement

Orthopedic surgeon leadership for the delivery of musculoskeletal care can be established through a medical directorship and/or appointment in an administrative role as part of a physician/administrator dyad. Policy setting and operational coordination can be shared with an orthopedic operating group or similar construct. This is often an excellent starting point for building more integrated arrangements.

Service Line Comanagement and Ownership

A management company can be created to manage orthopedic services, with physicians and the hospital each holding a portion of ownership. A typical co-ownership structure is shown below.



Under this type of arrangement, a portion of the payments made to the management company are contingent upon meeting specific quality and efficiency measures. The shared economic incentives of co-ownership create very meaningful collaboration in all parts of the service line.

Formation of an Institute

The size, complexity, and internal politics of some orthopedic services make comanagement and/or co-ownership of the entire service line problematic. In these situations, it may be useful to consider the creation of institute models in specialty areas such as spine, sports medicine, and joint replacement. Management and ownership can be shared in the same manner as with co-ownership of the service line but would be limited to a discrete set of services, generally provided by a subset of the orthopedic medical staff. The institute model is consistent with the trend toward orthopedic subspecialization and can ensure interested and committed physician partners.

Professional Services Agreement

The PSA model is becoming more widespread in a variety of specialties. Under this model, an independent medical group sells its assets and assigns its revenues to a hospital and is paid on a dollar per RVU basis or similar mechanism for services rendered. The physicians and hospital benefit from tighter alignment and in many cases the arrangement is designed to increase physician compensation. Further, the physicians can maintain their independent medical group structure (including their own compensation plan). This approach allows for joint decision making on key issues of cost and clinical coordination without requiring the physicians to become employees of the hospital.

The common goals of non-employment affiliations in orthopedics are to facilitate physician involvement in lowering the costs of care, reducing readmissions, ensuring coordination among providers, and adhering to care protocols. The reality is that none of these goals can be reached without significant physician involvement and leadership.

Longer-Term Trends Will Facilitate Closer Affiliations

Orthopedic surgeons have enjoyed increasing compensation and have benefited from structural changes to ASC reimbursement. However, moving forward, reimbursement for professional and technical services is expected to flatten, and orthopedics will be challenged by many of the same issues faced by other specialties.

Pressures on the orthopedic status quo include the following:

- New insurance models are being designed, especially in spine services, to reduce surgical cases and drive down the cost of certain procedures. For example:
  - Physiatrists are being leveraged as the first line of treatment for patients with back pain.
  - Programs are expanding that keep nonoperative patients out of the surgeons' office and increase volumes to primary care, sports medicine, physiatry, and other specialties.
- Health reform initiatives and value-based payments will grow in importance.
  - Provider networks (ACOs) may direct patients to lowest-cost facilities and reduce ASC margins.
  - Orthopedists and hospitals will share more risk for overall cost of care and outcomes, increasing incentives for cooperative initiatives.
  - The likely bundled payment mandate in 2016 will require increased integration between orthopedic surgeons and other providers of musculoskeletal care.

Over time, these and other pressures will potentially reduce the growth in orthopedic compensation and create a more receptive environment for employment and other affiliation relationships.

The Bottom Line

We've made the case that independent orthopedists in most communities are doing well and are not especially interested in working for a hospital. Don't try to push this rock uphill by attempting to move forward with employment initiatives unless there is clear benefit to both the hospital and interested orthopedists. Our advice is to closely monitor changes in your market and start substantive conversations with independent orthopedists to build trusting relationships that can add value in the current climate and avoid a crisis mentality when market dynamics change. Engage orthopedists in a discussion of the rationale and options for closer affiliation with the hospital and be prepared to move ahead with those who align with at least some part of your vision. After demonstrating your commitment to sharing leadership and rewards with physicians, the opportunities for affiliation will expand rapidly.

About ECG

ECG offers a broad range of strategic, financial, operational, and technology-related consulting services to healthcare providers. As an industry leader, ECG is particularly known for providing specialized expertise regarding the complexities of the academic healthcare enterprise, strategic and business planning, specialty program development, and hospital/physician relationships.

To learn more about this *Diagnostic* and issues related to orthopedic employment relationships, please contact the authors listed below for additional information.

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