

FEATURE STORY

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doing the math on physician employment

Conventional wisdom says that hospitals lose money on physician employment.

AT A GLANCE

- > When assessing the costs and benefits of a physician employment strategy, it's important to consider not only the direct costs and benefits of the strategy, but also its indirect benefits, such as increased revenue as a result of eliminating admission-splitting by employed physicians.
- > The indirect risks of physician employment, such as eliminating independent physicians, can be minimized by adjusting timing to match the market's physician employment stage.
- > The strategy will work if the combined direct and indirect benefits are significant enough to outweigh the direct costs.

It's not uncommon for hospitals to report losing \$50,000 to \$80,000 per physician as a result of an employment strategy. These figures may be accurate—as far as they go. But they fail to consider many of the true costs and benefits of a physician employment program.

To understand the mathematics of physician employment, a broader perspective is necessary. An accurate financial evaluation of physician employment must take both visible and hidden factors into account. The challenge is to identify the hidden costs and benefits and be able to quantify them. As an example of how to proceed, let's first examine the costs and benefits of physician employment, both visible and hidden, and assign values to those costs that are more or less typical for the average hospital. We can then “do the math” on a sample hospital's significant employment strategy involving the potential employment of 100 physicians.

Looking Beyond Practice Losses

When hospitals talk about losing money on physician practices, they are usually talking about professional revenues netted against the direct costs of the practices—operating costs, physician compensation, and the amortization of acquisition-related costs. There are also fewer direct potential sources of loss, as indicated in the exhibit on page 11. But as the exhibit also shows, there are considerable benefits not usually considered when discussing physician employment.

Direct benefits include avoiding or reducing several kinds of payments being made to independent physicians to provide services and align their interests with the hospitals. Indirect benefits include increased revenue as a result of eliminating admission-splitting by employed physicians and possibly reducing competition for ancillary services. The hospital also gains the opportunity to optimize revenue and control its costs by controlling physician practice and referral patterns. Employing physicians also makes it easier for the hospital to coordinate care and manage quality.

Note that to realize these indirect benefits, compensation models for employed physicians must provide the right incentives while being consistent with regulatory requirements. Although employed physician compensation is not scrutinized to the same degree as payments to independently practicing physicians, which must be at fair market value, such compensation must still be at reasonable levels.

Assuming that your compensation of employed physicians would be at appropriate levels, there remain two important considerations in weighing the relative indirect costs and benefits of a physician employment strategy versus maintaining an independent medical staff: Understanding the actual costs of your independent medical staff, and recognizing the importance of market timing.

Understand your actual costs. Hospital executives often discuss losses on their physician practices as if there were no cost to maintaining an independent medical staff. In fact, there are usually significant costs, and it is crucial to understand

COSTS AND BENEFITS OF PHYSICIAN EMPLOYMENT		
Direct	<p>Costs</p> <ul style="list-style-type: none"> Costs of management infrastructure Amortization of good will (a cost included in fewer practice acquisitions lately) Net result: Absorb operating loss on physician enterprise 	<p>Benefits</p> <ul style="list-style-type: none"> Reduced payments to independent physicians for: <ul style="list-style-type: none"> - Medical directorships - On-call coverage - Other practice subsidies
Indirect	<ul style="list-style-type: none"> Productivity and profitability loss if compensation arrangement is poorly designed Potential alienation of independent medical staff (physician concern that “the hospital is competing with me”) 	<ul style="list-style-type: none"> Revenue from all admissions by employed physicians (no splitting) Fewer pressures to purchase unnecessary equipment Additional hospital revenue due to reduced competition from independent physicians for ancillary and other services Better physician engagement in: <ul style="list-style-type: none"> - Cost control - Patient care quality - Care coordination

what they are in order to grasp the relative costs of physician employment. To understand the economics of a large physician employment strategy, we will perform a rudimentary analysis of the direct costs associated with a single physician in private practice compared with the direct costs if the same physician were employed. In calculation A on page III, we assume that the hospital’s average annual supplemental payments to a single physician in independent practice for on-call coverage and medical directorships would amount to \$30,000.^a If we assume that the operating loss incurred from employing the same physician is \$60,000, the true direct cost of employing the physician would be \$60,000 minus \$30,000, or \$30,000.

