2013 Physician Inpatient/ Outpatient Revenue Survey

MERRITT HAWKINS
an AMN Healthcare company

A survey showing net annual inpatient and outpatient revenue generated by physicians in various specialties on behalf of their affiliated hospitals

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2013 Physician Inpatient/ Outpatient Revenue Survey

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Introduction

Merritt Hawkins is a national physician search and consulting firm specializing in the recruitment of physicians in all medical specialties as well as other advanced practice clinical professionals. Established in 1987, Merritt Hawkins is a company of AMN Healthcare, the innovator in healthcare workforce solutions and the largest provider of healthcare staffing services in the nation.

Merritt Hawkins conducts an ongoing series of surveys covering a range of physician staffing issues including physician recruiting incentives, physician practice patterns, hospital recruiting patterns and related topics. This report summarizes Merritt Hawkins' fifth survey of the revenue physicians in various specialties generate for their affiliated hospitals. This periodic survey was conducted previously by Merritt Hawkins in 2002, 2004, 2007 and 2010.

The survey is intended to provide benchmark data hospitals can use to develop a "quantitative analysis" of their physician-recruiting programs. A quantitative analysis as defined by the U.S. Internal Revenue Service (IRS) establishes the financial benefits that newly recruited physicians may bring to a hospital. These benefits may support the hospital's mission of providing quality care to the community by creating revenue streams necessary to its continued or its enhanced operation. A quantitative analysis therefore may serve as part of a hospital's physician recruiting plan by demonstrating the financial benefits to the hospital of physician recruitment. It should be noted, however, that a physician recruiting plan also should include a "qualitative analysis" demonstrating how newly recruited physicians will enhance quality of care in the community by adding needed services.

Survey data also may be used in setting physician compensation levels or recruiting incentives through a cost-benefit analysis comparing the aggregate expense of recruiting physicians to the average revenue generated by physicians in various specialties.

Methodology

Merritt Hawkins emailed the Physician Inpatient/ Outpatient Revenue Survey to 3,000 hospital Chief Financial Officers (CFOs) nationwide using a list of names randomly generated by a healthcare database company. The survey form was emailed in January, 2013, and additional surveys were emailed at approximately the same time to a database of healthcare facility managers maintained by Merritt Hawkins. In addition, the survey was sent to 2,500 hospital CFOs by regular mail using a list randomly generated by a healthcare database company.

The survey could be taken anonymously or those CFOs requesting survey results could identify themselves and their facilities. The survey asked hospital CFOs to indicate the combined **net** inpatient and outpatient revenue generated annually for their facilities by a single, full-time equivalent (FTE) physician (employed by the hospital or in independent practice) in a variety of specialties through procedures performed at the hospital, tests and treatments ordered, etc.

In the case of primary care physicians (defined as family practitioners, general internists, and pediatricians), survey respondents were asked to determine revenue from direct admissions, procedures performed, lab tests, etc., not indirect revenue that primary care physicians may have generated from patient referrals to specialists utilizing the hospital.

The survey form listed various revenue ranges and allowed CFOs to select the most appropriate range for each specialty. In lieu of indicating a range, CFOs also had the option of indicating on the survey form the specific amount of revenue generated annually for their hospital by a single FTE physician in various specialties.

In cases where a range was indicated, the survey takes the midpoint of this range to determine a weighted average for each specialty. A total of 102 completed surveys were received. It should be noted that the volume of categorical responses varied by specialty. Not all returned survey forms included data for all specialties. In addition, the survey was self-selecting and smaller hospitals of fewer than 100 beds are somewhat over-represented. Given these factors, average revenue generated per medical specialty cannot be expected to reflect the experiences of all hospitals.

