Why most health systems lose money on medical practices

Steps to slow down the flow of red ink

Medical groups owned by physicians break even or experience a small profit in most years. So why do most integrated delivery systems (IDSs) report losses on the physician practices they own?

Do thousands of physicians across the nation slack off once employed by health systems? Or is nearly every health system in the nation too inept at managing those practices to break even?

Before pointing fingers at each other, IDS leaders and physicians would be wise to take a closer look at the several factors that may lurk behind the red ink.

The Medical Group Management Association (MGMA) Cost Surveys in recent years indicate that hospitals and health systems lose about $65,000 per full-time physician each year. For a system with 150 physicians, that’s a hefty $9.75 million in red ink each year.

Much of the money integrated delivery systems lose on their physician practices can be traced to the effects of a change in one more of the following areas:

- Ownership
- Accounting systems
- Goals and objectives

Losses due to ownership change

A change in ownership from an independent to a system-owned practice can produce financial loss due to changes in:

- Revenue or cash flow. Operational costs (including physician and staff compensation) are credited to the acquired practice from day one but collections may be delayed or depressed for months. Often times, physicians practicing under a new tax ID number must be recredentialed and a new revenue cycle initiated. The transition to a new practice management system also can slow cash flow. MGMA survey results indicate that first-year losses after a hospital purchase can reach to $100,000 or more per physician. Hospitals and health systems often take over the billing operations which can decrease the efficiency and effectiveness of the revenue cycle.

- Staff salaries and benefits. Many physicians joining an IDS want to keep key support staff. Staff payroll is the largest cost category in most medical practices (25 to 30 percent of gross income). While private practices tend to have more staff per FTE physician (to support their higher physician productivity), they also pay those staff less overall than do hospital systems. Bringing these staff up to the hospital system’s typically higher salary levels and richer benefits packages can increase overhead substantially—a cost that will be credited to the acquired practice year after year.

- Amortization of practice purchase cost. The days of sumptuous up-front cash for goodwill in practice purchases are over but acquiring a new medical practice still represents a cost on the IDSs’ financial statements that is usually charged back to the acquired unit.

Losses due to accounting system changes

Hospital accounting systems may or may not recognize (add or subtract) revenue and cost items of the medical practice such as:

- Ancillary revenue. Gross revenue attributed to imaging, lab and other departments may range anywhere from $50,000 per physician in smaller primary care practices up to more than $300,000 for multispecialty practices. This revenue, adjusted for collections and assignment of direct and indirect cost, may contribute as much as $100,000 per physician or as little as $20,000 in the case of smaller primary care practices that have only basic radiology and laboratory services. An independent practice’s financials would typically include revenue
from ancillary services and distribute it to the physician owners. In the integrated system neither the practice nor individual physicians typically receive full credit on financial statements for ancillary revenue—it becomes ‘down-stream’ revenue.

- **Indirect overhead allocation.** In most systems, general and administrative (indirect overhead), or G&A, is by policy charged to practice departments including ancillaries. This category of overhead usually includes several expense items not found in a private practice, such as compensation for the system’s chief executive officer and chief financial officer, human resources management, central executive office expenses, system purchasing, and system information technology costs.

- **Staffing.** Compared to IDS practices, private practices tend to operate with fewer management and administrative staff (but more clinical support staff to boost physician productivity). Thus, an additional administrative G&A burden allocated by a hospital methodology can be anywhere from two to five percent of gross income even when little direct benefit is added to the practice itself. These additional costs further contribute to the stated ‘loss’ by the practice.

**Losses due to changes in objectives**

Sometimes, efforts to bring practices into closer alignment with the system’s long-range objectives may do little to improve the practice’s profitability. For example:

- **Committee and meeting obligations.** Hospitals tend to have more intensive meeting obligations, if only to keep the large organization on track with mission and goals. That extra hour or two per week of committee commitments chops into productive clinical time. Physicians may welcome compensation for that lost time, but ultimately that clinical production is gone.

- **Payer mix.** As mission-based organizations, integrated systems manage payer mixes less aggressively than do private practices. The reduced income may be about one percent according to MGMA’s Cost Survey, which translates into annual revenue reductions of $5,000 or more per physician.

- **Facilities.** A facility upgrade or relocation might help the system to maintain a consistent look and feel but it comes at a cost to the practice. Hospital construction costs are usually higher per square foot in comparison to private practice space. Facility upgrades do not always result in greater volume or higher charges per encounter.

- **Additional departments.** These additions tend to benefit the IDS in the long run but do little for the practice in the short run. For example, a system may decide to create a department to track quality performance measures. While admirable, the practice’s share of staffing such a department will add little to its bottom line right away, but it will definitely cost the practice a few thousand dollars more per year from day one.

- **Information technology.** Deploying an electronic medical record or a new practice management system will add to the medical practice’s cost basis on the financial statement.

**The solutions to the loss problem**

Understand exactly what is behind the red ink. Decide if it is merely a quirk of the accounting system, something that actually builds value, or an area that demands action. Ask if the loss is due to:

- **New billing systems?** If so, the IDS should consider that it has developed a new asset in its accounts receivable.

- **Staff salary levels?** Consider establishing separate wage and salary levels for the medical practices in the system if the corporate structure allows.

- **Physician behavior?** Measure performance against benchmarks such as dollars, patient/hospital encounters, surgical cases, or wRVUs (work units). Consider adding in other incentive measurements, especially ones that support the system’s mission and major objectives such as quality, patient satisfaction, access, cost control, and citizenship.

- **Governance disconnects?** Create organizational structures that represent physicians—especially the physician leaders of the medical groups—in IDS decision-making. Sincere efforts to gain buy-in and commitment from physicians help build trust. Give physicians the ability to make ground-level decisions in their practices to improve patient flow and other areas of practice performance.

- **Resource utilization?** Physicians can exercise control over utilization but may choose not to do so
if they have no input into decisions. Benchmarking and involvement in governance issues can help deflect the ‘us vs. them’ worldview.

**Recognize the impact**

Surveys may say otherwise, but most hospital-owned physician practices do generate more revenue than loss. The most significant area leading to this reversal of popular notions is in ancillary services, which represent a significant source of hospital system revenue. The *MGMA Cost Survey: 2007 Report Based on 2006 Data* shows that physician-owned multispecialty groups reported median total laboratory gross charges per FTE physician that were $68,057 more than charges in hospital-owned multispecialty groups; radiology gross charges per FTE physician were $83,820 greater.

If these services were diverted to the hospital’s ancillary services departments, these systems would receive more than $90,000 additional revenue per FTE physician — more than making up for the operational loss.

The fact is that the red ink from medical practice losses may not be as red as it seems.

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