The question then becomes whether this \$30,000 in direct cost is covered by indirect benefits from employing physicians.

Know the importance of market timing. Note that the calculation above did not include among the

a. Note: The figures provided in this analysis are primarily for illustrative purposes, although they do reflect the reasonable experience of many hospitals. Actual amounts will vary for each hospital, and will need to be identified through an analysis that takes into account the organization’s unique circumstances.

indirect costs of physician employment the danger of alienating independent physicians due to perceived competition with them. That is because those indirect costs can be minimized by adjusting your employment strategy and timing to match the physician employment stage of your market, as indicated by the exhibit on page IV.

In many healthcare markets, there is movement from a stage in which there is virtually no physician employment, to a stage where many or most physicians are employed. Movement to the latter market stage is occurring more rapidly in some markets than in others. The speed of progression will influence the number and type of physicians you may want to employ, and will be an important factor in determining your near-term cost of employing physicians. Physician “stress” will be greater and progression more rapid when there are strong payers in the market and independent physicians must accept “take-it-or-leave-it” contracts with those payers. Under such conditions, independent physicians are more likely to seek employment, with its promise of more reliable income.

Quantifying Indirect Benefits

To illustrate the estimation of indirect benefits,

CALCULATION A: A COMPARISON OF DIRECT COSTS OF INDEPENDENT PRACTICE VERSUS EMPLOYMENT

	Independent Medical Staff	Employment
Professional billings*	\$450,000	\$500,000
Ancillary services provided in practice	\$40,000	
Practice operations†	<u>\$(320,000)</u>	<u>\$(350,000)</u>
Practice proceeds for physician compensation	\$170,000	\$150,000
Hospital supplemental payments		
On-call coverage	\$20,000	
AS&T/medical directorship	\$10,000	
Hospital loss on employed physician		<u>\$60,000</u>
Total physician compensation	<u>\$200,000</u>	<u>\$210,000</u>

*Better payer contracts may yield more revenue under an employment model.

†Stronger practice infrastructure often results in more costs under employment model.

we will use the example of the hypothetical Hospital ABC, profiled in the remainder of this article. Let us assume that this hospital is in a market where physician employment has become well accepted, but the hospital has not yet employed any significant number of physicians and is looking at the potential costs and benefits of developing a network of employed physicians. Let's also assume that ABC's basic financial profile is as follows:

Inpatient revenue	\$100 million
Outpatient/ancillary revenue	<u>\$110 million</u>
Total revenue	<u>\$210 million</u>
Expenses	<u>\$205 million</u>
Net income	\$5 million

Further, let's assume, as noted previously, that ABC is interested in potentially employing 100 physicians.

This analysis can be adapted if you already have some employed physicians and are considering expanding your existing physician network.

Retaining outpatient and ancillary revenue.

Physician employment eliminates competition between a hospital and the employed physicians for outpatient and ancillary services. Although an independent medical staff may compete with the hospital by developing its own services or referring to facilities that compete with the hospital, an employed staff will be expected to use hospital services.

In calculation A, the independent practice generated \$40,000 in ancillary testing revenue. Under employment, this volume and revenue would shift to the hospital. Calculation B below illustrates this result under our scenario involving ABC Hospital. Physician employment can yield ancillary services revenue with a significant positive impact on the hospital's bottom line. Depending on individual market circumstances, this positive impact may result from new volume and revenue as employed physicians change ancillary service providers, or from avoiding future diversion of hospital volume by independent physicians.

