Why hospital-owned medical groups lose money

In the mid-1990s, many hospital systems adopted strategic plans that included hiring physicians or purchasing medical groups to build vertically integrated delivery systems (IDSs) of providers and locations of care. This strategy worked well for many health systems, but others hemorrhaged money. By the end of the decade, monetary losses caused many IDSs to move from expanding services to “stopping the bleed” and divesting their providers.

Just like the fashion industry, healthcare goes through repeating cycles. And once again, many hospital systems are pursuing strategies to purchase physician practices and expand the size of their medical groups.

These systems continue to report operating losses. IDS-owned multispecialty medical groups lost $189,910 per full-time-equivalent (FTE) physician, according to the MGMA Cost Survey: 2011 Report Based on 2010 Data, which calculates a net profit or loss excluding operating subsidies. This loss compares with a reported median net profit of $3,376 per FTE physician for physician-owned medical groups.

The graph and chart provide a comprehensive view of practice financial performance. They show that while median total medical revenue per FTE physician for IDS-owned multispecialty groups was 74 percent of the $866,444 per FTE physician reported by physician-owned multispecialty groups, median total operating cost per FTE physician was 43 percent less. As a result, IDS-owned groups only had $140,430 median total medical revenue after operating cost per FTE physician to pay nonphysician provider and physician compensation and benefits. Since IDSs need to have competitive compensation packages for physicians, median total physician compensation and benefit cost per FTE physician is almost identical to the compensation of physicians who own practices, and the IDS-owned medical practices required a heavy subsidy.

After examining Cost Survey data, it is possible to speculate on the cause for this operational loss. The most obvious reason

**Relative performance of IDS*-owned and physician-owned multispecialty medical groups**

<table>
<thead>
<tr>
<th>Source: MGMA Cost Survey: 2011 Report Based on 2010 Data</th>
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<td>*Integrated delivery system</td>
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<td>**Full-time equivalent</td>
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- Median total medical revenue per FTE** physician |
- Median total operating cost per FTE physician |
- Median total physician compensation and benefit cost per FTE physician |
- Median total net profit or loss (excluding financial support) per FTE physician

**Data Mine**

Extracting wisdom from the numbers

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is the lower relative productivity for physicians who practice in IDS-owned multispecialty groups and report 5,647 median physician work resource-based relative value scale (RBRVS) RVUs per FTE physician, which is 29 percent less than doctors in physician-owned medical groups.

One of the lessons learned from the hospital system debacle in the 1990s was that hospitals needed to structure physician compensation on both market value and productivity. This strategy appears to have marginalized the difference in productivity, but other factors caused the 74 percent difference in practice revenue.

According to the chart, IDS-owned multispecialty practices have a different payer mix than physician-owned groups. The percentage of Medicare charges is approximately the same, but IDS-owned multispecialty groups have twice the percentage of Medicaid charges, five times the charity care and 10 percent less commercial insurance. These differences can be attributed to the patient mix of the practices’ parent healthcare systems, which often comprise the safety net for the under- and uninsured. As a result of the payer mix difference, IDSs are paid less for the same work done by independent physicians.

In addition to a payer mix that has lower reimbursement rates, IDS-owned practices are often part of health systems that use provider-based billing, which allows systems to bill facility fees to cover the costs of locations where procedures are performed, concurrent with reductions in doctor payment. The combined facility fee and reduced provider payment can be 20 percent more than the full RBRVS fee paid to private practice physicians, but doctors in the IDS group reflect substantially less revenue on their financial statements.

With lower revenue, similar operating costs and similar provider compensation, it is no surprise that IDS-owned medical practices require heavy subsidies from their parent organizations.

Given the factors noted here, it should come as no surprise that many health system-owned medical practices operate at a loss. While losses are generally unavoidable, they can be mitigated by good management. Stay tuned for more specifics about how this is done.

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