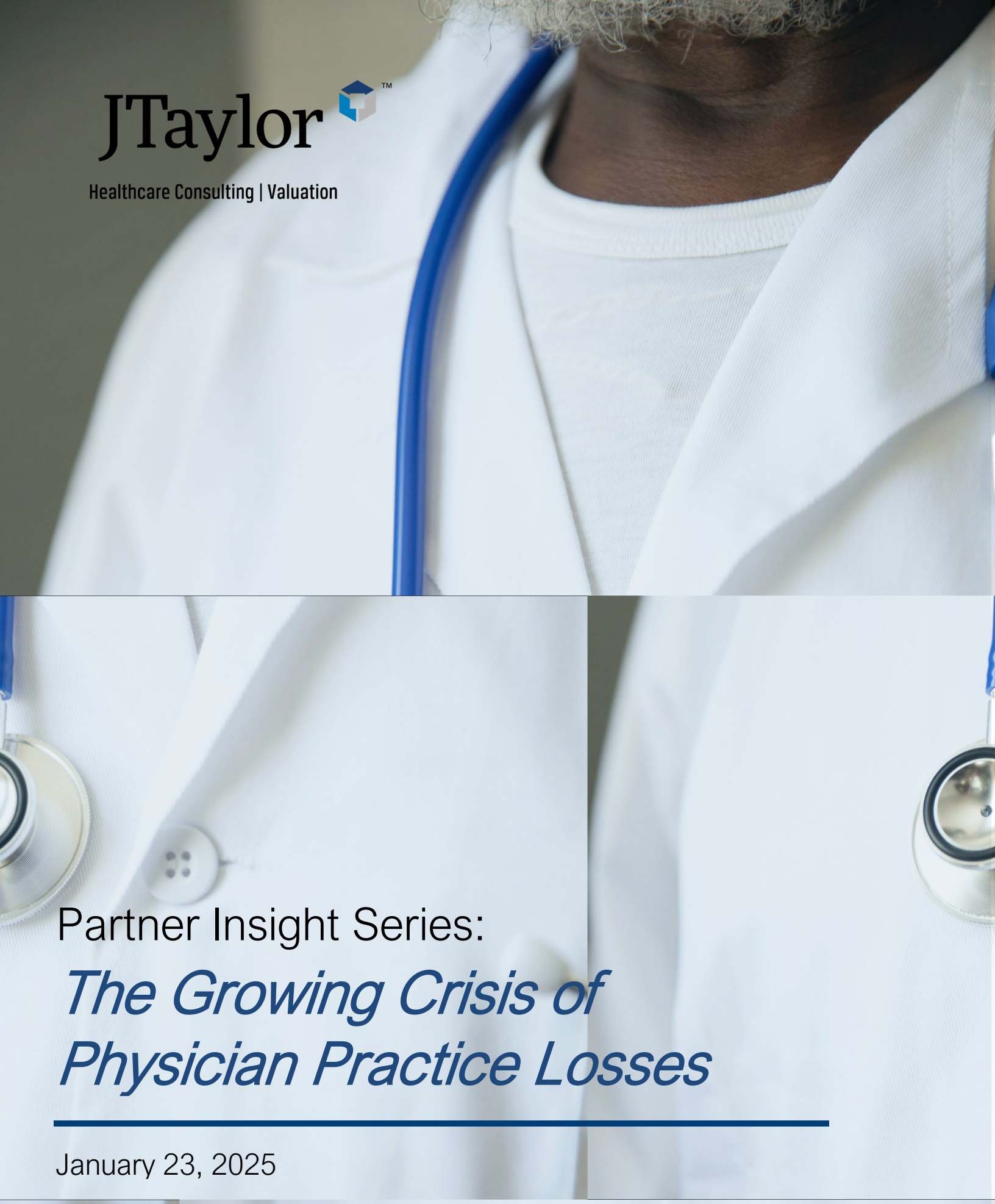

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Healthcare Consulting | Valuation

Partner Insight Series:

