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EXPERT REVIEWED

5 ways to **reduce losses** on hospital-employed physician practices

Hospitals and health systems can cut financial losses on employed providers by replicating the key features of a proven model — the physician-owned multispecialty group.

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Healthcare organizations in the United States continue to lose money on hospital-owned medical practices. According to the American Medical Group Association (AMGA), the median loss per employed physician is just under $250,000.[a]

Many factors contribute to these losses, but the basic driver is supply and demand. Shortages in the physician workforce are driving up physician compensation. At the same time, declining reimbursement means that physician payment is not keeping up with practice costs. The resulting gap between revenue and expenses requires significant financial support from healthcare organizations.

But even as hospitals pour money into these practices, employed physicians are not any happier. A 2023 survey from the American Medical Association found that 40% of physicians intend to leave their organizations within two years.[b] Such findings suggest hospitals need to revisit their approach to physician employment.

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a. AMGA, "New survey finds medical group operating costs continue to outpace revenue," press release, Dec. 18, 2023.

b. Berg, S., "40% of doctors eye exits. What can organizations do to keep them?" AMA, Nov. 28, 2023.

Outside of the hospital environment, the market is responding to these challenges in a predictable way. Last fall, Walgreens began pulling its VillageMD clinics out of several markets in an effort to cut costs. And last spring, Walmart announced its intent to shutter both its in-store primary care clinics and its telehealth operations.

For most hospitals, the strategic rationale of practice ownership is still valid — physicians are the marketing channel that supports system-wide volume. However, no hospital can afford to maintain an employed physician enterprise without improving its financial performance. One model hospitals have used to create a successful physician network is the *physician-owned multispecialty group*.

This idea may seem paradoxical, because hospital-owned practices are made up primarily of physicians who *left* a private group in favor of system employment. The key is to separate the clear negatives of private practice from the underappreciated benefits of the multispecialty group model.

A CLOSER LOOK AT A 'FAILED' MODEL

Over the past decade, physicians have exited private practice in significant numbers. But looking beneath the surface, this trend was essentially an attempt to escape the burdens of management, not a rejection of values like independence and entrepreneurialism. In fact, many physicians have learned to their chagrin that hospital employment has undercut these core values.

In reality, most physicians in multispecialty groups are more productive and happier than the majority of their hospital-employed colleagues. Why? Based on my experience in observing physicians in every practice setting, the reason is that the multispecialty group model creates a practice environment that supports energy, creative thinking and professional satisfaction.

5 STEPS FOR BUILDING A SUCCESSFUL PHYSICIAN NETWORK

By replicating this multispecialty group environment, hospitals can effectively reduce or even eliminate their losses on employed physicians. Following are five ways to reproduce the private group dynamic within a hospital employment setting.

The reality is that most physicians in multispecialty groups are more productive and happier than the majority of their hospital-employed colleagues.

1 Establish a physician-centered culture. In private multispecialty groups, physicians themselves define the group's strategic vision and make all key decisions. The result is a culture of ownership that drives high performance. Hospitals can reproduce this dynamic by giving employed physicians meaningful control of the organization's medical practice enterprise.

One key is governance structure. Hospital leaders who have spent any time working with employed physicians know that changes mandated from above are their leading source of frustration. The solution is for hospitals to place their employed practice network under the control of a physician-led governance board. The board should include both operating and policy committees, giving physician leaders full control of group policies and processes.

Many hospital leaders fear that physician-led governance will lead to even higher losses. In fact, such boards are highly effective at creating realistic plans for improving financial results. Instead of imposing a solution, hospital leaders simply provide the board with a clear target — for example, "We need to reduce our per-provider loss by 25% over the next 12 months." Physicians understand that their practices must be sustainable, and this approach lets the board decide how best to achieve that goal.

The other key is to give each physician meaningful control over how their practice operates.

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Again, the starting point is to provide high-level goals and allow each physician to decide how to staff and run their practice. Some physicians will prefer to staff their pod with nurses, medical assistants and scribes. Others will build out a full team-based model of care, with advanced practice providers. Many opt for team-based care because it provides patients with better access while allowing physicians to focus on the patients most in need of complex management.

Physicians also should have a voice in the selection of their practice manager. The overall goal is to create an environment where physicians feel like engaged participants, not just workers. By making physicians in an employed practice feel valued and appreciated, a hospital can expect that the practice will consistently do better financially.

2 Align physician compensation with business goals. The Medical Group Management Association (MGMA) has found that primary care physicians in private practice complete 373 more encounters and generate $124,000 more collections per year than their employed counterparts.[c] For private non-surgical specialists, the figures are 185 encounters and $172,000 in collections.

Because compensation for employed physicians is typically salary-based, this productivity gap is a major driver of hospital losses. However, hospitals can reduce these losses by replicating the productivity-based compensation model of private practice.

For example, hospitals can start new physician hires with a guaranteed salary and then transition them after two years to a compensation model based on charges, collections, relative-value units (RVUs) or some combination of the three.