Survey Findings

Responding Hospitals by Number of Beds

Responding hospitals in 2013 by number of beds are indicated in the first chart below. The second chart shows a year-to-year comparison of hospital respondents by number of beds

2013 Responding Hospitals by Number of Beds

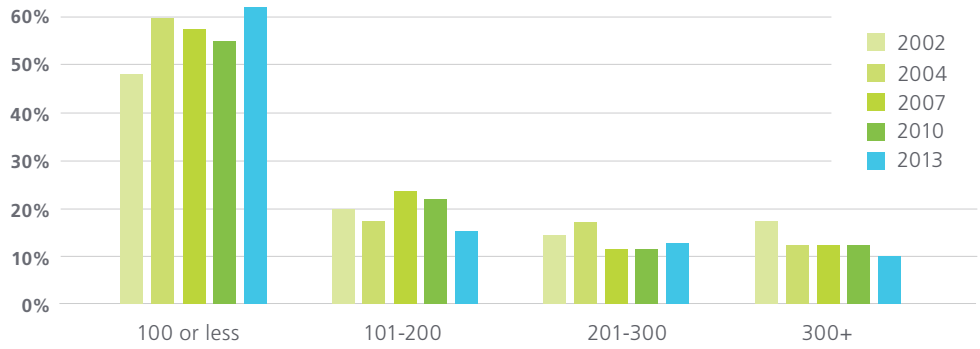
62%	15%	13%	10%
100 or less	101-200	201-300	301 and above

Hospitals by Bed Size in the United States

51%	21%	12%	16%
100 or less	101-200	201-300	301 and above

Source: The American Hospital Association Annual Survey of Hospitals

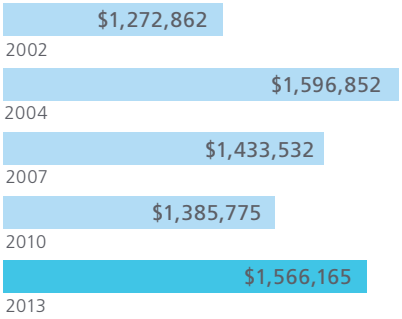
Responding Hospitals by Number of Beds (Year-To-Year Comparison)



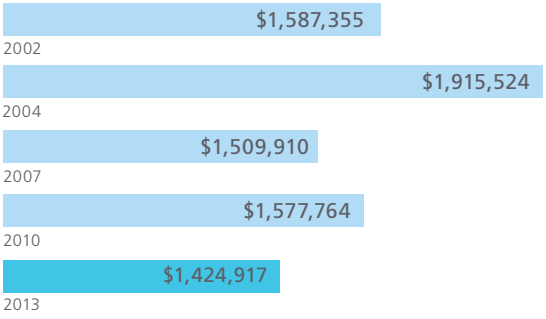
Average Revenue Generated by Primary Care Physicians, Specialists, and All Physicians

The first graph below indicates average net revenue generated by primary care physicians on behalf of their affiliated hospitals in the previous 12 months (a period generally corresponding to calendar year 2012), with comparisons to survey data from previous years. Primary care is defined in this survey as family practice, general internal medicine, and pediatrics. The second graph indicates average net revenue generated by specialist physicians on behalf of their affiliated hospitals, with comparisons to survey data from previous years. The third graph indicates net annual revenue generated by all physicians on behalf of their affiliated hospitals, with comparisons to data from previous years.

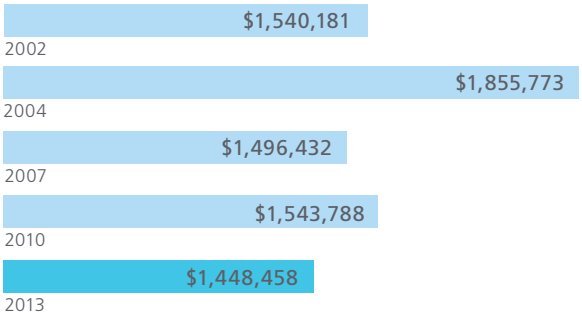
Primary Care Physicians



Specialist Physicians



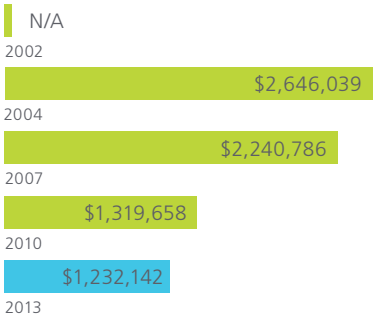
All Physicians



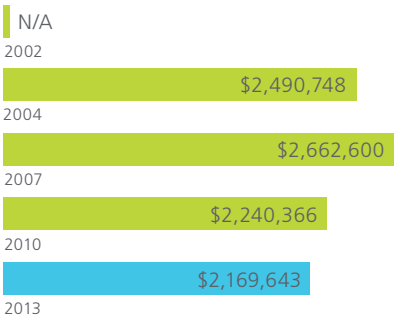
Specialty Revenue Comparison

The following graphs indicate average annual revenue generated by physicians in various specialties on behalf of their affiliated hospitals in 2013, with comparisons to data from surveys conducted in previous years.

