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physician compensation 5 mistakes, 1 solution

The most effective physician compensation models are productivity-based, using work relative value units to measure productivity.

AT A GLANCE

Compensation models for employed physicians should be based on productivity and adhere to four key principles:

- > Focus on factors physicians can control.
- > Include productivity-based risk and reward.
- > Allow physicians to control personal income.
- > Tie reward/consequence to behavior in a timely manner.

While policymakers continue to debate healthcare reform, two facts remain abundantly clear. First, provider payment will decline overall. Second, regulation and the costs of providing care will increase. These two trends are unfolding as the demand for healthcare services from an aging population grows. Chief among the resulting business imperatives for healthcare providers is the unprecedented need to dramatically increase productivity throughout the delivery process, while maintaining or enhancing clinical quality and service quality.

The key to success or failure in a medical office is the productivity of its most expensive resource: the physician. And physician productivity will be critical to the success of those health systems for which physician integration is a key strategy to enhance quality and lower costs. Although many factors affect productivity in a medical office, experience has shown that the physician compensation model is the key driver of the vital behaviors and attitudes that lead to high productivity. A sustainable physician compensation model is required to provide physicians with an opportunity to earn a market rate of pay for their specialty, while allowing the practice to remain financially viable. Any physician compensation approach that does not achieve these two fundamental objectives is broken.

Five Mistakes

Hospital executives and physicians developing or negotiating compensation have often made—and continue to make—five mistakes that challenge the sustainability of hospital-owned medical practices.

Relying too much on compensation surveys. In the rush to consummate acquisition and integration deals, hospital executives often ask, “Is the compensation between the 50th and 90th percentiles?” Ensuring that the compensation is within broad percentile boundaries may help to reduce the risk of review by compliance regulators. However, the rates and compensation levels summarized in the compensation surveys shed no light on what may be financially appropriate and sustainable within a specific practice.

One of the first questions that should be asked in any integration scenario is, “What income did the physicians or group generate during the most recent two years?” Regardless of the findings of compensation surveys, the most important perspective for what is appropriate in terms of the bottom line—and applicable to any specific practice situation—is the *actual historical performance of the practice*. This historical performance should be identified from two calculations:

- > The total dollars that the physicians have received from their current practice
- > The corresponding dollar rate per unit of productivity (often calculated in terms of dollars/work relative value unit [wRVU])

Failing to recognize the fallacy of graduated bonus tiers and economies of scale. Hospital executives often look to the ratio tables published in various compensation surveys and observe that the ratios (i.e., compensation/wRVU) always progress in magnitude from the lower quartiles to the higher quartiles. This progression leads many to assume that the higher producing practices must, by definition, achieve a higher level of compensation per unit than those with lower productivity and, therefore, a graduated tier approach to compensation must be appropriate. Some executives surmise that a graduated tier not only is appropriate, but also is the key to success.

However, medical practices are not small hospitals. Where hospitals are relatively high-fixed-cost operations, physician practices, especially ambulatory medical specialties, have a higher variable cost (with support staff being one of the

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major expense categories). Referencing the ratio tables as justification for graduated tiers in physician compensation is a common misinterpretation of the data. These ratios do not report an increased dollar rate per unit for those with higher wRVU productivity. They simply illustrate the distribution of physician compensation per wRVU as reported in the compensation surveys. (They also illustrate the impact of lower producing practices upon these ratio values.)

The exhibit below illustrates the impact of the lower productivity on these ratio tables.

IMPACT OF LOWER PRODUCTIVITY ON PHYSICIAN COMPENSATION/wRVU			
Actual Values			
	wRVU	Compensation	Compensation per wRVU
Physician A	6,200	\$225,000	\$36.29
Physician B	5,300	\$200,000	\$37.74
Physician C	4,500	\$165,000	\$36.67
Physician D	2,800	\$150,000	\$53.57
Summary Statistics			
	wRVU	Compensation	Compensation per wRVU
25th percentile	4,075	\$162,250	\$36.57
Median	4,900	\$182,500	\$37.20
75th percentile	5,525	\$206,250	\$41.69

\$41.69/wRVU is influenced by the low producer, not the higher producers. The higher producers experience compensation/wRVU closer to the 25th percentile or median at \$36 to \$37.

