HOSPITAL EMPLOYMENT AND SUCCESSFUL PRIMARY CARE OPERATIONS: BRIDGING THE GAP

An Exploratory Paper

Donna M. Bergman, MBA, FACMPE

February 28, 2014

This paper is being submitted in partial fulfillment of the requirements for election to Fellow in the American College of Medical Practice Executives.
The purpose of this paper is to explore the various physician compensation models and their applications in a hospital employment model, with the goal of demonstrating how to turn a money-losing venture into a highly reliable, profitable group with engaged physicians and practitioners. This paper will demonstrate that a practice is not built around a compensation plan, but rather a compensation plan is built around a practice with a sound business plan that supports the hospital’s strategic goals.

Pressure exists to increase the primary care base as a means to increase capacity. This shortfall in physician availability has led to rapidly increasing market competitive compensation among employed primary care physicians in order to attract and retain physicians. While increasing compensation may work in the short-term, it does not create sustainable change that answers the problem of limited capacity with increasing patient demand.

When more doctors are not available, the traditional approach is to focus squarely on increasing individual production: see more patients in the office; hire more staff to more quickly check patients into a broken system; automate vitals so work can be done faster. Many practices are also looking to hire non-physician providers in order to increase revenue streams, which also bring offsetting supervisory responsibilities. The need to increase production is answered in compensation models that are designed to reward production.

While these actions may help in the short run to increase capacity, they really do very little in terms of creating sustainable capacity. Many physicians burn out when they have to work substantially harder to achieve the same amount as the base guarantee (Heath, Chip, and Dan Heath. *Switch: How to Change Things When Change Is Hard*, 2010). In addition, as hospitals move towards compensation models that reward production in areas where there
is not sufficient patient demand, physicians are unable to achieve their compensation goals. Physicians look towards improving their quality of life leading to greater gaps in coverage as they retire early or move to the better offer next door. Meanwhile, hospitals and other physician employers are constantly adapting compensation models to try to stay ahead. As compensation models change, physicians are more open to change, and are more likely to change employers during a compensation model transition.

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**IS HISTORY REPEATING ITSELF?**

In the late 1980s and into the 1990s, physician employment rose and fell. Insurance companies, such as Kaiser, employed physicians, creating staff model health maintenance organizations (HMOs), as did hospitals. Hospitals, in particular, held three beliefs as to why hospital-employment would work better than maintaining a private practice:

1) Hospitals believed physician practices were mismanaged and that hospitals could provide much needed infrastructure to help physicians succeed.

2) Hospitals believed that economies of scale could be maximized by bringing physicians together.

3) Hospitals believed they had a lower cost of capital and therefore physicians would be able to financially keep up with technology and other capital requirements.  
   (Eisenberg, Steven A. Physicians News Digest, 4 Feb. 2009.)

4) In addition, hospitals used employment models to build market share for the hospital and their specialty physicians.

While some survived, many groups fell – disbanding and scattering physicians across cities, counties and beyond, disrupting health care for the community at large. The demise of the
employment model was largely due to compensation mal-alignment. Compensation plans were typically large base salaries based upon history with 3-5 year guarantees. Production among physicians fell but compensation remained the same. Financial losses to the employer reached up to $100,000 per year, per physician, resulting in the almost total abandonment of hospital employment of physicians in some areas. Losses were sometimes compounded by overhead expenses not generally found in private practice and reduced revenue streams resulting from a push to have ancillary services performed in the hospital versus in the medical office.