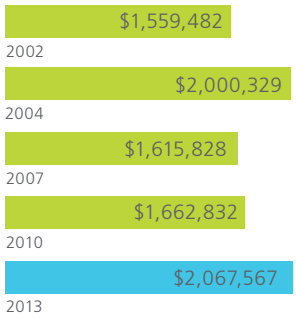
Cardiology (Non-Invasive)*



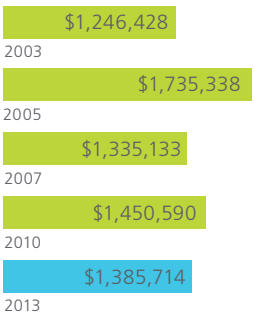
Cardiology (Invasive)



Family Practice

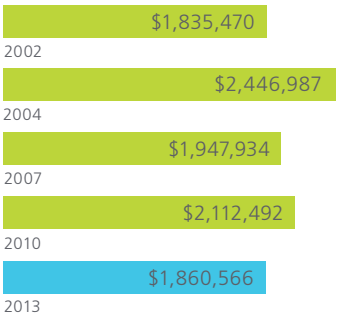


Gastroenterology

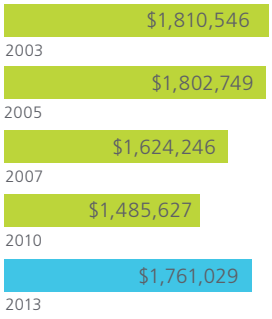


Specialty Revenue Comparison (continued)