Conversely, hospitals can tie compensation to overall practice income, which will reflect both net collections and costs. This approach can even be used for practices that operate at a deficit, simply by giving the physician a share (typically 25% to 50%) of any improvements against budgeted loss. As a theoretical example, let's assume the historical annual loss on a hospital-owned rheumatology practice is $250,000. So with a 50% share of improvements, a specialist who can reduce that loss to $200,000 shares $25,000 out of the improvement.

3 Build a self-sustaining ecosystem of care. One reason most private multispecialty groups do so well strategically is that they encompass a full vertical range of providers and services. Low- and no-margin primary care practices create the patient base needed to support higher-margin specialty practices and ancillary services. Moreover, offering a comprehensive array of providers and services (one-stop healthcare shopping) is a strong differentiator in the market. Hospitals that have replicated this structure in their employed physician enterprise

c Medical Group Management Association, *Provider pay and the dawn of a new era of productivity,* Provider compensation and productivity data report, May 2024.

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have achieved strong market growth and financial results.

One example is Ingalls Memorial Hospital, now part of U Chicago Medicine. Over the past 40 years, Ingalls has gradually built up an employed physician enterprise that encompasses emergency care, primary care, specialty practices, ambulatory surgery and a full range of standard and advanced ancillary services. This hospital-owned physician practice has long been self-sustaining due to margin from ancillary services, and it has allowed Ingalls to grow its share in an attractive market from 1% to 29%.

To support such a strategy, hospitals should establish Stark-compliant incentives to keep referrals within the employed practice group and utilize hospital-owned ancillary services. This revenue is a key driver of financial performance for multispecialty groups, but it is typically absent from employed practices.

When this strategy is well executed, it can increase physicians' professional satisfaction because it lets them easily link patients to the specialist care and ancillary services they need. In addition, having a large group of colleagues can reduce the call burden, affording a more balanced lifestyle and reducing physician burnout.

4 **Help physicians assume risk.** AMGA has found that hospitals are losing the most money on primary care practices. Annual salaries for internists, family medicine physicians and pediatricians now exceed $250,000, and increases are possible in the coming years.[d] The best opportunity to reduce such losses is to take advantage of risk-based payment programs.

As primary care physicians move into risk-based arrangements, providing them with support and guidance is critical. The priority is to help physicians establish systems for identifying, monitoring and managing patients with high-cost, high-volume diagnoses such as diabetes and obesity. As part of this effort, clinical protocols should be established that provide guidance on tests, medications, hospitalization and other key decisions. Hospital leaders also should consider panel size when transitioning physicians to risk arrangements, because providers with panels above 2,000 patients are more likely to be successful in risk-based contracts.

As a collateral benefit, participation in risk-based payment programs can also encourage physicians to better manage utilization. For example, better management of heart disease can reduce unnecessary emergency department visits and hospital admissions. Even in the setting of financial losses, primary care practices can break even by helping to control costs from a systemwide perspective.

5 **Take control of the back end.** While most employed physicians have gladly relinquished responsibility for their revenue cycle, most hospital employers have been slow to pick it up. This gap represents an opportunity. Hospitals that invest in managing the physician revenue cycle — and providing other support services — can strengthen the financial results of their employed practices and improve physician satisfaction.

Three steps are required:

- Perform regular charge capture audits for employed practices to ensure complete documentation of services.
- Create processes to support time-of-service collections (for example, collecting deductibles at registration) and pre-service collections (collecting deductibles and copays prior to scheduling elective procedures).
- On an annual basis, review all payer contracts and fee schedules to ensure market rate compensation and regularly update practice chargemaster records.

Hospital employers also have an opportunity to support better management of practice costs by outsourcing noncore functions. For example,

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The number of encounters completed per year by private practice physicians, on average, beyond those completed by employed physicians

Source: Medical Group Management Association, *Provider pay and the dawn of a new era of productivity,* Provider compensation and productivity data report, May 2024

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d. Darves, B., "Physician compensation still rising in primary care and fast-growing urgent care sector, but flattening is expected," *The New England Journal of Medicine,* Jan. 11, 2021.

a third-party provider can generally perform billing and collections more efficiently and economically.

Alternatively, many hospitals provide comprehensive support for employed physicians, including relief from administrative burdens, through a management services organization (MSO). An MSO's support includes office space, staff, supplies and complete billing services. In exchange, the MSO typically charges the practice a percentage of professional collections or a percentage of collections plus cost pass-throughs. The benefit for physicians is almost complete relief from the administrative burdens of practice. The benefit for hospital employers is the chance to consolidate and standardize practice management.

A FOCUS ON SUSTAINABILITY

Despite experiencing significant losses on owned medical practices, hospitals still have a strategic need for employed physicians. These losses cannot be prevented through minor tweaks to staffing, billing or marketing. The better way forward is to replicate the multispecialty group model within the employed setting. To ensure the long-term sustainability of their physician enterprise, hospitals must reduce or eliminate losses on employed practices. And they can best do so by cultivating a physician-centered culture, establishing business-aligned compensation, designing self-supporting systems of care and providing targeted administrative support. ▮

About the author

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