

Factors Contributing to Financial Losses Among Hospital-employed Physician Groups

Focus Paper

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As physicians increasingly have become directly employed by hospitals and health systems, so has the gap in profitability between private practices and hospital-employed physician groups. Among all medical groups, the operating loss per physician increased from 0% of net revenue in 2016 to 17.5% of net revenue (American Medical Group Association, 2018). Within integrated health systems, the losses were more dramatic. The median operating loss per physician employed by integrated health systems in 2017 was \$243,918, an increase of 15% over the 2016 median loss of \$211,961 per physician. However, private physician practices saw an increase in operating margins. Hospitals and health systems struggle with the financial performance of their employed physicians, and they often justify the weak financial performance with the downstream revenue generated by patient volume in the hospital, ancillary departments and referrals to affiliated physicians. But how do physicians and hospitals bridge the gap between the fundamental premises of independence and separatism that has existed for decades (Holm, 2000)? Medical practices are considered to be small cottage businesses, whereas hospitals are often seen as large, community-based industries. The objective of this paper is to explore the missteps hospital systems undertake in the recruitment, onboarding, management and operational controls of employed physicians that contribute to the weak financial performance of the hospital-employed physician groups, as compared to private practice physicians. Trends and reports from industry publications will be used to demonstrate the rising expenses of the hospital-employed medical groups, and their inability to produce the revenue required to offset the growing expenses of employed physicians. In order to reduce the widening gap between revenue and expenses, hospital systems that employ physicians should strengthen their operational monitoring and controls.

Employment Trends

Hospital employment of physicians has been rising, with more than one third (34.6%) of all physicians directly employed by a hospital in 2016, as compared to 30.4% in 2014 (The Physicians Foundation, 2016). Less than one third (32.7%) of physicians identify themselves as practice owners or partners in independent medical groups or practices. These trends indicate movement away from traditional private, independent practice models and migration to direct employment, whether within hospital-owned medical groups, or in non-equity/ownership positions within larger medical groups. The two most cited reasons for this trend toward employment are reimbursement pressures and overhead costs (Accenture, 2015).

Newly trained physicians are also more likely to seek employment with a hospital or health system. More residents (41%) indicated preference in hospital employment than any other practice option (Merritt Hawkins, 2017). This is a dramatic increase from the response rate of 22% preferring hospital employment in 2008. Only 1% of final-year medical residents would prefer a solo setting as their first choice for practicing medicine, a rate that has remained relatively the same for the past nine years of survey data. Residents cite a desire for a set schedule with regular vacations and extensive call coverage than what could be offered by independent practice.

Recruitment Process and Onboarding

With the increasing trends of hospital employment of physicians, combined with a competitive pool of candidates, the recruitment process to employ physicians is often fast-paced. Many hospitals, in an effort to enhance their influence on referrals and patient capture within their geographic market, might acquire existing physician practices and might recruit physicians from other geographies. With this fast pace and competitive market for candidates, many hospitals might experience a shorter time period between finding an interested candidate to an offer acceptance. Due to this expedited timeframe, details on aligned expectations may be overlooked.

Recruitment and employment of newly training physicians who are completing their residencies is highly competitive. Seventy percent of resident said they received 51 or more job solicitations from recruiters during their training, and more than 50% said they received 100 or more job solicitations during their training (Merritt Hawkins, 2017). Residents rated personal time as the most important factor, followed by geographic location, when considering a practice opportunity. Often weighted with substantial educational debt, a great majority of final-year residents (93%) would prefer a straight salary or a salary with a production bonus in their first year of practice. A common practice is to begin compensation for the newly training physician at the 50th percentile, which is established by the median productivity expectation. However, for a physician to earn median pay in their specialty, production needs to exceed the 60th percentile to meet the financial obligations of the compensation (Mertz, 2017). Prospects of hitting the 60th percentile, or even the median production threshold, may not be realistic, given the rigor and pace of practicing may be vastly different than the caseload experienced during residency. Many recruiters do not explore the patient caseload capabilities of a newly training physician nor their ability to adapt to the electronic medical record system of the hospital and office setting. Oftentimes, newly training physicians continue to document clinically as if presenting a case to their supervising faculty physician. The desire to over-document can limit the volume of patients they are able to see to meet production targets. Newly trained physicians may also be best served by seeking employment opportunities in which they will be mentored on patient flow, managing priorities, and refining clinical documentation to meet coding requirements and quality metric reporting efficiently. However, if the newly trained physician is being recruited into a unique specialty, the opportunity for mentorship might not exist, or might be limited.