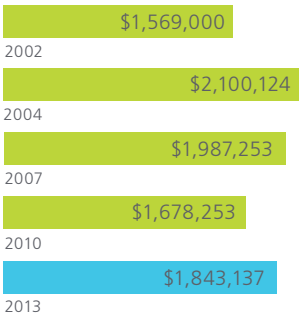
General Surgery



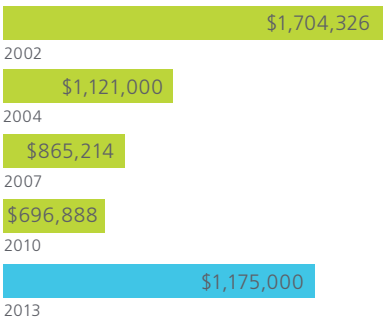
Hemetology/ Oncology



Internal Medicine

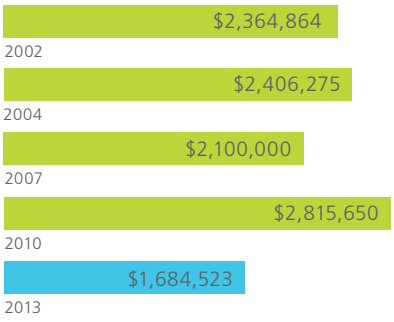


Nephrology

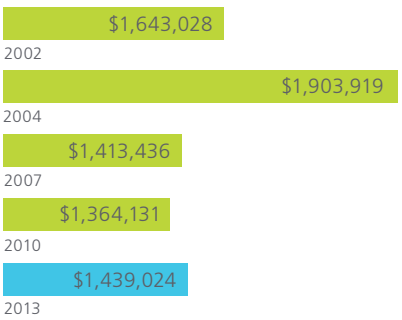


Neurology

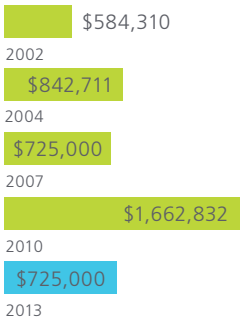
Neurosurgery



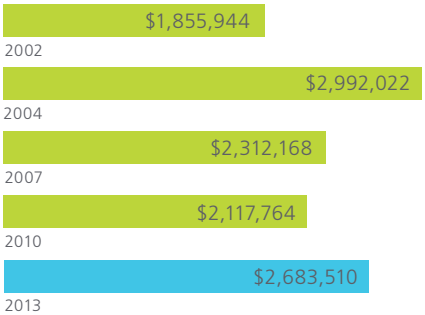
Obstetrics/ Gynecology



Ophthalmology



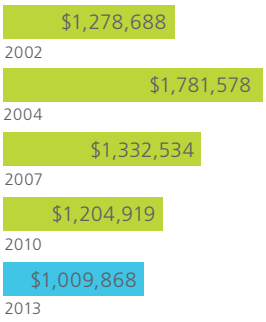
Orthopedic Surgery



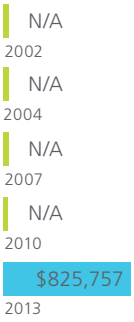
Pediatrics

Psychiatry

Pulmonology



Otolaryngology



Urology

Cost-Benefit Analysis

The numbers below compare the average annual inpatient/outpatient revenue generated by physicians in various specialties for their affiliated hospitals with average salaries or income guarantees offered to recruit physicians. Average salaries and income guarantee figures are derived from Merritt Hawkins' 2012 Review of Physician Recruiting Incentives and indicate the financial incentives offered to physicians in approximately 2,700 physician search assignments Merritt Hawkins conducted from April 1, 2011, to March 31, 2012. The numbers below may be used as part of a "quantitative" physician recruiting cost-benefit analysis showing costs of recruiting physicians relative to the revenue physicians generate for their affiliated hospitals. A "qualitative" analysis also will factor in the quality-of-care benefits that new physician services may bring to a given community.

Figure 1

Physician-Generated Revenue vs. Average Salaries

Specialty	Revenue	Salary
Cardiology (Non-Inv)	$1,232,142	$396,000
Cardiology (Invasive)	$2,169,643	$512,000
Family Practice	$2,067,567	$189,000
Gastroenterology	$1,385,714	$433,000
General Surgery	$1,860,655	$343,000
Hematology/Oncology	$1,761,029	$360,000
Internal Medicine	$1,843,137	$203,000
Nephrology	$1,175,000	N/A
Neurology	$691,406	$280,000
Neurosurgery	$1,684,523	$669,000
OB/GYN	$1,439,024	$268,000
Ophthalmology	$725,000	$295,000
Orthopedic Surgery	$2,683,510	$519,000
Otolaryngology	$825,757	$412,000
Pediatrics	$787,790	$189,000
Psychiatry	$1,302,631	$224,000
Pulmonology	$1,009,868	$321,000
Urology	$1,428,030	$461,000

*Source: Merritt Hawkins 2012 Review of Physician Recruiting Incentives)

Trends and Observations

Summary Highlights:

- For the first time, primary care physicians exceed specialists in revenue generated

- Physicians contribute $2.2 million a year in economic development to their communities

Merritt Hawkins' 2013 Physician Inpatient/Outpatient Revenue Survey provides benchmark data indicating the estimated amount of net inpatient and outpatient revenue physicians in 18 specialties generate annually on behalf of their affiliated hospitals through patient referrals, admissions, procedures, treatments, and tests.

The average annual net revenue generated by all 18 specialties examined in the 2013 survey was $1,448,458. This is a decrease of 9% over average annual net revenue generated by all specialties in 2010 ($1,543,788), and the lowest average number in the five years Merritt Hawkins has conducted this survey.

The average annual net revenue generated by primary care physicians, defined as family physicians, general internal medicine physicians, and pediatricians in the 2013 survey was $1,566,165, up from $1,385,775 in 2010, an increase of 13% and the second highest average number in the five years Merritt Hawkins has conducted this survey.

The average annual net revenue generated by specialty care physicians in the 2013 survey was $1,424,917, the lowest average number in the five years Merritt Hawkins has conducted this survey. For the first time, the 2013 survey indicates average annual revenue generated by primary care physicians exceeds that of specialty physicians.

In the five years Merritt Hawkins has conducted this survey, average annual revenue generated by all physician specialties has fluctuated from $1,448,458 in the 2013 survey to $1,855,773 in the 2004 survey. However, for four of the five years, average annual revenue generated by all specialties has fluctuated by a much smaller margin, from $1,543,788 in the 2010 survey to $1,448,458 in the 2013 survey. For this reason, Merritt Hawkins is confident in asserting that the average revenue generated by physicians in all specialties for their affiliated hospitals is approximately $1.5 million.

