Physician Employment Losses: Alarming Trend or Misunderstood Performance Metric?

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I. Examination of net loss per FTE physician metrics for Hospital/IDS Owned physician practices as reported by the Medical Group Management Association (“MGMA”) cost survey

a. The net loss per FTE physician for multispecialty practices has increased 83% from 2008 to 2010; the prior 10 year increase was 25%

b. There is nearly a $450,000 gap in net income/loss per FTE physician performance between the 10th and 90th percentile performers for multispecialty practices

c. The Southern geographic section of MGMA survey data reported the highest number of employed practices and the highest net loss per FTE physician for multispecialty practices

d. In most cases, the smaller the number of FTE physicians in the physician practice group the higher the net loss per FTE physician

II. An industry look at physician employment trends

a. Should we be alarmed at these losses per physician or are they a misunderstood performance metric?

   i. The contributing factors most often blamed include physician productivity, physician compensation, system overhead and the transfer of ancillary services from inside the practice to an outside hospital-owned facility

b. Is this a repeat of the 1990’s?

   i. An inflation adjusted loss per FTE physician from 1998 (i.e., $83,000) would equate to a loss per FTE physician today of approximately $110,000

c. Is this a problem or predicament?

   i. Problem defined as “something we can solve”
   ii. Predicament defined as “something we cannot solve; we can only manage our response”
   iii. Leadership is critical and requires consideration of financial, operational, strategic and potentially legal matters

d. HealthLeaders Intelligence Report (September 2011) on Hospital/IDS owned employment trends highlighted several matters including:

   i. 70% of hospitals and health systems plan to employ a greater percentage of physicians in the next 12-36 months
   ii. The top five service lines considering physician employment included primary care, hospitalist medicine, general surgery, cardiology and orthopedics
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III. Physician practice ownership data based upon the last six years (i.e., 2005-2010) of respondents to the MGMA Cost Survey
   a. Hospital/IDS Owned: 53% in 2010, 21% in 2000
   b. Physician Owned: 42% in 2010, 76% in 2000

IV. Practice model characteristics are different as reported by the 2011 MGMA Cost Survey
   a. Hospital/IDS Owned practices reported having nearly 25 fewer FTE physicians in their group than Not Hospital/IDS Owned practices
   b. Hospital/IDS Owned reported having nearly half as many Non-Physician Provider FTEs in their group than Not Hospital/IDS Owned practices
   c. Hospital/IDS Owned reported having three times as many branch clinic locations in their group than Not Hospital/IDS Owned practices

V. Physician specialty mix does influence the Hospital/IDS Owned survey data for multispecialty practices as reported by the 2011 MGMA Physician Compensation and Production Survey
   a. 68% of physician responses for Hospital/IDS Owned practices include family practice, internal medicine, hospitalists, OB/GYN, pediatrics, cardiology, general surgery, and orthopedic surgery
   b. An examination of these eight (8) specialties shows wide variances in physician compensation as a percent of collections and net loss per FTE physician
   c. An examination of the multispecialty and certain single specialty practices data shows significant per FTE physician variances for medical revenue, operating cost and physician cost per work RVU between Hospital/IDS Owned and Not Hospital/IDS Owned practices. Total physician cost ranges from $6 to $22 per FTE physician higher for Hospital/IDS Owned practices; general surgery is the lone exception of the five single specialties examined in the survey data with a lower physician cost per work RVU for Hospital/IDS Owned practices

VI. Physician practice financial performance based upon MGMA data for Hospital/IDS Owned and Not Hospital/IDS Owned practices with revenue and operating cost growth across a 10-year period (i.e., 2000-2010)
   a. Revenue growth in Not Hospital/IDS Owned practices has outpaced Hospital/IDS Owned practices
   b. Operating costs per FTE physician appear to have trended up at a similar pace for both Hospital/IDS Owned and Not Hospital/IDS Owned practices, but as a percent of
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revenue have significantly worsened in recent years for Hospital/IDS Owned practices

c. The medical revenue gap between Hospital/IDS Owned and Not Hospital/IDS Owned practices is significant at $368,180 per FTE physician

d. Physician costs as a percent of total cost and medical revenue are much higher for Hospital/IDS Owned practices