Meeting the demands of increasing volume and intensity appears insurmountable without the backing of a large corporation, such as a hospital. Physicians and hospitals alike have found solace in employment often disregarding the failures of the past. With base compensation for primary care increasing (see Table 1) and financial losses attributed to employed physicians in the millions at each group, the hospital employment model appears almost destined to fail.
<table>
<thead>
<tr>
<th>Specialty</th>
<th>2011 Median Compensation</th>
<th>2012 Median Compensation</th>
<th>Percentage Change</th>
</tr>
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<td>Family Medicine:</td>
<td>$184,196</td>
<td>$195,827</td>
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</tr>
<tr>
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<td></td>
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<td>Internal Medicine:</td>
<td>$189,081</td>
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<tr>
<td>Pediatrics: General</td>
<td>$203,132</td>
<td>$213,378</td>
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TABLE 1: MGMA PHYSICIAN COMPENSATION AND PRODUCTION DATA BASED UPON HOSPITAL EMPLOYED PHYSICIANS

The employment model has returned largely with the same premise that brought it forward 20 to 30 years ago. So what is different today? Some organizations have learned from past mistakes, have matured and become better employers attracting better physicians. For instance, Virginia Mason transformed how its healthcare system approached physician employment models, leading to profitability for the group, increased physician retention and greater stability for Seattle and the surrounding areas. Virginia Mason's journey is well documented in Charles Kenney's book: Transforming Health Care: Virginia Mason Medical Center's Pursuit of the Perfect Patient Experience. The book recounts Virginia Mason's progress towards improving the patient experience and in the process, significantly improving clinic operations. These improvements resulted in stable and lasting relationships with physicians.
Other lessons learned include the design of compensation models and the need for models to drive the right behaviors. In years past, many compensation plans were long-term guarantees with high salaries and large capital purchases for practices. Capital purchases included both tangible (furniture, fixtures, etc.) and non-tangible assets, also known as “goodwill” (patient lists, value of the physician’s name, etc.). Today, the industry uses primarily short-term guarantees and a wide variety of models, all used to try to correct the errors of yester-year and create a sustainable future for physicians and hospitals.

Roughly 40% of primary care physicians are now employed by hospitals, strongly indicating a return to the employment model that dissipated in the 1990s. (Herman, Bob, Becker’s Hospital Review, 25 Jan. 2013.) It is essential to maintain a balanced alignment between physicians and hospitals to ensure physician stability within the community.

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THE EMPLOYMENT RELATIONSHIP
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An employment relationship is no different than any other type of relationship – business or personal. It’s important for both parties to understand why the relationship exists and what each party, respectively, hopes to gain from that relationship.

Hospital expectations are just as important as the expectations of the physicians. If the expectations are focused around the community benefit of a stable physician network, a hospital is more likely to focus on processes that build and sustain that network. If expectations are largely focused on revenue generation for the hospital or revenue protection from competitors, physicians may find themselves conflicted with high referral pressures and pressures that appear to place volume over quality of care, undermining the long-term viability of the relationship.
An employed physician’s role within a practice must also be clearly defined. There are three basic categories or levels of engagement where physicians will find themselves. When physicians are employed, it’s important they know what they can **CONTROL**, what processes they can **INFLUENCE**, and which parts of the practice they are merely a **PARTICIPANT**. Establishing this up front begins the foundation of trust, which is required for any healthy, highly reliable practice. In private practice, this step is typically done during the formation of the corporation, the bylaws and the governing board. This step is equally important in the hospital employment model and must be transparent to employed physicians. Virginia Mason spent a great deal of time and energy self-reflecting and involving physicians in the practice operations. The organization created and shared a clear vision of where it wanted to go and elevated the engagement level by changing the number of processes in which physicians merely **PARTICIPATED** and allowed them to **INFLUENCE** them instead.

If a physician knows his or her role within the organization and the reasons for employment are aligned with the organization’s employment strategy, both parties are now on track to become successful contributors to the long-term health of the organization. Failure to establish a solid foundation for the new relationship may cause long-term barriers with implementing a successful compensation plan.

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**THE DECISION TO EMPLOY PHYSICIANS**

Employment models are re-emerging at many hospitals across the country (Eisenberg, Steven A., Physicians News Digest, 4 Feb. 2009). Hospitals primarily look to physician employment in order to create a stable and competitively larger network that supports the hospital by generating referrals to the hospital either directly or indirectly. The market
footprint of the hospital is very important to facilities in a highly competitive marketplace. Where there is no or minimal competition hospitals like to stabilize their primary care base.