An additional point to be considered is that physicians also generate economic development income for the communities they serve, apart from income they generate for their affiliated hospitals. According to a study by The Lewin Group, office-based physicians contribute an annual average of $2.2 million in economic development to their communities through the purchase of goods and services, and payment of wages, benefits and taxes (see State Level Economic Impact of Office-Based Physicians, The Lewin Group, February, 2011).

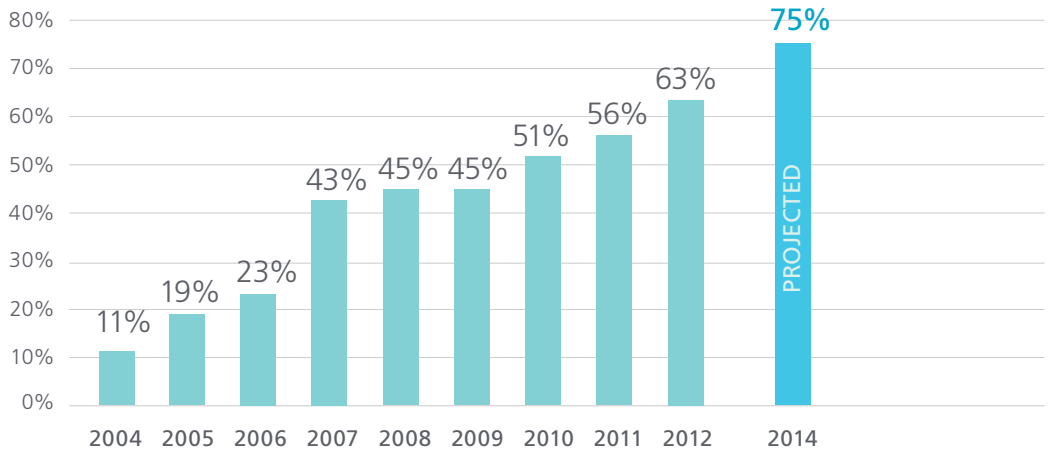
Gains in Primary Care

Net revenue generated by primary care physicians increased in the 2013 survey relative to 2010, the last year the survey was conducted. This was particularly apparent in family practice, where average revenue generated increased to $2,067,567 in the 2013 survey compared to $1,692,832 in 2010, a gain of 22%. This was the highest average seen for family practice in the five physician revenue surveys Merritt Hawkins has conducted. Gains were also apparent in internal medicine, where average revenue generated increased to $1,843,132 in 2013, up from $1,678,341 in 2010, a gain of 9%. The exception in primary care was pediatrics, in which revenue generated in 2013 was down slightly compared to 2010.

Increases in revenue generated by family medicine and internal medicine physicians may be a result of the recent trend toward hospital employment of doctors. A growing number of physicians in recent years have opted out of traditional, independent practice and have become hospital employees. In 2004, only 11% of Merritt Hawkins' physician search assignments featured hospital employment of the physician. By 2012, that number had risen to 63%. If this trend continues, Merritt Hawkins projects that by 2013, 75% of all newly hired physicians will be hospital employees (see Figure 2 below).

Figure 2

Search Assignments Featuring Hospital Employment



Source: Merritt Hawkins 2012 Review of Physician Recruiting Incentives

As primary care physicians become hospital employees, they may be more likely to divert tests, therapies and other services "in-house" to their hospital employer, rather than to outside resources such as radiology groups or labs, which may have been their pattern when they were in independent practice. In Merritt Hawkins' experience, family medicine and internal medicine physicians are more likely to be employed by hospitals than are pediatricians, which may be one reason why revenue generated by pediatricians did not increase over the previous survey period.

The gains seen in revenue generated by family and internal medicine physicians also may be a result of delivery models that are shifting toward a preventive, primary care-driven approach, typified by the patient-centered medical home. As primary care physicians gain status as directors of the medical team, they will gain more control of how patients access the system and how revenue streams are directed.