For hospitals and health system seeking to recruit experienced physician candidates from outside their geographic area, compensation and community fit can become primary considerations. While production-based compensation is perceived positively for candidates, more in-depth discussions on sources of patient volume might not be adequately explored during

candidate interviews. On-boarding at hospitals often includes an introduction to the medical staff and key referral sources, and an initial marketing campaign, but the ongoing patient acquisition process must be assumed by the physician to ensure long-term success.

Another element in the hiring process that is often overlooked is evidence-based assessments. This process involves the use of an assessment tool to determine behavioral characteristics of the candidate, such as entrepreneurship, adaptability and flexibility, trust and respect. Healthcare organizations who have incorporated evidence-based assessments and behavioral assessments into the hiring process have been able to evaluate candidates for fit between their goals and expectations. They have decreased turnover and burnout, and have identified candidates for future physician leadership positions (Becker's Hospital Review, 2017).

When employing physicians who were previously in private practice within the hospital's community, there is often the assumption that the physicians can continue their operational oversight of the practice going forward, even when employed. Many hospital systems assume the employment of the physician group's staff, whereas the physicians previously may have had a direct reporting relation over the clinical and clerical staff. However, in a large hospital medical group with a standard electronic medical record system, billing systems, and employment policies, this may not be the case going forward. Clearly defining roles and expectations as to the supervision of staff, operating hours, patient volume, staffing ratios to volume, and billing systems (including denials management and pre-authorization requirements) is vital to the success of the employed physician model. Employment agreement contracts are often vague in the definition of roles and responsibilities for practice operations. When vague, the demands for staffing and overhead by the physicians can excessive costs to the practice that are inconsistent with benchmark financial performance. Since physicians seeking employment often cite the demands of reimbursement pressure and overhead costs as the primary reasons to become employed, it is in the best interest of all parties to define these responsibilities to the hospital and its medical group management structure rather than retain these decisions with the clinical

providers. However, financial losses are often attributable to hosting rather than managing, practices effectively (Goldsmith, 2018).

Another misstep common in the hospital-employment structure is timely credentialing and payer enrollment for the physicians upon employment. Oftentimes, a hospital may offer employment to a physician candidate with a start date to activate payroll, but before the physician is fully credentialed and enrolled to ensure claims for patient encounters can be submitted and paid appropriately. Establishing a realistic onboarding plan that does not activate payroll until the physician can actively see patients and bill for services is essential to managing financial losses in the early months of employment (McWilliams, 2018).

Strategic Intent

Hospital and health systems may not be consistent in establishing and communicating their strategic intent for the employment of physicians. The inability to articulate the strategic rationale for hiring physicians often clouds the purpose. Reasons cited include: increase market share, respond to competitive acquisitions, increase bargaining power with payers, and positioning for value-based care (Goldsmith, 2018). This lack of clarity will create vague and broad criteria for selecting which physicians are ideal candidates for employment within the local market. Clear strategic goals can establish the foundation for the employed physician enterprise, including defining the size, specialty mix, and geographic reach of the physician office locations. Quantifying the budget (expenses and revenue) and the expected operating margin from practice operations is key. Appointing accountability among the management for achievement of financial and operating target will serve to manage the operating margin or acceptable operational losses.

Compensation for Production, Quality and Citizenship Metrics

Employment of local independent physicians through practice acquisition may pose the most challenging situations for hospitals. A thorough review of historical patient volume, revenue and referral sources is essential to determine if previous volumes can be sustained once employed. An audit of coding compliance can validate the Worked Relative Value Unit (wRVU) productions of the past, and whether or not it can be sustained going forward with hospital-based coding support. A defensible system for medical billing with justifiable coding from documentation becomes essential for revenue cycle management. Denials management with the structure to appeal denials with acceptable clinical documentation, along with reduction in denied claims, can yield a return on investment that exceeds the drive for increased patient volume.