CALCULATION B: ESTIMATING RETAINED ANCILLARY SERVICE REVENUE

Total hospital outpatient and ancillary revenue	\$110 million
Estimated proportion of ancillary service revenue at risk of shifting to competitors or available for redirection	20%
Outpatient ancillary service revenue at risk or available	\$22 million
Estimated contribution margin of these services	40%
Estimated contribution to margin from retaining outpatient and ancillary services	\$8.8 million

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PHYSICIAN EMPLOYMENT STAGES AND STRATEGIC CONSIDERATIONS		
Market Stage	Characteristics	Strategic Considerations
Virtually no employment	Independent medical staffs will punish any hospital that makes the first move to “compete” with them.	<p>Must be willing to accept that initial physician employment efforts may result in some loss of admissions.</p> <p>Hospitals primarily align with physicians through contractual relationships (e.g., on-call coverage, medical directorships, joint ventures).</p>
Some employment	<p>Hospitals have begun to employ physicians, but independent medical staff still dominates the market.</p> <p>Hospitals are still deferential in how/where they employ physicians to avoid alienating independent physicians.</p>	<p>Hospitals should employ primarily physicians who:</p> <ul style="list-style-type: none"> > Were previously independent and sought employment by the hospital > Are hired to locate in areas where they would not compete with independent medical staff <p>In addition to employment, hospitals continue to align with independent physicians through various contractual relationships.</p>
Significant employment	<p>Hospitals employ a significant proportion of physicians, and hospital employment of physicians is accepted as one approach to practice.</p> <p>Independent physicians with established practices may be relatively secure in independent practice.</p> <p>Most new physicians are hired by the hospitals.</p>	Hospitals need to invest in strong practice management infrastructure and develop effective compensation models.
Virtually complete employment	<p>Virtually all primary care and many specialist physicians are employed.</p> <p>Orthopedists and some other specialists are often an independent exception to the employment model.</p>	<p>Compensation design and governance of physician enterprise are key to success.</p> <p>Hospitals focus on engaging physicians in strategy development and clinical leadership.</p>

A large employed physician network may also deter those specialists who remain independent from developing their own competitive facilities, such as an ambulatory surgery center or even a surgical specialty hospital. When primary care physicians are employed and referral relationships are tight, independent specialists may conclude that it is better to be in the referral loop and avoid the loss of referrals. In weighing the potential gains in investment income from a venture against the risk of losing their bread and butter professional revenues, many independent specialists will avoid the venture.

When a hospital also employs some specialists, the message is even stronger, as employed specialists are a viable alternative recipient of referrals from

employed primary care physicians. However, directing referrals by employed primary care physicians to employed or loyal specialists must be carefully evaluated for regulatory compliance.

Increasing inpatient revenue. There are several ways in which developing an integrated network of employed physicians can have a beneficial financial impact on the hospital. The most obvious way is through increasing admissions by employed physicians who previously split their admissions between two hospitals. In early-stage markets, this effect may be somewhat limited, as physicians seeking employment by a hospital are often those who already admit a significant portion of their patients to the hospital at which they are seeking employment.

CALCULATION C: FINANCIAL IMPACT OF ADDITIONAL INPATIENT VOLUME

Inpatient revenues	\$100 million
Estimated increase in inpatient volume by increasing the proportion of referrals directed to loyal physicians	10%
Increase in revenues	\$10 million
Estimated contribution margin of these services	30%
Estimated contribution to margin by keeping referrals within an integrated system of care	\$3 million

CALCULATION D: FINANCIAL IMPACT OF COST CONTROL BENEFITS FROM PHYSICIAN EMPLOYMENT

Inpatient revenue (assumes cost control efforts would focus on inpatient care)	\$100 million
Percentage savings achievable with physicians engaged in managing costs	2%
Potential cost control value of employing physicians	\$2 million