An employment model may be part of a recruiting strategy for attracting new physicians to the community, as many are looking for the stability found with hospital employment versus joining or creating an independent practice. In addition, many hospitals see the employment strategy as a defensive move citing that failure to employ physicians will allow competitors the opportunity to swoop in, employ them and drive away referrals.

In cases where hospitals have a strong support system of independently owned practices, an employment model may still be used for recruiting and then leasing the physician to an established practice. While rare, this type of scenario is used when either the independent practice or the recruited physician is particularly risk-adverse.

Market growth through increasing geographical presence and the patient capture rate is another common reason for hospitals to create an employment model. Rural outreach, in particular, is difficult to recruit for as it typically means a slow start that may not be financially viable for a private practice physician without significant support. An employment arrangement allows a hospital greater flexibility to provide this additional support, and if well managed, the support may be at a lower overall cost to the system.

As healthcare reform continues to alter the landscape of the industry, some hospitals are looking beyond the acute-care setting, creating narrow networks and becoming fully integrated systems. Many are also attempting to lock in the referral base for their already aligned medical surgical specialists. With successful primary care practices the foundation of the system, an employed model emerges to fill this void.
Employment options are very popular among physicians and understanding each physician's specific motivation behind seeking employment is critical for the long-term success of the relationship.

Some physicians are looking for economic stability. Hospitals typically pay physicians a base salary plus incentive payments. The base salary comes in the form of a base guarantee, thus creating a stable income for the physician, regardless of collection activity. In private practice, physicians are subjected to variations in monthly compensation based upon collection activity, including delays due to temporary pauses in government payments.

Increasing policies and regulations such as the Patient Protection and Affordable Care Act (ACA), Accountable Care Organizations (ACOs), Health Insurance Portability and Accountability Act (HIPAA), Physician Quality Reporting System (PQRS), ICD-10 implementation, and Meaningful Use can be overwhelming for a small practice without sufficient infrastructure. Failure to meet new regulations can result in payment reductions from government payers. Hospital employment can give physicians the security and support they desire.

Quality of life may improve with a larger group where call duties are lighter, collaboration with other physicians and practitioners may be greater, and support staff may be more stable.

Some physicians are looking to leverage group-purchasing discounts on professional liability insurance and supplies. Health insurance and retirement benefits for both the physician and their staff can be attractive, as well.

A larger group may be beneficial for managed care contract negotiating; however, there is an industry shift towards value-based contracting. Simply being a large group will not be
rewarded in the coming years. Groups must prove to be a valuable asset to the payer’s network to successfully leverage better rates. Value is defined by combining both cost and quality. Proving value depends on a physician’s (or group’s) ability to abstract and measure data, as well as leverage the data to promote continuous improvement efforts in terms of overall value. This requires infrastructure beyond that of most smaller and medium-sized independent practices, and thus, the hospital employment model may be looked upon as a vehicle to provide this level of sophistication.

UNDERSTANDING AND OWNING THE GAP: EXPECTED VS. ACTUAL PERFORMANCE

Understanding and owning the gap between expected performance and actual performance is key for designing a compensation model that works for the organization. This step fits naturally with an existing group looking to change its model, but is equally important, although less apparent, for a newly formed group that is looking to create a model for the first time.

The first step in defining any gap is for the organization to have a very clear picture of what the expected performance looks like. Without that vision for success, any gap in performance becomes nebulous and results in constantly shifting priorities. Without clear priorities, a compensation model may be mal-aligned with the hospital’s values or its value proposition to its stakeholders. It may also result in driving behaviors that are counter-productive towards the goals set forth in the business plan.