Physicians who have been practicing medicine for several years are often more inclined to pursue a production-based compensation system. Establishing the appropriate tension between a base salary and production-based incentive pay is key to driving an acceptable volume target. Physician candidates with a historical record of maintaining wRVU volume at or above the Medical Group Management Association's median for their specialty are best served with a compensation system that establishes less than 50% of their compensation as a base salary, and 30-40% as production-based incentive compensation. The remaining portions of their total compensation can be linked to quality metrics, value-based insurance contract (i.e., Accountable Care Organization metrics) and corporate citizenship. Approximately three-quarters of health care organizations have a portion of physician compensation tied to achievement of quality metrics (Elliott, 2012). Holding a small percentage of total compensation (10-15%) for metrics such as timely chart completion, coding accuracy, denials management, clinical hours, encounters per week and panel size can have a positive impact in revenue cycle management and improved patient access. In addition, corporate citizenship metrics for attendance at medical group meetings focused on quality initiatives and physician governance can help ensure physicians remain engaged in medical group strategies and operational improvement.

The Dilemma of wRVUs

When creating a production-based compensation system for employed physicians, the primary metric and motivator is often designated at the wRVUs generated from billable encounters. Hospitals, especially tax-exempt organizations, often are payer-agnostic for the patient volume generated by the employed physicians. In order to comply with the Office of Inspector General's requirements, hospitals have cautiously valued all patient encounters equally, regardless of the patient's payer or reimbursement for the encounter. As a result, the same wRVU is applied for a similar clinical encounter, regardless of whether revenue was received. This caution most likely emanates from the Civil Monetary Penalties Law prohibition on payments to reduce or limit care, in which a hospital may not knowingly make a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided to a Medicare or Medicaid beneficiary under the direct care of the physician (Federal Register, 1997). As such, most hospitals do not restrict or monitor the payer mix of the physician's encounters, and apply a wRVU for each encounter regardless of the revenue actually realized. Employed physicians then are incentivized to treat all patients, and may absorb a disproportionately weaker payer mix from the market, than the independent physicians. This practice can create a scenario in which a physician is compensated to a large volume of wRVUs, but revenue falls far short of the activity, creating a financial loss in the operating margin for that physician.

Revenue Cycle Management

Revenue cycle management is a complex and rapidly evolving component of healthcare transformation. Reports on the increased demands of pre-authorizations for referrals and treatments is often a source of frustration for physicians and administrators. A *Stat* poll conducted by the Medical Group Management Association reveals that 82% of respondents reported an increase in prior authorization requests from health plans and requests for supporting documentation (MGMA, 2016). With increasing demands and requests for prior authorization,

medical groups, especially those within a hospital or health system, struggle to develop consistent processes and policies. Central Business Offices may not identify that an encounter did not receive the appropriate prior authorization until the claim is denied.

Denials management is an additional component of hospital employed physician revenue cycle management that may have inconsistencies in approach. The ability to track the reason for the payment denial may not be established. In addition, the time-cycle requirements to appeal the denial can often be overlooked. Many hospital Central Business Offices may not have dedicated resources to devote to professional fee appeals and denials management. The absence of resources with standardized processes can often result in substantial decreases in revenue. Unless the process is monitored, and feedback provided to the physicians when prior authorizations were overlooked, the situation perpetuates and claims are written off, resulting in decreased revenue for services rendered. The impact can be on the physicians' professional revenue, but it can also have adverse effects on hospital-based ancillary services, such as imaging, diagnostic studies and laboratory services.

Clinical Documentation, Coding and Timely Filing

Another factor that drove more physicians to seek hospital employment was the meaningful use provisions of the HITECH Act of 2009, which provided both incentives and penalties for physicians to adopt electronic records. Many small physician practices did not have the resources to comply with meaningful use requirements, and those doctors sought employment with hospitals, where robust electronic medical records could be leveraged in the physician office environment. In addition, the Affordable Care Act increased documentation requirements. While hospitals have invested financially in the electronic health records in ambulatory environments, the training and proficiencies in the adoption rates may not be sufficient to obtain the gains in efficiency expected.