The Growing Crisis of Physician Practice Losses

January 23, 2025

The Growing Crisis of Physician Practice Losses

It is an open secret among health system and hospital operators that hospital-owned (or affiliated) physician practices generally operate at a loss. As hospitals have acquired or expanded physician clinics over the past twenty years, these losses have increased at a rate that threatens the long-term sustainability of this model. Hospitals must subsidize these practices to close the gap between revenues and expenses. The required subsidy is impacted by several factors, including:

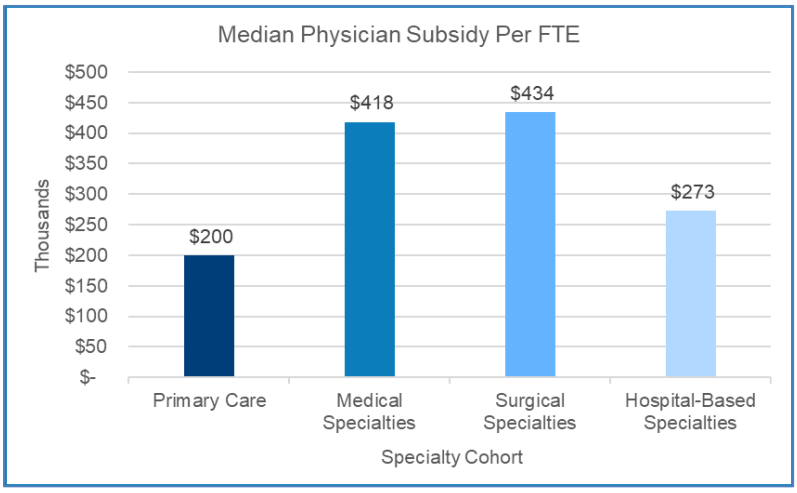
- High compensation levels driven by market supply and demand for physician services;
- Compliance with regulatory staffing requirements, such as trauma level designations that require the availability of certain physician specialties; and
- The community need for healthcare services and the high cost of physician recruitment and retention.

Additionally, physician practices that are part of larger health systems generally do not provide ancillary services (e.g., lab and radiology) that are typical of their independent counterparts, since these services are offered in other hospital departments. The absence of that revenue stream exacerbates the disparity between revenue and expenses when looking at the physician practice segment in isolation.

While the need for subsidies is clear, the amounts are increasingly unsustainable and are threatening the financial stability of healthcare systems. This white paper explores differences between private and hospital-owned physician practices, sources of healthcare revenue, industry trends impacting subsidies, and potential solutions to address this growing concern.

Rising Subsidy Trends

A recent report from Kaufman Hall[1] highlighted that the median subsidy per physician full-time equivalent (FTE) exceeded $300,000 for the first time in the third quarter (Q3) of 2024, reaching $304,312 across all specialties. Subsidies for the quarter were significant across all specialty cohorts, as shown below. Each of these reflects an increase from Q3 of 2023, and all but primary care reflect a fourth consecutive quarter of increases.



This trend of rising subsidies in hospital-owned physician practices reflects a broader issue: rising expenses

[1] Kaufman, Hall & Associates, LLC. (2024). *Physician Flash Report: Q3 2024 Metrics.* https://www.kaufmanhall.com/sites/default/files/2024-11/KH_PFR-Report-Q3-2024-Metrics.pdf