Whether the impact primary care physicians have on hospital revenue continues to grow may be tied to the trend toward physician employment in another way. A survey Merritt Hawkins conducted for The Physicians Foundation (www.physiciansfoundation.org) suggests that employed physicians may be less productive than physicians who are independent practice owners (see Figure 3 below)

Figure 3

Patients Seen Per Day/ Employed Physicians vs. Independent

	Employed	Independent
Patients seen per day	18.1	21.9
Hours worked per week	53.1	54.1
Work less than 40 hours per week	20.1%	18.4%

Source: A Survey of America's Physicians: Practice Patterns and Perspectives, Merritt Hawkins and The Physicians Foundation, September, 2012

These numbers indicate that employed physicians see 17% fewer patients per day than do independent physicians, work fewer hours per day and are more likely to work less than a full-time, 40 hour- per- week schedule. As the employed model becomes more established, revenue generated per primary care physician may plateau or begin to decline, as the impact of bringing services "in-house" is offset by a decline in per-physician productivity.

Another development to watch, which may pose a conundrum for hospitals, is that as payment models change, rewards will be given to those providers who can deliver quality care within a hospital's overall budget. In delivery models such as Accountable Care Organizations (ACOs), hospitals may not want high-cost imaging and other expensive services on their ledgers when these services can be provided more economically at free-standing centers. Should the transition from fee-for-service to value- based models proceed as currently envisioned, the value of physicians to hospitals may be less tied to their revenue-generating ability than it is now, and more tied to their ability to deliver quality outcomes in an efficient manner.

Specialty "Haves"

Some specialty areas also showed gains in revenue generated on behalf of affiliated hospitals. Notable among these is nephrology, in which revenue generated increased to an annual average of $1,175,000 in 2013 from $696,888 in 2010, a gain of 69%. These gains may be attributable to the increasing incidence of diabetes nationwide and by Medicare and other third-party payments that continue to be relatively favorable for dialysis treatment. Dialysis treatment typically is extremely expensive, to such an extent that Medicare will pay the entire cost of a kidney transplant for some beneficiaries since such a course of treatment may be more cost- effective than prolonged dialysis.

Summary Highlights:

- Rewards will be given to those providers who can deliver quality within a budget.

- Medicare continues to pay for more sophisticated and expensive drugs.

Orthopedic surgery also experienced gains in revenue generated, increasing to an annual average of $2,683,510 in 2013, up from $2,117,764 in 2010, a gain of 27%. The reason for this increase most likely is not linked to growing Medicare and other third-party reimbursement for orthopedic surgery services. A more likely reason is the increasing sophistication and cost of replacement hips, knees and other devices used in orthopedic surgery. In addition, "certificate of need" (CON) restrictions have been put on physician-owned hospitals and ambulatory surgery centers, reducing or limiting venues where orthopedic surgery is performed to the benefit of hospitals.

Hematology/oncology showed an increase in average annual revenue generated, rising to $1,746,323 in 2013, up from $1,484,627 in 2010, a gain of 18%. This is another instance where Medicare and other third-party reimbursement for physician services is an unlikely cause for the increase in annual revenue generated. In recent years, services provided by hematologists/oncologists have seen significant reimbursement cuts. However, new, more sophisticated and more expensive chemotherapy drugs have come into use and Medicare generally does not deny payment for the use of these drugs. In some markets, hospitals have purchased independent cancer centers, capturing all of cancer care and not just the lower margin care that independent centers did not pursue.

The rising revenues generated by hematologists/oncologists for hospitals are part of an American healthcare success story. Cancer has largely been transformed from a terminal diagnosis to a treatable disease. There are now over 10 million cancer survivors in the United States, many of whom continue to require treatment that is growing increasingly hospital-based as hematologists/oncologists migrate from independent practice to hospital employment.

Specialty "Have Nots"

Declines in average annual revenue generated were seen in neurology, general surgery, and neurological surgery. Declines in the latter may be connected to specialty cross-over patterns in which orthopedic surgeons and interventional radiologists now are performing procedures that were formally the province of neurosurgeons. This cross-over pattern is apparent in other specialty areas, such as cardiology, where some work has migrated to radiologists, and radiology and psychiatry, where some work has migrated to primary-care physicians. However, it should be noted that the survey sample size for neurosurgery, which is not available at many hospitals, also may account for the variation seen in 2013 relative to 2010.