Training on the use of the electronic health record system is an investment of time, and efficiencies may only be realized if there is a paradigm shift in the method in which clinical documentation enters the electronic medical record. Templates can be leveraged that pre-populate the most common clinical notes, requiring only minimal modifications to apply to each unique patient. However, the development of clinical note templates requires a commitment of time, and this process is often omitted in the rush to deploy the new electronic medical record system.

Many of the most frequently used electronic medical record vendors used by hospital systems may include alerts and prompts to ensure the physician is capturing the most appropriate documentation to result in strong coding compliance. However, many hospital systems allow physicians to “opt out” of these alerts until they have more fully adapted to the electronic health records basic systems. Months or years can go by before these auxiliary systems of alert and prompts are re-engaged in the electronic health record system.

Prudent health systems will also utilize a third party to conduct coding audits to ensure the clinical documentation is consistent with the billing code assigned to the encounter. Monitoring the distribution of the Evaluation and Management codes of office visits, compared to national norms for the physician’s specialty, can review if the coding is consistent for the patient population being served. A coding audit only becomes actionable if there are recommendations and action plans developed for modifications in clinical documentation and coding to increase compliance.

Timely payment for professional services is often directly linked to the timely filing of the billing codes and requests for payments. Oftentimes, physician employment contracts do not establish the maximum allowable time for which to submit documentation and conduct charge entry. Tighter parameters, with monitoring of compliance to parameters, can ensure a quicker, and more accurate, revenue cycle management process. Best practices have often indicated the physicians are responsible for documenting all services within 24 hours of the date of service. In

addition, physicians are to submit all procedure and diagnostic codes within 24 hours of the date of service, when rendered in the office setting, and within 72 hours for services out of the office (Keegan and Woodcock, 2016).

Wage and Benefit Packages

As a large employer, hospitals must comply with mandated employee benefits that a small physician practice does not. These include retirement benefits, workers' compensation, family and medical leave, and even state-mandated time off. The richer wage and benefit packages can add a substantial amount of overhead to the profit and loss of a hospital-employed physician enterprise.

To comply with federal labor, retirement and pension benefit requirements, hospitals employing physicians will fund a richer retirement plan than what can typically be attained through self-employment or small employers of less than 50 employees (ERISA, 2018). Hospitals also often enrich the retirement benefits for physicians in order to attract and retain physicians (Todd, 2011). Hospitals also provide for paid vacation, sick leave and paid time for continuing medical education. This non-productive paid time benefit will impact the overall profit and loss of the physician financial situation. Employed physicians also have access to life insurance and health plans that they may not have been able to attain in private practice; however, the cost of these benefits are often attributed to the financial performance of the employed physician practice.

Hospitals use economies of scale in purchasing liability coverage for its facilities, staff and the physicians they employ. The economies of scale provide for general liability coverage per physician than what can typically be obtained on the open market when underwriting an individual physician. However, hospitals often make the offer of liability coverage for physicians after they terminate from employment. This coverage, often referred as "tail coverage," can add

to the overhead costs of the physician enterprise of employed physicians. This is especially the case in which the tail coverage is a separate rider or policy from the group liability coverage.

When physicians are in independent practice, they are often employing a small workforce and are financially incentivized to keep costs down and manageable. However, when a physician becomes employed by a hospital, the staffing ratios often tend to be richer than found in the private practice setting. Skill mix of the clinical staff is escalated, with a richer mix of registered nurses than found in private practice offices. And hospitals often require a higher level of certification for its workforce, including certified medical assistants, certified phlebotomists and nurses. The support staff within the medical office of an employed physician also receives a benefit package of vacation time, sick leave, retirement, health plans, life insurance and salary increases that are consistent with the hospital workforce. These benefit packages are usually richer than those within private practice offices.