VII. Analyzing procedural data from the 2011 MGMA Cost Survey for Hospital/IDS Owned and Not Hospital/IDS Owned practices (both inside and outside the practice) shows material differences

a. Ancillary service data (gross charge per physician and patient, and procedures per physician) for clinical lab/pathology and diagnostic radiology/imaging are significantly lower in Hospital/IDS Owned compared to Not Hospital/IDS Owned practices

b. Surgical (including anesthesia) and medical procedure data (gross charge per physician and patient, and procedures per physician) are higher outside the practice but lower inside the practice for Hospital/IDS Owned compared to Not Hospital/IDS Owned practices

VIII. Key financial performance metrics (e.g., A/R, net collection percentage, and overhead) and payer mix appear less favorable for Hospital/IDS Owned when compared to Not Hospital/IDS Owned practices; the gap is even wider when compared to better performing practices

IX. Preliminary focus areas to begin examination of Hospital/IDS Owned losses

a. Do you have an absolute understanding of the revenue, expense and physician compensation environment (both pre-and post-employment) of the employed physician practice(s)?

b. Can you adequately explain the performance variances in the employed physician practice specific to revenue, expense and physician compensation 1) pre- versus post-employment and 2) compared to other industry benchmarks?

c. What impact, if any, does the post-employment performance have on legal matters (e.g., FMV and commercial reasonableness)?

d. Are there other unintended consequences?

X. Mitigating the Debate

a. Identification of root causes will help an organization get focused on the “real” problems
b. It is important to educate board members and certain members of senior management with the purpose of minimizing finger pointing and its impact on the organization’s culture

c. It is important to have a well-established and disciplined physician practice integration process

d. The focus of physician integration initiatives should ultimately point toward return on investment (ROI) realization

e. It is important to understand the limitations of survey data; it is directional in nature but often not conclusive

f. Other observations
   i. Most significant variances are hospital-based and surgical specialties associated with core service lines
   ii. Physician shortages and transfer of practice-based services to the hospital facility will continue to strain compensation as a percent of revenue and total cost
   iii. Practice model differences (i.e., Hospital/IDS versus Physician-owned) complicate the ability to compare apples-to-apples performance in survey data

g. Do not neglect the importance of having a pre- versus post-employment financial analysis of the physician practice(s); the post-employment environment (i.e., Hospital/IDS Owned) will present variances that need to be appropriately categorized, defined and addressed. A common classification of these variances include the following three areas:
   i. Uncontrollable – system induced, often includes payer mix and other strategic decisions unique to the Hospital/IDS Owned environment such as outreach locations and coverage tactics that would otherwise not be utilized by a Physician Owned practice
   ii. Accounting – system induced, often includes the transfer of ancillary services and additional overhead expense allocations
   iii. Controllable – important financial areas of focus include revenue, billing and collections, A/R management, physician compensation and overhead

XI. Important action to be taken immediately by Hospital/IDS Owned practice leadership to mitigate the debate over “net loss per physician” includes the following:
   a. Focus on the “controllable” – this includes strategy, vision, culture and leadership, integration process, compensation, on boarding, revenue and expenses; these are
building blocks and all of these items matter to shift focus from problems to the maximizing the ROI of Hospital/IDS Owned practices

b. Design a disciplined integration process – this includes specific activity associated with the 1) pre-alignment, 2) on boarding, and 3) post alignment stages of physician integration

c. Educate the board – this includes discussing strategy, vision and culture, the “anatomy” of employed physician losses, current financial performance of the employed physician practices, the integration process and trip wires established to protect the organization from untenable losses in the future