Downstream Revenue Funding

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Outline

• Why?, Definition
• Primary care profitable?
• Literature / Data ACGIM
• Pros / Cons
• Solutions
Dean’s Tax
East Carolina University

Prior (02-03)
- Flat tax 29%
- DOIM 29%
- GIM
  - 29%
  - $441k

Current (03-04)
- Formula: # invoices
- DOIM 26%
- GIM
  - 53%
  - $900k
Downstream Revenue “Multiplier Effect”

- Revenue associated with a defined panel of patients during a defined period of time

- Amount of gross income generated to
  - hospitals
  - ancillary services
  - specialty physicians
  - health systems ... for each $ that GIM collects
GIM - Downstream Revenue

Primary Care

EM / Procedures

Ancillary Labs, radiology Other (Echo…)

Outpatient

Prof fees Referral

Hospital

Prof fees Referral

Facilities
Could Primary Care Brake Even / Be Profitable?
Medical Group Management Assoc

- Net loss/ FTE (hospital owned practices):
  - 2001 $75,000
  - 2002 $82,000
- Costs: ↑ 8.4%, ↑ Revenue: 4.5%
- Loss maintained
  - Referrals, ancillary services
  - Stable network, call schedule, planning

AMA News March 8, 2004
### GIM Roles / Revenue / Costs

<table>
<thead>
<tr>
<th>Role</th>
<th>Revenue</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Med Students</td>
<td>(+) / (-)</td>
<td>(+)</td>
</tr>
<tr>
<td>– Residents</td>
<td>(+) / (-)</td>
<td>(+)</td>
</tr>
<tr>
<td>• Patient Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Insured</td>
<td>(+)</td>
<td>(+)</td>
</tr>
<tr>
<td>– Uninsured</td>
<td>(-)</td>
<td>(+)</td>
</tr>
<tr>
<td>• Research</td>
<td>(+)</td>
<td>(+)</td>
</tr>
<tr>
<td>• Administration</td>
<td>(+) / (-)</td>
<td>(+)</td>
</tr>
</tbody>
</table>
What Do We Know About Downstream Revenue or Multiplier Effect?
MD Referrals in a Competitive Environment
Estimate of Economic Impact of a Referral

• 1982-84, MO, 6 m, n=225
• Rural fam practice → University specialists
• Each referral, charges: $2,944
  – Hospital $2,120
  – Professional fees $824

Glenn JK. JAMA 1987 258:1920-3
Economic Impact and Multiplier Effect of a Family Practice Clinic on an AMC

- 1986-87, WA, 12 m
- Family practice clinic → University hospital
- Each $1 billed, $6.40 billed elsewhere
  - $1.1 Clinics/ ED
  - $1.1 Outpatient Ancillary
  - $3.6 Hospital/ Professional fees
  - $0.6 Hospital/ Ancillary
- Charges/ FTE: $784,752 (hospital) $241,276 (specialty)

Assessing Primary Care’s Contribution to AHC

• AMC consultant
• Each $1 revenue, $15 revenue elsewhere
  – $ 10.3 Hospital
  – $ 4.7 Specialist
• Revenue/ FTE:
  – $ 2.2 mil Hospital
  – $ 0.5-1 mil Specialist
Indirect Institutional Revenue Generated from Academic Primary Care Network

• 1998-99, OR, 6 m
• Primary care network → Health system
• Each $1 billed, $7.7 billed elsewhere
  – $6 Hospital
  – $1.2 Professional fees
  – $0.5 Outpatient Ancillary (partial)

Saultz JW. Fam Med 2001 33: 668-71
Financial Effect of a Hospital Outpatient Senior Clinic on an AMC

- 1998, AR, 6 m
- Outpatient senior clinic → Univ hospital
- Each $1 billed, $17 billed elsewhere
  - $ 8.6  Hospital inpatient
  - $ 5.5  Hospital outpatient
  - $ 2.9  Professional fees

Dang S. JAGS, 2002: 50: 1621-8
## ACGIM Survey, 2004 (n=8/14)

<table>
<thead>
<tr>
<th>GIM</th>
<th>Downstream</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1 revenue</td>
<td>$11-12 specialist/hospital/ancillary</td>
</tr>
<tr>
<td>$1 billed</td>
<td>$15-35 specialist/hospital</td>
</tr>
<tr>
<td>Charges/FTE</td>
<td>$3-5 mil profit-net loss</td>
</tr>
<tr>
<td>Revenue/hospitalization</td>
<td>$9,493 hospital</td>
</tr>
<tr>
<td></td>
<td>$1,717 professional fees</td>
</tr>
</tbody>
</table>
GIM - Downstream Revenue

Primary Care
$ 1 Billed

Outpatient
Prof fees Referral
$ 1.1

Hospital
Prof fees Referral
Facilities
$ 3.6 -10

EM / Procedures
$ 1.7

Ancillary Labs, radiology Other (Echo…)

$
Pros and Cons?
Solutions?
Arguments Pro

- Downstream revenue exists
- Primary care under funded
  - Education
  - Patient care (uninsured)
  - Mission, administration
- Integrated health system
  - Primary care base needed
Arguments Con

• Referrals will continue even if no prim care
• Internal referrals not needed
  – External will support specialists
  – External more profitable
• Stark II violation if support
• Sub-specialty downstream > primary care
• Subsidies already in place
• Measure downstream revenue
Problems

- Assumes primary care the only gatekeeper, downstream revenue from other sources
- Net profits vs. expense (downstream costs!!)
- Works if closed or integrated health care delivery system
GIM - Downstream Revenue

Primary Care

Outpatient

Hospital

EM / Procedures

Ancillary Labs, radiology Other (Echo…)

Prof fees Referral

Facilities Prof fees Referral

Separate System

$
Downstream Revenue Referrals - ECU

• Internal
  – 5,400 referrals (Jul 02-Jun 03: 3,000 FPC, 2,400 GIM)
  – Estimated $ 3,000/ each referral *
  – Estimated $ 16.2 million

• External
  – Services available at ECU
  – Services not available at ECU
    • Radiology
    • Labs
    • Specialties

* = MGM Journal March/April 1999
GIM - Downstream “Expense”

Primary Care

EM / Procedures $(\$)

Ancillary Labs, radiology Other (Echo….) $(\$)

Outpatient

Prof fees Referral $(\$)

Hospital

Prof fees Facilities Referral $(\$) $(\$)
Downstream Revenue
AMC - Solutions

• “Cost of supporting primary care likely offset by revenues generated from hospital and referral services…”

• Support
  – ↓ Tax (Dean)
  – ↑ Income support
  – Recognize ancillary services
  – Improve community relations
  – Local politics
Cape Hatteras  Ocrakoke