Information System Overhead Expenses

As previously discussed, the requirements of the electronic health record system may be one of the driving factors compelling physicians to seek employment from hospitals. The total cost of the electronic health record system is not merely the software, but the training costs, and the hardware requirements of the system. Independent physicians often use small office computer networks for their information systems, whereas hospital systems require more integration between locations, electronic scanning, printing, and larger band width of Internet communication lines. As hospital information systems have expanded to numerous locations, a virtual private network is also implemented to ensure compliance to electronic communication privacy requirements. To meet Life-Safety codes, hospitals also ensure the electronic equipment is commercial-grade and more durable than the personal-use equipment often purchased by small physician group practices. Each of these devices have a higher purchase price, even with group purchasing discounts applied. Lastly, the hospital system typically has an enterprise wide

telecommunication system, requiring more sophisticated (and expensive) telephone handsets that integrate with the entire hospital and health system.

Corporate Overhead

As a small business, many physician practice offices employ a dedicated administrative leader responsible for non-clinical activities. These functions often include accounting, human resource administration, purchasing and managed care/payer negotiations. Once a physician is employed by a hospital, these functions are delivered via hospital departments, with an overhead allocation of the fixed expenses of these departments provided to the employed physician practice. The overhead allocation of the hospital fixed expense department is often at a higher rate than attributed to the small business of a physician practice.

Regulatory requirements of the hospital system

Employed physicians in practices affiliated with a hospital system often must comply with the regulatory requirements of the hospital system, including life-safety codes, infection control, waste management and risk management protocols. Each of these requirements may add to the overall operating costs of the employed physician. As part of the hospital and health system, fire systems often require buildings have sprinkler systems and security alarms integrated into the main hospital security network. Compliance to the Americans with Disabilities Act may require facilities to include accessibility features, such as ramps, bathroom alerts and other adaptive equipment. Retrofitting a physician office to comply with the hospital requirements for accessibility can require capital improvements and operating expenses to the physician office.

Infection control and hazardous waste disposal often become more complex concerns and expenses once a physician is employed by a hospital system. Sharps disposal, biohazardous waste, and sterilization of medical equipment in the office setting may have additional requirements when under the domain of a hospital. Enhanced requirements for patient privacy

and confidentiality (HIPAA, 1996) may necessitate the change from a small office shredder to a secure document-removal service with added operational costs to the practice. While the Privacy Law is equally applicable to physicians regardless of employment status, hospitals often have a higher level of compliance and enforcement, commanding tighter controls of document disposal.

Loss of ancillary revenue

The addition of numerous overhead requirements of hospital employment of physicians can certainly contribute to a weaker financial performance than a private practice physician. Expense management is key; however, the reduction in revenue opportunities may have a greater financial impact in the negative operating margins of hospital-employed physicians. When physician practices are acquired by a hospital, the ancillary services typically generated in the physician office are moved to the hospital outpatient departments. The ancillary services can include imaging, laboratory services, pharmacy, durable medical equipment and therapeutic services (physical therapy, occupational therapy, speech pathology, audiology, etc.). The net margin of the ancillary services, previously sitting in the practice setting, can have a detrimental effect on the financial outcomes of the physician practice. Hospitals may benefit from the downstream revenue of the ancillary services, but often accounting systems do not allow for a contribution margin to be attributed back to the physician enterprise.

Conclusions and Mechanisms for Improving Performance

One of the keys to successful physician employment is establishing a monitoring system to continuously provide feedback to physicians, especially as it pertains to production, quality and operational indicators. However, establishing these expectations of performance during the candidate selection process can solidify the success. Appropriate alignment of incentives is the first test of cultural fit. Oftentimes, the candidate selection process focuses disproportionately on

production alone, without clear understanding by either the employer or the physician on how the encounters will be acquired to meet the production thresholds.

Once an employment offer has been accepted, it is critical for the hospital employer to have a detailed onboarding plan to ensure the physician is appropriately credentialed and enrolled in health plans to productively bill for clinical activity upon the first day of employment. To ensure the physician assimilates into the new practice environment of hospital employment, the onboarding plan should include the appropriate time to ensure proficiency in electronic health record entry, both in the office setting and hospital systems. A mentoring program that also allows the newly employed physician to develop referral networks among his or her medical colleagues will further ensure success (McWilliams, 2018). The onboarding plan should also include the establishment of the monitoring systems for production, quality indicators and citizenship metrics (timely completion of records, accuracy of coding, etc.).