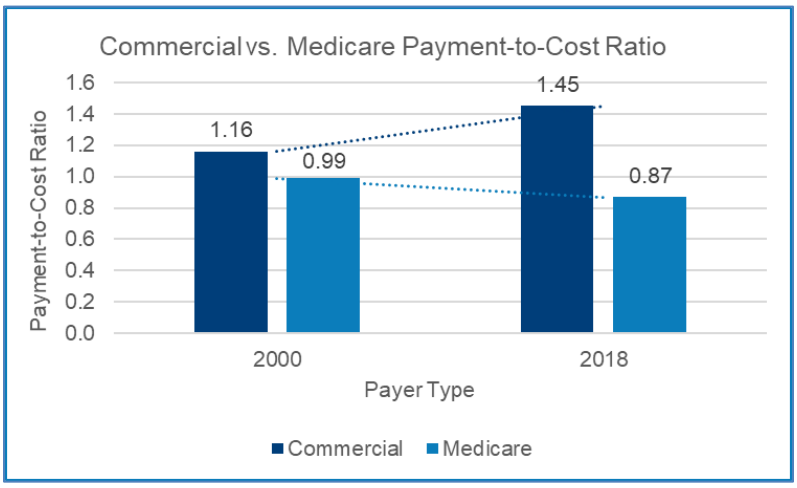
that outpace revenue increases for physician practices. Subsidy amounts are often derived as **Net Patient Revenue** (including fee-for-service, capitation, and quality payments) minus **Total Expenses** (labor costs, support services, occupancy expenses, supplies, equipment, and revenue cycle expenses). Ancillary service revenue is not included in this subsidy calculation, which is a crucial distinction when comparing hospital-owned practices to private practices. While private practices often have access to ancillary services as a part of their revenue stream, these revenues are stripped out of physician practices when they become hospital owned as they generally shift to other hospital service lines. While the hospital-owned practices do not incur the expenses associated with providing ancillary services, they still lose the profit margin inherent in such services, which can be significant depending on the specialty and impacts the overall bottom line.

As hospitals continue to operate on tight profit margins, the subsidy model becomes less sustainable – especially as expenses grow faster than revenue. And although physician employment arrangements can still be considered both fair market value and commercially reasonable despite operating at a loss, higher deficits invite more scrutiny and are more likely to violate these Stark and Anti-Kickback regulatory requirements.

Sources of Healthcare Revenue for Physician Practices

The primary sources of **Net Patient Revenue** for physician services are private insurance, Medicare, Medicaid, and self-pay patients. Private practices have more flexibility in selecting patients, often accepting primarily those with private insurance or individuals who can afford to pay cash for services and limiting or declining other patients. In contrast, hospital-owned practices have limited flexibility due to regulatory requirements and their mission to serve broader community needs. Consequently, hospital-owned practices tend to have a less desirable payer mix, often treating patients who generate reimbursement far below the cost of providing care – particularly Medicaid and self-pay/uninsured patients.

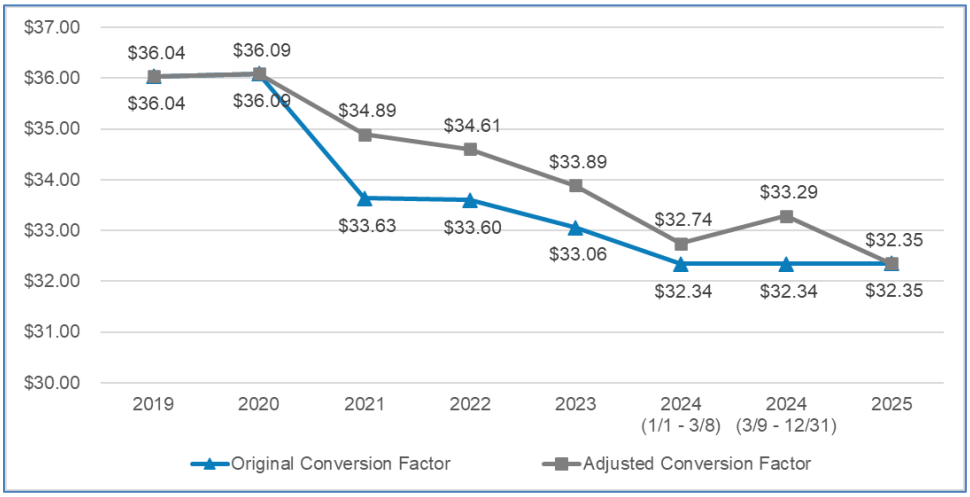
Medicare reimbursement, once regarded as a break-even proposition, has not kept pace with inflation. The Congressional Budget Office reported that Medicare's payment-to-cost ratio decreased from 99% in 2000 to 87% in 2018.[2]



The situation has only gotten worse since 2018. The Medicare Physician Fee Schedule (MPFS) has seen decreases in the **Conversion Factor**, the payment rate for each Relative Value Unit (RVU) associated with physician services, every year since 2020, except for 2024 when Congress applied a mid-year legislative fix. This decline was significant in 2021 as a result of rebalancing RVU values to favor primary care services. Due to statutory budget neutrality requirements, the increase in RVU values necessitated a decrease in the

[2] Cohen, M., Maeda, J., & Pelech, Daria. (2022, January). *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services.* Congressional Budget Office. https://www.cbo.gov/publication/57778

Conversion Factor to keep the overall spend consistent with the prior year. Each year since, the Conversion Factor has continued to decline, as shown below – even with Congressional intervention.



