Do Most Hospitals Benefit from Directly Employing Physicians?

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How can hospitals and health systems generate a return on their investment in their physician enterprises? According to the most recent figures, from the American Medical Association, over 25% of U.S. physicians practiced in groups wholly or partly owned by hospitals in 2016 and another 7% were direct hospital employees. Yet, according to the Medical Group Management Association, hospitals' multi-specialty physician groups lost almost $196,000 per employed physician.

As a result, some larger health systems' physician operations are generating nine-figure operating losses, which are major contributors to the deterioration in hospital earnings. It is time for hospitals or health systems to rethink their strategy for their physician enterprises.

Let's first revisit why independent physicians were receptive to becoming employees and why hospitals and health systems felt the need to hire them.

The surge in hospital employment of physicians predated Obamacare by at least six years, and had two key drivers. The first was independent baby-boomer physicians — particularly those in primary care — found themselves unable to recruit new partners. Newer physicians, heavily burdened by student debt, were not inclined either to take on entrepreneurial risk or the 60-hour work weeks independent practice entailed.

The second was cuts in Medicare payments for office-based imaging. Thanks to the Deficit Reduction Act of 2005, specialties such as cardiology, orthopedics, and medical oncology that relied on the revenue that imaging generated were hit hard. As a result, many found it advantageous to be employed by hospitals. Under Medicare rules, in addition to professional fees, hospitals can charge a Part B technical fee for their services and therefore can pay practitioners more than they could earn in private practice.

Then, beginning in 2009, the Obama administration's policies increased the exodus of physicians from private practices to health systems. The "meaningful use" provisions of the HITECH Act of 2009 provided both incentives and penalties for physicians to adopt electronic records, but hospitals and very corporate enterprises had more resources to comply with meaningful-use requirements.

The value-based-payment schemes created by the Affordable Care Act also markedly increased documentation requirements and, as a result, the overhead of practices, driving more physicians into hospital employment models.

There have been a number of reasons hospitals have been hiring physicians. Some, particularly those in rural areas, had no choice but to turn physicians into employees. Retiring independent physicians were leaving large gaps in care in their economically challenged communities. Consequently, hospitals

that did not step in to fill the gaps were in danger of closing.

Separately, some hospitals or systems sought to grab business from their competitors by acquiring physicians who hospitalized their patients at competing facilities. These physicians' inpatient and, particularly, outpatient imaging and laboratory volume generated additional revenues for the acquiring hospital or system.

A third apparent motivation was to corner the local physician market in order to obtain more favorable rates from health insurers. This seemed to have been a major rationale for St. Luke's Health Systems acquisition of Seltzer Medical Group, Idaho's largest independent, multi-specialty physician practice group, which led to an anti-trust action.

Yet another reason for making physicians employees was to position the organization for capitated, or value-based, payment. Hospitals believed that "salarying" physicians would help control clinical volumes and thus make it easier to perform in capitated contracts.

Finally, some hospital and system CEOs were tired of negotiating with local independent physician groups or national physician-staffing firms like MedNax and TeamHealth over incomes and coverage of the hospitals' 24/7 services such as the emergency department, the intensive care unit (ICU), and diagnostic services like radiology and pathology. Building an in-house staff of physicians seemed like an attractive alternative.

Many health systems have gotten into trouble because their strategic rationale for hiring physicians became a moving target. A hospital system we followed morphed from a ""grab market share" strategy to a "respond to competitive acquisitions" strategy to a "bailout" strategy for loyal independent physicians to a "increase bargaining power with payers" strategy to a "position for value-based care" strategy over a period of eight years. By the time it was done, it was the proud owner of a 700-plus physician group and losses of more than $100 million per year.

Hospitals lose money on their employed physicians because physicians' compensation plus practice expenses and corporate overhead significantly exceed the collections of practices. These direct losses are, to a degree, an artifact of accounting, because hospitals frequently do not attribute any bonus for meeting "value-based' contract targets, or incremental hospital surgical, imaging, and lab revenues to physician practice income.

However, even factoring in the accounting issues, much of the losses are attributable to "hosting," rather than managing, practices effectively. Many systems employing physicians have done so without developing a cohesive physician organization and lack standardized staffing and operational support functions, such as effective purchasing and supply chain operations, effective scheduling systems, and centralized office locations.

Managing up the return, rather than managing down the loss, is the key to a successful physician strategy. Here's how to do that.

Establish a clear strategic goal and a target return on investment. Physicians reside at the core of any successful health system. Yet as the Cheshire Cat said in *Alice in Wonderland*, "If you don't care where you are going, then it doesn't matter which way you go!" If you establish strategic goals for the physician enterprise, then the physician organization can be sized and located appropriately. As a result, the physician group may end up either a lot smaller or with a more defensible specialty and/or geographic distribution. Management should then quantify and budget the expected return on the practice's operational loss.

Strengthen operations. Effective management of the physician group then becomes the essential challenge. For example, revenue-cycle issues such as inconsistent coding or missing data often damage the profitability of the medical group. Are systems in place to assure that medical bills are defensible and correct, and that patients understand what they owe and agree to pay? Seeing that encounters are adequately documented and translated into a fair and timely bill that patients are willing to pay is not rocket science. The

return on investment for getting the revenue cycle right is often 3X to 5X.

Revamp compensation and incentives. Medicare's policy for paying employed physicians will likely come under fresh scrutiny during the Trump administration. It is possible that Medicare's relatively favorable payment for hospital-employed physicians will be reined in. If that happens, it might require a painful revisiting of employment contracts when they come up for renewal.

Performance incentives in those contracts should also match the strategic goals established above. For example, compensating physicians through a production-based model that encourages them to increase visits, procedures, or hospital admissions, while value-based insurance contracts (like those for accountable care organizations) demand reducing them could damage the overall performance of the health system.

Pursue reality-based contracts with insurers. The Affordable Care Act ushered in a profusion of narrow network, performance-based contracts with private insurers, with significant front-end rate concessions by hospitals. These discounts often far exceeded the potential rewards from the "value based" incentives in the contracts! Larger health systems also rushed to assemble "clinically integrated networks" (CINs), comprising their employed and contracted physicians as well as private practitioners in their markets, to participate in these new contracts. Treating physician group losses and CIN expenses as loss leaders for value-based contracts and then losing *yet more money* on those contracts, as is happening in many places, doesn't make sense.

Both enrollment and financial performance under these contracts have been disappointing in most markets. Reviewing and pruning back these contracts, or renegotiating them to provide more adequate rates or to compensate hospitals for patient non-payment is an essential element of an effective physician-enterprise strategy. Hospitals and health systems also should ask: "Is the CIN functioning as intended? Is it adding value that patients notice or

is it just an additional layer of administrative expense without compensating benefits for clinicians or patients?

Motivate employed and independent physicians. Finally, hospitals and systems must understand the value they are creating not only for their employed clinical workforce but also for the two-thirds of their physicians who are not full-time employees — those who are contracted, independent participants in CIN's or in part-time administrative roles. What would motivate all these physicians to want to work with the organization over the long term?

Hospital and systems need a unified physician strategy and operating model that encompasses all these diverse arrangements. Beyond that, they must engage their physicians in planning and organizing care. Physician are complex, highly trained professionals. They cannot be mere employees; they must be owners of the organization's goals and strategies.