CALCULATION E: FINANCIAL IMPACT OF IMPROVED QUALITY MANAGEMENT FROM PHYSICIAN EMPLOYMENT

Revenue associated with contracts that include a quality incentive	\$80 million
Payment incentive if quality targets are achieved	2%
Additional potential funds received if incentive quality targets are met	\$1.6 million
Percentage improvement in performance that can be expected with employed physicians	50%
Potential quality management value of employing physicians	\$0.8 million

In addition, with some encouragement and facilitation by the hospital, primary care physicians who previously split their referrals among specialists at different hospitals may concentrate them to a much greater extent once they become employed. (Note that a hospital must be sure that its efforts to influence the referral choices of employed physicians do not raise regulatory issues regarding patient choice.) Both this effect and the effect of reduced splitting of admissions have the potential to generate new volume and revenues. However, any anticipated increase in volume must be netted against any anticipated reductions from remaining independent physicians.

Sometimes, employment of physicians defends against a future shift of patients to a competing hospital. Calculation C above is conservative in that it considers only the increase in volume, not the avoidance of a decrease.

Controlling costs. Controlling operating costs is increasingly important, and remains difficult without physician engagement. Approaches considered with independent medical staffs suffer from physician apathy or raise complex regulatory concerns

(e.g., gainsharing). When physicians are employed by the hospital, they focus more readily on hospital cost management efforts relating to support staffing, supply chain, and patient length of stay. These reductions in operating costs go straight to the bottom line, as indicated in Calculation D above.

Improving quality and reporting transparency.

Quality measurement and public reporting continue to gain in strategic importance. A network of employed physicians can both actively participate in development of evidence-based guidelines and be directly encouraged and given incentives to implement these and other quality measures. These activities can result in a top line revenue benefit that drops straight to the bottom line for hospitals with employed physicians, in markets with contractual quality incentives, as shown in calculation E above.

Improving care coordination. A physician employment strategy combined with the use of an integrated electronic medical record, provides a foundation for improving outcomes through enhanced coordination of care between providers. As payment methodologies shift to value-based

SUMMARY CALCULATION: ESTIMATED BOTTOM LINE IMPACT OF 100-PHYSICIAN NETWORK FOR HOSPITAL ABC

	Annual Bottom-Line Impact
Savings from elimination of payments to independent medical staff for on-call coverage, medical directorships, etc.	\$3 million
Retaining ancillary service revenue	\$8.8 million
Additional inpatient volume	\$3 million
Cost control	\$2 million
Quality management	\$1 million
Total benefits	\$17.8 million
Estimated direct loss on physician network	\$(6 million)
Net gain/(loss) on physician network strategy	\$11.8 million

purchasing with penalties for avoidable waste, these strengthened capabilities for coordinated care will provide financial benefits that go beyond those from contractual rewards for quality of care. When these opportunities develop, they can be accounted for with the same methodology as used above for estimating quality improvement payments.

The Complete Picture

Heavy losses on physician practices are like the old Henny Youngman joke:

A bum came up to me saying, "I haven't eaten in two days!" I said, "You should force yourself!"

When hospitals say they are "losing money" on their physician practices, they are missing part of the picture. In particular, they are usually not accounting for all of the benefits they derive from physician employment. These benefits often land in other parts of the hospital's financial reports. And some benefits, such as deterring the loss of revenue, do not appear at all—yet they still have value.

Physician employment strategies work when the direct and indirect benefits, taken together, are significant enough to outweigh the direct costs. Timing is critical, as a hospital that acts before the market is ready will be punished by independent physicians who will align with a competing hospital or hospitals. Hospitals that act too late may see their market position eroded by competitors.

Hospitals that pursue a physician employment strategy can save money on payments for services

such as on-call coverage, and can tap into indirect benefits such as improved cost control and quality and preempted competition for ancillary services and surgical services by independent members of the medical staff.

In our example, with a committed physician employment strategy in a market where such a strategy is possible, the financial benefits will more than make up for the costs. These costs and benefits are depicted in the summary calculation above. The only way to understand the full picture for your own organization is to do the math. ●

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