Providing incentives for citizenship. Should a licensed professional be paid extra for practicing appropriate medicine? Should a professional be paid extra for being nice to patients or being sensitive to the needs, wants, and priorities of referring physicians? The most successful private practice physicians have long known the importance of clinical quality. They are trained to practice according to the latest science and their best judgment. Occasionally, a medical community learns just how critical clinical quality is and how quickly one mistake can destroy lives and a medical practice.

Similarly, the most successful primary care physicians have long known the importance of service quality in building and maintaining a primary care practice, which depends on word-of-mouth referrals from satisfied patients. Successful specialty physicians learn early on about the importance of access, communication, and patient service in motivating referrals from primary care providers, especially those who have other specialty alternatives.

The difficulties of agreeing on clinical quality standards in a practice setting or measuring performance (particularly outcomes) in a timely manner have fueled arguments against including these factors in physician compensation models. In reality, practicing appropriate medicine and being responsive to referring physicians and their patients is not a compensation issue. Quality is not an option. It is a condition of continued employment for those licensed to practice medicine. Private practitioners go out of business if they fail in these matters. Successful employers don't tolerate poorly performing employees, including physicians.

At the same time, current payment trends are placing increasing emphasis on clinical quality as a cost reduction initiative. In some settings, the rush to meet quality standards is occurring nearly to the exclusion of high physician productivity or practice financial viability. Successful compensation models will acknowledge excellence in clinical and service quality *in the context* of the high

productivity required to ensure practice financial viability in a fee-for-service setting or in a risk setting where access for large patient panels is essential.

Offering salary guarantees in the face of declining payment. One of the primary motivations for physicians seeking employment with hospitals is to ensure a level of income security amidst the uncertainty surrounding payment. In situations where the physicians are transitioning from private practice into employment, it is most appropriate to provide guarantees for the rate/unit, rather than the specific dollars paid. Guaranteeing the compensation rate, rather than the compensation dollars, maintains the incentive to uphold productivity levels, regardless of the underlying payment received.

Ignoring the practice bottom line. Again, when involved in the excitement of "closing the deal," hospital executives often accept (even push for) physicians' compensation terms, which are not sustainable at reasonable levels of productivity. They might agree to physician compensation beyond what the practice has traditionally supported, with the expectation that they can address the issue later when renegotiating subsequent contract terms. The inevitable practice losses invariably result in pressure on the providers to increase productivity to levels that might not be achievable, or to cut expenses (i.e., support staff) to levels that could be detrimental even to current productivity. The resulting climate is usually one of frustration, blame, and finger pointing resulting in irreparable damage to the very relationship the parties sought to strengthen and secure through physician employment. The end result is often the loss of key employed physicians and risks the loss of trust and support from other physicians in the community.

One Solution: wRVUs

The medical practice "game" is always won on the revenue side of the income statement, and highly productive physicians are the key to success even under risk models. Certainly, key expense areas must be controlled, but as many

hospital executives have learned the hard way, success in a medical practice is not achieved solely through cutting costs. Revenue is the key, and the key to revenue is volume. Although several other factors also affect revenue, the key driver of volume is productivity. And the key to productivity is the physician compensation model.

The most effective compensation models for hospital-employed physicians are productivity-based and adhere to four key principles:

- > Successful productivity models focus on factors that employed physicians can control.
- > The models include a healthy dose of productivity-based risk and reward.
- > They allow physicians to have control over their personal income.
- > Successful models attach the reward/consequence closely to the behavior.

Approaches based on work relative value units (wRVUs) can readily address all four of these factors.