According to the American Medical Association (AMA), Medicare physician payments have declined 29% from 2001 to 2024 when adjusted for inflation in practice costs.[3] As of now, another 2.8% decrease is in place for 2025.

Impact of Private Equity on Hospital Bottom Lines

The increased involvement of private equity in healthcare services has reshaped the financial landscape. According to the Lown Institute, private equity buyouts of physician practices increased six-fold from 2012 to 2021.[4] Many of these acquisitions focus on higher-margin sectors like telemedicine, diagnostics, and ambulatory surgery. This shift leaves hospitals with a higher proportion of low-margin – or even negative-margin – services such as emergency care and ICU services, reducing the revenue sources they rely on to subsidize physician practices. As private equity expands into these high-margin areas, hospitals face increasing difficulty subsidizing physician services without the same aggregate level of revenue available historically.

Solutions to Address the Subsidy Crisis

Addressing the growing physician subsidy crisis will not be easy because the industry did not get into this situation overnight. The problem has been growing for as long as hospitals have been running physician practices. However, there are actions that both the government and specific hospitals can take to reduce the pace of subsidy growth.

Regulatory Action

At the Federal level, Congress needs to develop a permanent fix to the Medicare Physician Fee Schedule and take steps to increase the supply of physicians.

- **Increase MPFS Conversion Factor:** Due to the budget neutrality constraints under current law, the MPFS faces a cut each fiscal year. In recent years, Congress has provided a temporary solution to reduce the impact of the rate cut. However, these short-term fixes are problematic because they

[3] American Medical Association. (2024, June 17). *Medicare physician pay has plummeted since 2001. Find out why.* https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-physician-pay-has-plummeted-2001-find-out-why
[4] Garber, J. (2024, January 23). *The rising danger of private equity in healthcare.* Lown Institute. https://lowninstitute.org/the-rising-danger-of-private-equity-in-healthcare/

are always last minute (or even after the fiscal year is underway) and create significant uncertainty. Congress must raise the conversion factor for the Medicare Physician Fee Schedule and address the long-term structural problems to ensure reimbursement levels reflect the true cost of care. Rather than only rebalancing CPT codes and RVUs while decreasing the Conversion Factor, a comprehensive increase in overall reimbursement is necessary to address rising labor costs and operating expenses, especially in an inflationary environment. In its March 2024 report to Congress,[5] the Medicare Payment Advisory Commission (MedPAC) recommended that the payment rate for physicians and other healthcare practitioners should be increased by 50% of the projected increase in the Medicare Economic Index (MEI), a measure of inflation. While legislation to this effect has been proposed, it remains to be seen whether it will pass. Short of legislative intervention, budget neutrality requirements prohibit such an increase from being reflected in the MPFS.

- **Increase Residency Slots**: Physician compensation is a significant component of practice operating expenses, and compensation levels are often driven by the high demand for physicians compared to a low supply. This dynamic is heightened in certain geographical areas – in particular, rural markets – as well as high-demand physician specialties. To combat physician shortages, more residency positions must be created. Currently, there are more medical school graduates than available residency slots, which artificially restricts the supply of physicians. Increased Medicare, Medicaid, and state funding for residency slots would help alleviate the labor cost pressures caused by physician shortages. A 2022 provision added 1,000 new residency slots[6] but this is not enough to address current physician shortage projections. The Association of American Medical Colleges still projects a physician shortage of up to 86,000 physicians in the U.S. by 2036, but indicates the shortage could be even worse if GME investments do not grow at current rates.[7]