Reasons for declines in revenue generated by general surgeons and neurologists are less apparent, as demand in these areas remains strong and reimbursement has not suffered the declines seen in other specialties such as hematology/oncology and cardiology. General surgery losses, however, may be tied to changing venues of care as urgent care centers and occupational medicine centers absorb general surgery work previously done in hospitals. Whether or not findings for general surgery and neurology are anomalies may be revealed in subsequent surveys.

Average annual revenue generated also declined slightly in invasive cardiology. In the last several years, some services provided by cardiologists have been considered reimbursement "outliers" by Medicare and have been targeted for significant reimbursement cuts. Many cardiologists have sought relief from decreasing reimbursement and increasing costs by becoming hospital employees. However, reductions to payments in cardiology may not necessarily be offset by increases in drug, device, or treatment costs, as they have been in other specialties. Average annual revenues generated by invasive cardiologists for hospitals can be expected to decline in coming years.

Average annual revenue generated by other specialties referenced in the survey, including urology, pulmonology, obstetrics/gynecology, and psychiatry, were more or less stable in 2013 relative in 2010. For the first time, the 2013 survey includes data on otolaryngology.

Summary Highlights:

- Specialty cross-over patterns may explain some revenue decreases

- Revenues generated by invasive cardiologists can be expected to decline

Conclusion

Today's healthcare system is in the midst of a transition from one in which volume of services is predominantly valued and paid for, to one in which quality outcomes and other "value" metrics will be valued and paid for. This transition also includes a wave of hospital and medical group consolidations and a landscape in which competition may be more between venues than between medical specialties.

However, this transition is still in its initial stages. In March of 2013, the Catalyst for Payment Reform (CPR), an independent, non-profit group working on behalf of large healthcare purchasers, released a study indicating that the great majority of payments made by commercial health plans to providers (89.1%) are still based on traditional fee-for-service models and are not tied to improving quality or reducing inefficiency. Only remaining 10.9% of payments were tied to these and other value metrics.

For today, volume remains the name of the game in payments for healthcare services, and volume of services continues to be largely driven by physicians. Little takes place in medicine that is not ordered by, reviewed by, or performed by a doctor. Merritt Hawkins' 2013 Physician Inpatient/Outpatient Revenue Survey quantifies the financial impact physicians have on hospitals as the initiators and providers of care – an average, per physician, of $1,404,980 in revenue generated per year. The data included in the survey may be of assistance to hospital executives preparing a "quantitative analysis" of the impact of physician recruiting on their facilities. Such an analysis should be accompanied by a "qualitative analysis" documenting the impact on quality of care provided to the community of newly recruited physicians.

For additional information about this or other surveys conducted by Merritt Hawkins and other companies of AMN Healthcare, contact Phillip Miller, Vice President of Communications, at **469-524-1420**.

Additional Information from Merritt Hawkins and AMN Healthcare

Merritt Hawkins and AMN Healthcare are committed to providing survey data and other information of use to healthcare executives, physicians, policy makers and members of the media.

- Clinical Workforce Issues: Survey of Hospital Chief Executive Officers
- Review of Physician and Recruiting Incentives
- Survey of Patient Appointment Wait Times
- Review of Temporary Physician Staffing Trends
- Survey of Registered Nurses
- Survey of Temporary Therapist Staffing Trends
- Survey of Final Year Medical Residents
- Survey of Physician Practice Trends

In addition, AMN Healthcare offers speakers to address healthcare industry trends in staffing, recruiting and finance. Topics include:

- Physician and Nurse Shortage Issues and Trends
- New Strategies for Healthcare Staffing
- Healthcare Reform and Workforce Issues
- Economic Forecasting for Clinical Staffing
- Allied Staffing Shortages
- Vendor Management
- Recruitment Process Outsourcing
- Other topics Upon Request

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An Educational Resource

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- Clinical Workforce Solutions
- Evolving Physician Staffing Models
- Physician and Nurse Shortage Issues and Trends
- New Strategies for Healthcare Staffing
- Healthcare Reform and Workforce Issues
- Economic Forecasting for Clinical Staffing
- Allied Staffing Shortages
- Vendor Management
- Recruitment Process Outsourcing
- Other Topics Upon Request

For more information or to schedule a speaking engagement, please contact:

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