Focus on controllable factors. Eight revenue factors affect the success or failure of a medical practice:

- > *Volume/capacity mix*—The ability to attract enough market share (patients and/or their referring physicians) to fill the physician capacity
- > *Payer mix*—Attracting patients who are insured or who can pay for the services they receive in addition to taking a fair share of those who cannot
- > *Fees for services*—Charging appropriate fees (e.g., not overcharging or undercharging) for the services performed, whether under a fee-for-service or a capitation model
- > *Service quality*—Providing high-quality customer service to patients and their referring physicians, especially given that primary care medical practices live or die by word-of-mouth referrals from happy patients to their friends and relatives and specialty practices live or die by referrals from satisfied primary care and other referring physicians
- > *Physician productivity*—A function of individual motivation and the effectiveness of the “productivity zone” (i.e., the physician’s work setting, including support staffing, physical layout, technology, and processes)

- > *Coding and documentation*—Accurate coding supported by compliant documentation that accurately describes the services performed to demonstrate medical necessity
- > *Revenue cycle management*—Effective when it starts and ends in the medical office, not in the hospital central billing office (e.g., the “central processing office” approach promotes accountability in the medical office for such functions as point-of-service collections, data verification, and credit extension, while accountability for clean claims “processing” and producing patient statements is centralized)
- > *Service mix*—Services offered in the medical office as a convenience to patients and services that enhance revenue per visit, and also including the office schedule to provide access to those services

Although a physician owner can directly influence all eight revenue factors, an employed physician has direct influence only over service quality, physician productivity, coding and documentation, and service mix. Work RVU models are driven by patient volume (a function of productivity and service quality) and services provided to patients. They require effective CPT coding that can easily be monitored by coding/documentation audits to ensure that the coding is optimal and appropriate for the services rendered.

Include productivity-based risk and reward. In private practice, most physicians’ income depends on an “eat what you treat” model. The harder a physician works, the higher is his or her income. If the physician goes on vacation or does not work as hard, his or her income drops. In bottom-line private practice models, the support staff and other bills are paid first. The physician gets what is left over, creating a 100 percent risk model. Such risk is essential in employment approaches, as well. Once a physician has had the opportunity to build a successful practice, he or she will usually prefer a model with substantial risk due to the potential upside in compensation. A recommended approach is 50 percent base pay and 50 percent based on wRVU productivity. Smoothing the productivity pay by using a three-month

moving average protects the physician against the impact of time off (allowed time off rather than paid time off) while maintaining the benefits of a risk model.

Allow control over personal income. Closely related to risk is the physician's ability to control his or her personal income. In a private practice setting, physicians each pay a fair share of overhead and then receive some type of distribution, usually attached to a personal performance formula. Physicians can choose to be the top performer in the practice with the associated financial rewards, or they can choose to be the low performer (as long as they cover their fair share of the overhead). For example, family physicians can earn from \$120,000 to more than \$200,000 on the same wRVU compensation model and the same rate paid per wRVU. Orthopedic surgeons can earn \$500,000 to \$900,000, again depending on their willingness and ability to build a busy or a very busy practice. No one has cause to complain because each physician controls his or her own compensation destiny within the constraints provided by the productivity model.

Tie reward/consequence to behavior. Successful compensation models tie the risk and the reward closely to choices or behaviors. Even quarterly payouts that reward physicians for January behaviors in April are inadequate. Private practices reward behavior every other week when support staff payroll hits the bank account. If there is cash left over, the physician(s) gets paid as well. Successful employment models tie the reward or consequence for decisions more closely to the behavior with a monthly productivity check based (at least in part) on the prior month's activity. In many successful practice models, physicians receive 50 percent of their compensation as base pay in equal installments over 24 or 26 pay periods. Their productivity pay occurs every month on the second payday.

Avoid Monumental Mistakes

Physicians are increasingly turning to hospital executives to provide a degree of income stability within the current climate of medical practice

uncertainty. To protect service lines and to meet community need, hospital executives are feeling tremendous pressure to acquire medical practices and to provide competitive compensation models for physicians seeking employment. Executives are also finding that newly trained physicians are insisting on an employment approach.

Hospital executives can avoid some of the most significant physician compensation pitfalls by being aware of the monumental mistakes that often result from misinterpretation and misapplication of survey data and/or quickly structured or expedient compensation arrangements. By structuring a compensation model using work RVUs, at sustainable rates per wRVU and with timely payment of those incentives, hospital executives can effectively "partner" with their employed physicians allowing them to earn a competitive market rate of pay while sustaining practice viability over the long term. ●

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