Hospital-Specific Actions

Hospital operators must also make concerted efforts to minimize the need for subsidies as they work to maintain and improve their operating margins. Such efforts could include the following:

- **Maximize the Use of Advanced Practice Providers (APPs)**: Hospitals should increase the utilization of Nurse Practitioners (NPs), Physician Assistants (PAs), and Certified Registered Nurse Anesthetists (CRNAs). These providers offer a cost-effective solution to expand capacity, particularly in states with more flexibility in their scope of practice. APPs can relieve physicians of routine tasks, allowing physicians to focus on top-of-license procedures and services.
- **Participate in Value-Based Care Initiatives**: Hospitals should actively engage in value-based care initiatives, such as Accountable Care Organizations (ACOs) or Value-Based Enterprises (VBEs). These collaborations can help reduce costs without sacrificing quality, enabling hospitals to manage financial pressures more effectively. Additionally, effective value-based care programs can lead to enhanced revenue as more payers seek to shift from fee-for-service to value-based payment arrangements.
- **Regularly Review Payer Contracts**: Hospital systems should regularly assess and optimize their payer contracts. With the rise of price transparency, hospitals have greater visibility into reimbursement rates and can negotiate more favorable agreements with insurers, potentially increasing revenue from private insurance.

Outside of subsidy concerns, hospitals must also ensure physician arrangements meet a Stark exception and Anti-kickback safe harbor. These include requirements that compensation paid to physicians is fair

[5] Medicare Payment Advisory Committee. (2024, March 15). *Report to the Congress: Medicare Payment Policy*. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC-3.pdf
[6] Hitchell, K. S. & Johnson, L. (2022, April 14). *CMS Finalizes Rules for Distribution of 1000 New Medicare-Funded Residency Positions and Changes to Rural Training Track Programs.* Journal of Graduate Medical Education. https://pmc.ncbi.nlm.nih.gov/articles/PMC9017251/
[7] GlobalData Plc. (2024, March). *The Complexities of Physician Supply and Demand: Projections from 2021 to 2036*. https://www.aamc.org/media/75236/download?attachment

market value, commercially reasonable, and not based on the volume or value of referrals. Compensation that results in a practice operating loss can still be fair market value and commercially reasonable, but such arrangements are inherently higher risk than practices that do not operate at a loss. The civil penalties for violating Stark or Anti-kickback regulations are significant, leading to sometimes multi-million-dollar fines for offending arrangements. It is therefore important that in addition to determining the financial feasibility of physician arrangements, hospitals ensure such arrangements achieve a valid business purpose. Additionally, hospital management should regularly review their physician contracts and engage an outside firm, as necessary, to evaluate physician arrangements to determine whether they are compliant with regulatory requirements.

Final Thoughts

The growing subsidies required to keep attract and retain quality physicians and keep physician practices afloat is an unsustainable trend that requires both federal and hospital-specific interventions. While short-term measures like increasing the use of APPs, participating in value-based care, and optimizing payer contracts can help alleviate financial pressures, long-term solutions require federal action to increase Medicare reimbursements and expand residency programs. Only through these measures can hospitals manage physician subsidies without sacrificing care quality or financial viability.

JTaylor's healthcare consulting team includes a group of professionals who specialize in physician practice dynamics, including both independent and hospital-based physicians. The team also includes individuals who focus on strategy and operations. If you are interested in exploring opportunities to improve the bottom line for your physician practices, with their unique services and payer mix, we can help. To find out more or to contact a member of our team, please visit our website. We will continue to monitor developments related to legislative activity impacting the healthcare industry.

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Haley leads the firm's physician advisory service line where she serves clients in the areas of compensation valuation, compensation plan design, provider practice valuations, physician transaction related due diligence and general consulting related to hospital / physician arrangements. Her clients include large multi-hospital health systems, rural hospitals, critical access hospitals, physician-owned hospitals, and physician practices. Haley is passionate about helping her clients recruit and retain talented providers by ensuring provider compensation is competitive and compliant with applicable regulations such as the Stark Law and Anti-Kickback Statue.

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