Understanding both where an organization is currently at and what success looks like depends heavily on the facts and data available to the administrative leadership. Prior to creating a compensation model, it is important to understand what data can be abstracted and ultimately leveraged in order to drive the desired behavior.
The following factors should be easily extracted from any practice management system and will be important to identifying gaps in the current performance as compared to the desired results. These data points are key to measuring the success of a particular model:

- Volume (based upon completed appointments and billed evaluation and management codes (E&M))
- Payer mix
- Visit types (acute and physical exams – each broken out by new or established)
- E&M coding distribution
- Active patient panel
- Annual visits per patient

In addition, it will be important to have consistent and reliable reports from the hospital’s accounting system (or the medical group’s system if the two are separate) including:

- Cash collections
- Contractual write-offs (either actual or accrued depending on the accounting method used)
- Bad debt
- General expenses

Similar to the data gathered from the practice management system, the financial system also helps a practice identify gaps between expected and actual performance. It is these gaps that help define the model best suited to improve the practice’s financial operations and ultimately – close the gaps.

While financial health is important, it is merely one aspect of a healthy practice. Service, quality, people, finance and growth are the pillars professed by Quint Studer in his book,
**Hardwiring Excellence.** Extracting the data points above will allow the practice to identify gaps in the finance and growth pillars.

- **Financial** metrics may include revenue per visit, operating income, bad-debt rate, cash-to-net collection ratio, days in accounts receivable, coding compliance, etc.
- **Growth** metrics may include payer mix, ratio of new patients to established patients, patient volume, active panel size, referrals to the practice, etc.

In keeping with Studer's philosophy this is only two-fifths of the equation to achieve true operational excellence. If a compensation model is to be designed to achieve overall operational excellence, it is logical to assume that all five key areas must be evaluated for performance gaps and incorporated, as appropriate, into the model created to serve the practice.

Looking at each of the remaining pillars, the practice must logically and honestly evaluate each area of the practice for specific performance gaps. Practices must have real-time, consistent, reliable and readily accessible metrics in each of the three remaining areas.

- **Service** metrics deal specifically with patient satisfaction and loyalty scores. Service or response times may also be indicators of service.
- **Quality** metrics may include adherence to evidence-based practice guidelines, patient safety metrics, etc.
- **People** specifically talks to staff and all aspects of maintaining a well-trained, satisfied and highly engaged workforce. Metrics in this area may be staff surveys, staff turnover, sick-time or call-outs, or possibly employee injuries. Studies show a
link between poor job satisfaction and increased on-the-job injuries. (Occupational Health Management, July 1995).

It is important to look at all aspects of the organization, identify and quantify the gaps between expected and actual performance, and then develop a model that promotes behaviors in the organization that closes these gaps.

If an organization does not have actual performance data for whatever reason – but will have performance data moving forward, the same philosophy to building a compensation model applies. However, there will likely be equal weight given to each pillar instead of customizing the focus of the compensation model based upon documented gaps.

A well-functioning compensation model is one that rewards positive behavior and potentially becomes punitive for behavior that does not improve the organization’s core values or its value proposition to its stakeholders. In order to design a successful model, an organization must be clear on what success looks like and be able to use real-time data to show physicians and administrators whether the relationship is achieving its goals.

**COMPENSATION MODELS**

Understanding the problem or gap the hospital is trying to bridge as well as why the physician is looking for employment are important to creating a business model that works for both parties. The compensation model then supports the program by driving the behaviors necessary to sustain the business plan and reasonable physician expectations.

The best compensation models are designed to reinforce positive behavior that fosters a lasting relationship and supports the goals set out in the business plan. Compensation plans should never be used as a way to “balance the books” nor should a compensation model be
used as a giant carrot to lure a physician into an unsustainable future. If it is the latter, the group will forever be changing the model until the books are, in fact, balanced. In either event, this leads to excessive physician turnover and subsequent expenses.

Models need to be organically grown to meet the needs of the hospital and physician. The models below are merely examples of the various frameworks already in use across the country. There are numerous variations and combinations. These examples are suitable as starting points, but in the end, the compensation model must be born from the needs of the hospital and physician as documented in a clear business plan. Compensation models are rarely successful when used in a plug-and-play fashion from another system or practice.

Through the entire development process, keep handy a clear, concise list of needs and wants for both the hospital and physician. This list should be derived directly from the business plan. Keep the list visible and before implementing the model – validate that both the list and the model are in alignment with the organization’s strategy and goals.

