The Challenges of Integrating Physician Group Operations

2014 Kentucky Healthcare Industry Study
INTRODUCTION

Healthcare reform and market dynamics continue to accelerate the transformation of the traditional healthcare delivery system. Many providers have consolidated to weather the impact of the Affordable Care Act and diminishing reimbursements from governmental and commercial payers. In addition, the impending shift from volume to value-based payment models, the necessity of improved coordination of care and population health management continue to be forces that will shape our current healthcare structure in the future. We believe that the successful systems will be those who have effectively integrated physicians into their delivery system. However, as it stands today, integration of physicians continues to be an issue most systems struggle with.

This report on the challenges of integrating physician groups into hospital operations is based on a recent survey of hospitals and health systems conducted by Dean Dorton. It is a follow-up to the initial report and survey conducted in 2013, but has been expanded to include more detailed questions and considerations. The end result was more in depth questions regarding technology, data integration, payment models, and a further understanding of physician practice losses by specialty.

Dean Dorton believes that today’s integration of physician groups into hospitals and healthcare systems is much different than in the past. With the transition of reimbursement models focused on improved outcomes, effective integration and physician leadership is critical to creating a truly aligned delivery network.

We thank the many physician and administrative executives who have taken the time to provide feedback and insights into their respective organizations and to those who have participated in discussion forums across Kentucky regarding the initial outcomes and considerations for this follow-up survey.
The Integration Challenge Continues

The reported average annual loss per hospital-employed physician increased as compared to our 2013 study. This year’s survey results indicate that 58% of respondents reported annual per physician losses of at least $100,000 as compared to only 41% in the 2013 study.

This year’s survey also sought detail on average losses incurred by type of physician provider. Respondents were asked to provide average losses for primary care physicians, hospitalists, and specialists. Based on the results of the survey, we noted that primary care physicians incurred lower losses on average ($0 - $100,000) than did the hospitalist and specialist physicians (> $100,000). Additionally, all reported losses exceeding $200,000 annually were for specialist physicians.
Size of System and Hospital

When losses incurred were segregated by the size of the entity reporting the losses, it was evident that bed size or the number of facilities did not affect physician losses in a discernible way. 100% of hospitals with more than 200 beds reported physician practice losses exceeding $100,000 per physician with one third of those respondents reporting losses exceeding $200,000 per provider.
The reported losses for hospitals under 200 beds and systems with 3 or fewer hospitals were spread across all loss ranges. Consistent with our original survey, some smaller hospitals reported little to no losses, potentially reflecting better reimbursement due to special facility classifications.
Consistent with the 2013 survey, we noted that the longer physicians have been employed by a hospital or a system, there is an increased probability for higher operating losses. In our prior year’s survey, we indicated that a possible explanation for the larger losses for those organizations employing physicians for a longer time could be due to those hospitals or systems having a higher percentage of direct recruited physicians compared to acquired practices. The direct recruited physicians would not have the private practice experience and would potentially have less favorable payer mix based on the hospital mission.

The survey data for 2014 did not reflect clear cut differences in respondents recruiting versus acquiring physicians. Newly employed physicians in 2013 were brought onboard almost evenly through acquisition (46%) and through recruitment (54%).

42% of respondents report that they are more heavily employing physicians straight from school rather than through acquisitions of existing practices and 60% of these respondents experienced losses above $100,000.

33% of respondents attained their employed physicians primarily through acquisition of existing groups with 75% of these respondents incurring losses of $101,000 – $200,000.

We believe this mix is understandable in a maturing market for physician employment. The maturing hospital employed physician market is reflected in both the length of employment and the larger number employed (58% have employed greater than 31 physicians).

Along with this trend has been an increase in the employment of specialists. Practice losses are greater for specialists but they likewise provide greater hospital revenues and contribution margins.

The survey responses also indicated that only 20% of organizations have lost important physicians to competitors and only 10% have consolidated or reduced their number of employed physicians.
1 to 7 Years

- No loss: 50%
- $0 - $50,000: 50%

>7 Years

- No loss: 60%
- $0 - $50,000: 10%
- $51,000 - $100,000: 20%
- $101,000 - $200,000: 10%
- Greater than $200,000: 10%
Similar to last year, the most common compensation model utilized was an RVU productivity based method, used by 67% of all respondents. 63% of organizations utilizing an RVU methodology reported losses of $101,000 - 200,000 per physician per year.

Productivity Based- RVU

In addition to utilizing an RVU-based productivity methodology, some respondents are incorporating other key considerations into their compensation models. While less than 10% of the respondents are including the organization’s payor mix into the equation, this small shift from last year’s results does reveal a need to include operational factors into the hospital or healthcare system’s physician integration plan.