Implement feedback of Key Performance Indicator metrics on regular basis

The cadence of production reports should be monthly, at a minimum, and should reflect monthly volume, year-to-date volume, and comparisons to previous periods. Reports that indicate the gap or achievement of production thresholds can provide continuous feedback and monitoring for both physician and employer. A dynamic productivity monitoring system will also prove invaluable as contract renewal periods approach. If employed physicians request a higher compensation, it will be important for both the physician and the hospital to understand the fair market value of the current production activity volume and the comparable market rate compensation (Elliott, 2013).

Hospitals employing physicians can also incorporate dashboards of metrics that not only demonstrate the performance to production thresholds, but comparisons to industry benchmarks. Production benchmarks, as measured by wRVUs and office encounters, are widely available

through the Medical Group Management Association's DataDive (MGMA, 2018) as well as other professional society published reports.

For hospitals systems that are payer-agnostic, medical group administrators should still keep a watchful eye on the payer mix of the patient caseload of each physician employed. While volume is important for productivity and patient access, the payer mix can become disproportionate and not bear the revenue to maintain financial viability. Monitoring and reporting on net collections can create an open dialogue of how the physician contributes to the financial health of the organization.

Revenue Cycle Management metrics, including charge lag reports, denials trend reports, and coding distribution, can provide feedback on how well a physician is ensuring that the patient care being delivered is realizing revenue expectations.

Open Dialogue of Patient Care Hours and Support Staff Needs

Frustrations with operational requirements is often stated as one of the primary reasons physicians seek employment (The Physicians Foundation, 2017). Many physicians express the desire to give up the managerial responsibilities of running a practice and concentrate more on clinical activities. With the relief of management responsibilities, the physician is then able to devote more time per week to clinical activities. Expectations of clinical hours per week is best defined in the physician employment agreement, in addition to administrative time to attend to clinical documentation, quality reporting and meeting attendance. Inevitably, the combination of billable clinical time plus administrative time will exceed a 40-hour work week, as is the case for most professional career positions. Expectations of how patient care hours are set and managed should be a discussion that initiates during the candidate selection process. Once employed, an open dialogue between the physician and practice management should occur so that roles and responsibilities are clearly understood and aligned. Specific roles and authority should be defined for support staff oversight, appointment scheduling process, and office hours for patient care.

Industry benchmarks are available to gauge the use of support staff to the patient care volume of the practice. Dyad leadership models, in which physician/administrator teams jointly lead healthcare organizations, have been established at healthcare systems dating back to 1908 at the Mayo Clinic (Zismer & Brueggemann, 2010). Successful medical groups in hospital systems have developed a weekly meeting cadence in which the lead physician at each office site meets with the practice manager to review operational metrics and incorporate both strategic planning and budgetary dialogues.

Eliminate verbal agreements and memorialize expectations in employment agreements

Becoming employed by a hospital often requires conformity to policies and procedures. Practice operations are optimized when policies and procedures are well known, documented and accessible. In addition, practice administrators should be fully aware of requirements memorialized in physician employment agreements to be mindful of any exceptions from the normal, and to ensure physicians are empowered to meet their performance expectations. Verbal agreements in which a physician implies a pre-determined exception to operating policies should be avoided to ensure a mutually respectful working environment. Employment agreements should be viewed as contractual obligations to ensure the success of both the employer and the employee in financial performance, patient access and job satisfaction.

Conclusion

The employment of physicians within hospital systems should not only fulfill the strategy of tighter control of an integrated delivery network. The employed medical group should be treated as a business entity with financial parameters in which to measure success, along with key performance indicators and metrics. It is necessary to understanding the potential pitfalls that can decrease the financial viability of the employed physicians as a business unit in order to set the

tolerance limits and continuously monitor the operations to manage the strategic support, which contributes to the overall financial health of the health care organization.

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