With each model, there are specific applications and drawbacks. This is why compensation models are born rather than prescribed. It is also the reason that blending the various models to create a model that works for the specific needs of both the hospital and physician is becoming more popular and more effective.

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**REVENUE TARGET MODEL**

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**WHEN TO USE THIS MODEL**

A “Revenue Target Model” focuses solely on production. This is a popular model in which physician production is the most important aspect of the relationship. In this model, the hospital does not want the physician to be distracted by costs. This model is typically used
when recruiting a physician into a situation where growth is anticipated to be slow and all efforts need to be focused on quality of care, service excellence and growth.

It may seem counterintuitive to have a physician ignore costs, but under certain circumstances, this may be a viable option. Physician experience with building a practice from the business perspective is likely limited. This model removes the unknown and puts the focus on what physicians are good at – seeing patients. By accepting responsibility for the cost side of the equation, hospitals free their physician to focus on building the practice versus allowing them to cut expenses to manage the bottom line.

Although not the typical application, this model has also been shown as affective for a physician who is struggling with productivity in an established practice. By eliminating distractions and lowering the expectations in order to achieve a small incentive, physicians and their practices can adjust slowly to increasing production. In this situation, it is advisable to escalate the target periodically until the desired goals and targets are met.

HOW THE MODEL WORKS

In this model, a physician is given a revenue target to hit. In its simplest form, the physician has a guaranteed base salary earning additional compensation as revenue targets are met and exceeded. This incentive portion is typically a set percentage of revenue over the target. Revenue targets can be set as a flat target for specific contractual periods or they may be set to escalate at specific intervals to promote steady growth.

The revenue target can be net revenue, gross revenue or cash collections. Variations of the model can also be applied using volume formulas, which can be helpful in practices with poor managed-care contracts or a large quantity of charity care.
In accrual accounting, the net revenue equates to anticipated cash collections. Contractual adjustments are estimated and deducted from the gross charges. If utilizing a net revenue target, it is also important to explicitly include or exclude bad debt in the contract as a factor in calculating the incentive. When using accrual-based accounting, Generally Accepted Accounting Principles (GAAP) requires that revenue is recorded at the time it is generated and that bad debt is recognized and deducted from revenue in the period the revenue is generated. Failure to clarify in the contract how bad debt affects the incentive plan can potentially undermine the foundation of trust required in the employment relationship.

If the hospital uses cash accounting for its medical practice, this same model can be used with a collection target. Similar to net revenue targets, cash targets also factor in collection rates and payer mix. In addition, collection rates tends to lag behind anywhere from 30-90 days, depending on a variety of factors including the maturity of the practice, the strength of the billing and collection team, and the credentialing status of the new physician. The collection lag can be confusing to a physician in a month where he/she has worked very hard but is being paid for prior months.

**CHALLENGES WITH THIS MODEL**

The revenue target must be achievable in a way that is aligned with the hospital – for both volume and coding compliance. Monitoring the type of volume and the coding compliance is critical for the success of this model. It is best to implement and monitor standard practice guidelines on chronic-disease management, preventive-health guidelines, communicating diagnostic results, etc. Without these specific guidelines in place, the model itself may reward practice patterns that conflict with the hospital’s brand in the community. The same warning applies to coding compliance. Without a rigid compliance monitoring
and education program, the model may inadvertently reward coding practices that are again, not aligned with the hospital's values.

Since this model is wholly focused on the financial health of the practice, payer mix, bad debt and contractual allowances will need to be transparent.

There are other drawbacks to this model. Physicians do not have a financial interest in the expense side of the equation. If the incentives are mal-aligned, the physician may make unreasonable demands on the staffing, marketing or other aspects of the practice operations, hindering the hospital’s ability to properly manage the practice. There is a tendency to add people, inventory (supplies or equipment) or both to solve a problem versus understanding and addressing the root cause. The administrative arm must be able to quickly identify and solve problems restricting a physician's ability to generate revenue and meet their individual compensation goals. Physicians may tend to correctly or incorrectly blame operating efficiencies on their productivity results. Regardless, these issues need to be addressed before they fester and undermine the compensation plan objectives.

