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The Second Wave of Physician Employment
How to Avoid Excessive Losses

By Robert F. Hill and Craig E. Holm

With pending implications of healthcare reform and other challenging economic factors, increasing numbers of hospitals and physicians are seeking the safety of employment relationships. Yet, the hospitals that employ these physicians often suffer significant financial losses. Here are some strategies to create financially sustainable employment arrangements.

The second wave of physician employment is well under way. Estimates indicate that one third of active U.S. physicians are employed by a hospital or health system.

The first wave, which occurred in the mid-1990s, focused on primary care physicians in an effort to redirect referral relationships and have primary care physicians serve as gatekeepers for integrated healthcare systems.

Today, healthcare organizations continue to employ primary care physicians, but are increasingly seeking specialists in fields where it is hard to obtain coverage or difficult to recruit. Healthcare organizations today also often use explicit recruitment and selection criteria and are more purposeful, as opposed to the more reactive and opportunistic "take one, take all approach" of the mid 1990s.

Hospital employment in the mid-1990s also featured long-term contracts (e.g., 5-10+ years) with income guarantees. Today, hospitals are employing physicians with much shorter contract terms and compensation plans based on incentives for performance—or productivity-based compensation and targets for physicians to improve efficiency, patient satisfaction, and quality. In particular,

Factors Driving Physician Employment

Factors that are driving increased physician interest in employment arrangements include the following:

- Declining professional reimbursement
- Lost or diminished ancillary service revenue
- Expenses that are increasing at higher than inflationary rates
- Magnitude of capital and resource requirements required for IT and other infrastructure components
- Opportunity to increase reimbursement (per unit of service) and earn higher compensation
- Security and a balance between professional and personal lives

For healthcare organizations, physician employment can help establish a platform for clinical integration and/or development of accountable care delivery models. Other factors that are driving renewed hospital interest in physician employment include:

- Shortage of physicians and the challenging recruitment environment
- Need to fulfill call coverage requirement
- Opportunity for collaboration and alignment with physicians
- Increased bargaining power with commercial insurers

Source: Health Strategies & Solutions, Inc.

emerging models of physician employment are beginning to replace payment for production with payment for value such as quality outcomes and efficiency.

One constant with physician employment is that almost all hospitals lose money on employed physicians. While the amounts vary, losses of $75,000 to well over $100,000 per employed physician per year are common. These losses on direct revenue versus expenses are often tolerated because employed physicians generate a positive margin on direct and indirect admissions and downstream revenue for diagnostic and treatment services. Even networks that are considered advanced in managing practice subsidies typically experience losses that range between $30,000 and $50,000 per employed physician per year.

In light of current trends and findings from a recent survey, healthcare organizations that employ physicians are vulnerable to substantial financial drains and should establish tolerable loss targets for their networks.

Financial Performance Improvement Steps to Consider

The following steps should be considered as options for improving financial performance and enhancing the future viability of employed physician networks:

- Structure employment contracts with limited terms such as one to three years and be explicit regarding expectations and performance incentives
- Provide regular feedback and data to employed physicians on productivity, quality measures, revenue generation, expense levels, overall operations, and other practice performance measures
- Centralize larger administrative functions like billing and collections to achieve economies of scale and scope, and permit physicians to focus on day-to-day operations of the practice
- Establish metrics for the per-physician operating loss or subsidy that will be tolerated by the network
- Conduct ongoing evaluations of employment relationships to identify if changes in the practice or regulatory environment warrant a change in the employment relationship

The evaluation tools listed below can help employed physician networks make effective decisions about performance and avoid excessive losses. These tools should be applied on a regular and ongoing basis, with as close to real-time data as possible.

Dashboard indicators. Define what needs to be measured and establish metrics based on regional and national databases. Specific indicators should be developed and agreed on for productivity, expense levels, quality and patient satisfaction, and overall performance.