One third of the respondents are also starting to incorporate collections into the compensation model. While the results of including these factors into physician compensation are mixed, it appears that organizations are being more proactive and strategic in the development of their physician compensation and integration structure.
Utilization of Alternative Models

One way to combat the losses incurred is to seek alternative arrangements with physicians that will allow the hospital or system to build an integrated system. Some respondents reported they have begun to use alternative arrangements in addition to direct employment. A majority of respondents (64%) have implemented or are considering professional service agreements (PSA). At this time there is no correlation of physician loss levels with those organizations who have implemented or are considering, nor with those not considering PSA’s. 40% of the survey respondents have implemented co-management agreements. All those who have such agreements incur physician practice losses between $101,000 and $200,000, whereas those who are not considering such agreements report losses in all levels. Only 20% of respondents indicated that they have implemented joint operating agreements (JOA’s) and 70% are not even considering it. As with co-management, 100% of those who have implemented JOA’s report physician losses between $101,000 - $200,000. We believe over time, these alternative models may stem the tide from the increasing operating losses incurred from a direct employment model.
Use of Withhold Tied to Key Metrics

Respondents indicated that a majority of hospitals and healthcare organizations are starting to bundle physician compensation with key metrics such as quality outcomes, patient satisfaction, and system goals. While there were no discernible results tied to physician practice losses, there is a definite trend towards including such measures. We believe that this transition will guide improved future results.

The largest percentage (64%) of respondents is tying compensation to physician-based quality indicators while the smallest percentage (36%) is connecting compensation to hospital and health system goals. Physician leadership within the hospital or healthcare system is necessary to effectively align physician compensation with organizational goals.

Withholding Arrangements
The value of a physician practice to a hospital or an integrated delivery network goes well beyond the individual practice’s profit or loss. In this survey, we sought to understand the extent to which respondents are tracking and measuring the downstream contribution margin from employed physicians.

42% of respondents said they are not currently tracking employed physician downstream contribution margins. Most reported that this data was difficult to obtain or not available to their organizations, and thus it could not be tracked effectively. This group of respondents reported losses spread evenly across all loss ranges as seen below.

Of the 58% that do track physician downstream contribution margins, 72% of those respondents are reporting average annual losses of $101,000 to $200,000 per physician.
While the capabilities and results of tracking downstream contribution margin were quite varied, we believe it is imperative to measure this information in order to fully understand the financial impact of employed physicians to a hospital or healthcare organization. Decision support and data analytics are key investments in this regard.

For those respondents who track downstream contribution margins we found that there was wide variation in definitions of downstream contribution margins.

- 22% Hospital net revenue less direct and indirect variable expense
- 22% Hospital net revenue less direct expense
- 33% Hospital net revenue less fully allocated variable and fixed expenses
- 22% Track only hospital net revenue

The variation above warrants caution in comparing your specific organization’s results to industry benchmarks without first confirming the calculation methodology. For internal tracking and reporting it is less of an issue as long as you stay consistent so that trending results are from performance changes, not calculation changes.

For those who track only downstream revenue it is important that readers (e.g. Board) understand that actual contribution margin, after expenses, is substantially less than the revenue.

89% of respondents reported that their overall financial results were breakeven or profitable when taking downstream contribution margins into account.

This may very well be the case; however, noting that 42% of respondents indicated they do not track downstream contribution margins, we encourage detailed decision support systems to confirm combined operating results.

Information technology integrating hospital and physician data allows for sophisticated assessment of physician contribution to the health system as a whole.
Physicians with Best Hospital Revenues

Respondents were asked which physician specialties best offset practice losses with increased hospital revenues. Based on the respondents’ data, those specialists were:

- Hematology/Oncology
- Cardiology (Invasive)
- Cardiac/Thoracic Surgery
- General Surgery
- Neurosurgery
- Orthopedics

The significant hospital revenues and contribution margins that hospitals and health systems generate from these specialties generally create an overall positive financial return notwithstanding the larger physician practice losses.

The challenge for integrated networks with strong specialty revenue will be the transition to bundled payments and value-based care. As the transformation of the healthcare system progresses, there might be less need for specialists. Coordinated care for population health and improved quality outcomes should result in less ancillary tests and procedures. In the new care model these will generate costs, but not additional revenue.
Addressing Physician Underperformance

In response to how a physician’s underperformance was addressed, the respondents were fairly evenly spread among different courses of action taken.

No respondents indicated they replace the physician with mid-level practitioners. There was not a consensus action for respondents in the higher loss ranges ($101,000-$200,000 and greater than $200,000). Average annual physician losses were not a determining factor in which course of action was chosen by the hospitals or healthcare systems.

The results lead us to conclude that this topic – underperformance – is a very difficult one for hospitals and systems to address. There appears to be some discomfort in addressing this. We believe as integration continues to mature, that underperformance needs to be addressed consistently and directly. In areas where underperformance is not addressed, we believe that this will impede the further development of the integrated system.
Information Technology: Practice Management System and Electronic Health Records

80% of respondents indicated they use a single practice management (PM) system for all employed physician groups, while 100% stated they use a single electronic health record (EHR) solution for all physicians. 90% responded that their physician PM and EHR are integrated.