Databases for comparison should include internal figures/statistics from practices within the respective network and external sources such as American Medical Association and Medical Group Management Association survey data.

Desktop audits. Assess practice performance versus benchmarks and highlight areas of concern that may benefit from a more thorough operations review. Typical areas of concern may relate to revenue generation, employee turnover, outcomes measures, and/or overall performance.

Operations review. Build on results of the desktop audit and conduct interviews

Survey of Employed Physician Networks

A survey conducted by Health Strategies & Solutions, Inc., at HFMA conferences and seminars in 2010 generated responses from 65 organizations that employ physicians. Nearly one half of respondents employ more than 100 physicians, indicating large, developed networks. Summary findings from the survey are as follows:

- Nearly two-thirds of respondents have less than 50 percent primary care physicians in their employed networks, which is a major shift from employed networks that were typically dominated by primary care physicians.
- Approximately three-quarters of respondents indicated that they use a productivity-based compensation system. Of those that are productivity-based, two-thirds base compensation on relative value units (RVUs), and one-third base compensation on visits, collections, or charges.
- Nearly 40 percent of respondents indicated that they use quality measures to reward compensation. Although compensation rewards for quality and outcomes are more prevalent, they still represent only a small portion of overall physician compensation. Most networks are evaluating these types of incentives in light of healthcare reform and anticipated reimbursement changes by Medicare and commercial payors.
- Approximately 20 percent of respondents continue to use a straight salary method of compensation.
- The average and median annual subsidy reported was approximately $75,000 per employed physician per year. One quarter of respondents reported an average annual subsidy in excess of $100,000 per employed physician per year.
- More than two-thirds of respondents indicated that reimbursement rates are within 15 percent of private practice levels in their respective market. Five respondents indicated that their employed network is reimbursed at rates that are more than 20 percent higher than private practice physicians in their market.
- Changes to compensation methodology and practice promotion (e.g., marketing) were overwhelmingly cited as the most effective initiatives to improve financial performance.
- Approximately 90 percent of survey respondents indicated that the size of their employed physician network is increasing.

Source: Health Strategies & Solutions, Inc.

with physicians and staff to identify operational and system impediments to productivity. Physicians often cite inadequate practice promotion and marketing, practice location/facility deficiencies, staffing levels, and/or ineffective hospital oversight of practices as impediments to productivity.

Strategy development. Based on the previous three activities, develop strategies and initiatives for the respective practice to improve performance. These may include a modified compensation structure or practice promotion, and may also include recruitment of new physicians, changes in staffing, and/or upgrades to information systems.

Performance Improvement Targets

Successful networks focus on high-impact performance improvement initiatives and/or avoidable practice expenses. Targeted financial performance improvement per full-time equivalent (FTE) should be realistic and achievable. Targets should vary based on the size of the network, specialty complement, mix of new versus established physicians, service area characteristics, and other factors. Ultimately, if practice performance fails to improve or achieve what is determined to be acceptable financial performance, contract termination or divestiture should be a consideration.

A reasonable performance improvement target for an employed network is often $10,000 per FTE over one year, and $25,000 per FTE over three years.The results of achieving a $25,000 per FTE improvement (based on an average of 75 physicians per network) over three years are outlined in the exhibit below.

Financially Sound Employment

Physician employment is here stay. Steep and ongoing losses from networks of employed physicians no longer need to be considered standard operating procedure. Carefully crafted employment contracts and a performance improvement process that identifies high-impact initiatives that will improve the operational and financial performance of employed physicians are the first steps in moving to a new era of financially sustainable physician employment relationships.

Reasonable Performance Targets for Employed Networks

	Year 1	Year 2	Year 3
Average improvement per FTE	$10K	$20K	$25K
Aggregate network improvement*	$750K	$1.5M	$1.875M

*Based on the calculated average number of physicians per network (75), as identified in a Health Strategies & Solutions survey.

Source: Health Strategies & Solutions, Inc.

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