Integrated PM and EHR

Yes (90%)

- 11%
- 11%
- 22%
- 56%

No (10%)

100%
Integration of Patient Data Between Physicians and Hospitals

Notwithstanding the integrated, single solution PM and EHR systems for the employed physician groups, only 40% of respondents currently exchange patient record data with their Hospital EHR system. Of the 60% of respondents that have not integrated their physician and hospital systems, 84% experienced losses exceeding $100,000 of which 17% were experiencing losses over $200,000.

We believe that the current employment of physicians is a step to become an integrated system caring for the health of a specific market. To do that effectively, and to be able to navigate changing payment methodologies, patient data will need to be shared between the hospital and the employed physicians.
Achievement of Meaningful Use

50% of respondents reported that over three quarters of their physicians had attained meaningful use (MU). The other 50% of respondents reported that 26-75% of their physicians had attained MU.

There does not appear to be a correlation of high or low physician practice losses relative to who has achieved MU. The implementation, utilization and integration of this technology will be critical, however, for future success under healthcare reform.
Pathway to Improved Integration?

Respondents reported various measures taken to better integrate physicians into their organizations. Adding physician leadership to the health system’s executive and management teams was done by 80% of respondents. The annual physician losses for these organizations spanned several ranges, from as low as $0-$50,000 to the high of $101,000-$200,000.

For the 20% of organizations that have not added physician leadership to their teams, half of them have physician losses exceeding $200,000 and half $101,000-$200,000. While the benefit of integrating physicians in health systems would be in the efficiency and quality of care across the system, it is also interesting that physician practice losses are larger in organizations that keep physicians and hospitals somewhat separate.

In addition to physician executive positions, there was mixed use of paying physicians to lead projects (40%), tying incentive compensation to system goals (40%), or using a dyad model pairing physician and administrative leaders (40%). There was not a strong correlation of physician loss levels with adopting these approaches or not.
Adding Physician Leadership to Hospital System (80%)

- 50% No Loss
- 25% $0 - $50,000
- 25% $51,000 - $100,000

Did Not Add Physician Leadership (20%)

- 50% No Loss
- 50% $0 - $50,000

Legend:
- Yellow: No Loss
- Gray: $0 - $50,000
- Light Blue: $51,000 - $100,000
- Blue: $101,000 - $200,000
- Red: Greater Than $200,000
30% of responding organizations are participating in Accountable Care Organization (ACO) pilot programs and 60% are either developing or have plans to develop a Clinically Integrated Network (CIN). There is no discernible correlation with reported losses, as would be expected at this early state. The movement to utilize CINs in strategic relationships was borne out in the fact that 67% of the reported CIN developments are also contracted with payers through the CIN. Also, 33% of all respondents stated they have risk/gain sharing arrangements in place.

These responses reveal that health systems are acting strategically to the transformation of healthcare delivery by progressing with CINs and accepting risk in contracting.

To better manage these arrangements it is important to have clinical and financial data shared from the physician EHR and hospital EHR patient records. For 60% of respondents, this is not currently the case.

The development of this integration technology for many respondents has lagged the speed to enter the CIN and ACO arenas. In the short term, while enrollees and contracts are smaller, the value of early market entry and learning is worth this risk.

For long term success in the transformed population health delivery model, the technology must be in place ahead of large scale contracts.
Effective integration of physician group operations remains a top challenge and strategic imperative for hospitals and health systems today. Our second survey revealed the commitment to building integrated networks as part of the transformation of the healthcare delivery system; it also highlighted the breadth and depth of challenges that must be faced.

It is clear that losses on physician practices alone are not going to disappear anytime soon, and successful transformation to align physicians for the clinically integrated model of the future takes time. The losses are a part of the overall cost of investment to build the system of the future under healthcare reform. The important initiatives many survey respondents are implementing today will impact their success tomorrow.

- Including physician leadership within the health system
- Developing ACOs & CINs
- Incorporating quality, satisfaction, and other metrics in evolving compensation models
- Building towards integrated data management capabilities

The healthcare organization of the future will need to coordinate care across the full continuum, starting with wellness and including effective chronic care. Accepting risk for contracted population health requires a substantial infrastructure and exchange of clinical and financial data, as well as coordinated communication across the patient population, employers, providers, and payers. Quality and patient satisfaction (publicly reported) will be essential.

To this end, the majority of respondents are planning to develop clinically integrated networks as the vehicle to accomplish this. The most important key to succeeding may very well be the effective integration and leadership of physician groups.

MORE FROM DEAN DORTON

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ABOUT DEAN DORTON

Dean Dorton Allen Ford provides unmatched knowledge and expertise in healthcare industry accounting, tax, and business consulting. The firm’s team of healthcare advisors offers experience, expertise, and proven leadership to clients seeking to successfully adapt to a continually changing healthcare environment. Dean Dorton Allen Ford is located in Kentucky, and serves healthcare clients throughout the U.S.

The firm has decades of experience working with health systems, hospitals, physician groups and other providers to improve operations. Its advisors consult on physician compensation arrangements, operation efficiency analysis, coding support, underpayment recovery, revenue cycle assessment, technology needs analysis, mergers and acquisitions, community health needs assessments, and strategic plan development, among other services.

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