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**OPERATING INCOME MODEL**

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**WHEN TO USE THIS MODEL**

This model closely resembles that of private practice and therefore is best applied in a practice that operates like that of a successful private practice. Consider the elements of a successful private practice:

- Established practice with predictable volumes and payer mix
- Clear practice goals and vision
• Fully engaged physician(s) and staff who are all aligned with the practice goals
• High functioning revenue cycle management
• Low patient turnover
• Expense management

These are just a few of the key elements of a high functioning, highly reliable physician practice. These elements are representative of intrinsic motivations on the part of the staff and physician(s). If this is the case, the operating income model becomes a simple model that maintains alignment with existing behaviors compared with a model that is designed to change behaviors. The hospital-employment situation requires alignment between practice and hospital, generally bridged by together creating a shared vision and the goals to achieve it.

There must also be implicit trust between the physician and the administrative arm of the hospital. In private practice, the physician likely has an accountant and an attorney who help to ensure proper balance and create a system of checks and balances. In the case of hospital employment, the hospital becomes the bank, the business partner and the manager all wrapped into one entity. While the hospital very likely has checks and balances in place, it’s important that these systems be shared with the physician. This level of transparency is critical to establishing and maintaining the trust required for a lasting partnership.

This model is one that rewards entrepreneurial thinking. As physicians and administrators collaborate around a simple, clear, goal that both parties can easily rally around, calculated risks, continuous improvement and innovation come alive. While the model itself will not breed innovation, the combination of the model and the right people will.

HOW THE MODEL WORKS
The typical operating income model mimics private practice in that physicians are rewarded based upon the overall health of the practice. Essentially, if the practice makes money, the physician makes money.

Revenue is captured, recorded and presented on a profit-and-loss statement each month. Expenses are also captured, recorded and presented and deducted from the revenue. Any amount left over is the basis for incentive payments or draws for the physician. Cash or accrual accounting can be used in this model, so long as the method is consistent for both revenue and expenses.

Most operating income models offer a base salary to the physician and then use the surplus to fund the incentive pool; however, in the absence of a guaranteed salary, the model can be used to create monthly draws for the physician. In this case, the physician’s entire compensation is based upon the financial health of the practice.

This model relies on active and personal involvement in the business on the part of the physician. This additional level of involvement requires that the physician receive the information needed to make decisions with an administrator informing the physician by providing sound advice based upon facts and data. Success with this model is dependent upon a good working relationship between physician and administrator.

There are several variations of this model, with the most common version including all expenses (interest, taxes, depreciation and amortization). Some systems keep some or all of these expenses in, others may pull them out. Leaving these items in, specifically depreciation, allows the practice to more closely represent private practice, although in a slightly different application. In a private practice situation, depreciation is a non-cash expense which, in theory, is offset by payments on debt. If depreciation is not included, it
could inadvertently lead to excess physician distributions. In addition, if a hospital is purchasing hospital-grade equipment, depreciation may well exceed that which would be normally seen in a private practice.

Capital rules also should be considered when evaluating the operating income model. Many hospitals have high limits for what is considered capital versus routine expenses. If these rules are not clearly laid out with the physician prior to the implementation of this model, it could jeopardize the trust necessary to effectively use this compensation model. Hospitals’ capital policies can vary from as little as $500 up to $5,000. Most equipment used in a typical primary care office will be under a $5,000 capital rule and therefore will be classified as routine operating expenses. If the policies are clear, the physician and the hospital are more likely to be successful under this arrangement.

Other variations on this model include limiting the expenses either as a percentage of revenue or a flat amount, frequently referred to as a “flat hospital tax.” In this latter case, the expenses overall, or possibly select line items, are pooled together for the entire group and then a flat amount is charged to all physicians under this agreement. This could be a percentage or a flat dollar amount per FTE physician.

**CHALLENGES WITH THIS MODEL**

The typical operating income model mimics private practice in that physicians are rewarded based upon the overall financial health of the practice. While this makes sense to most in the business world, it does not always resonate with physicians. In fact, many physicians avoid private practice due in large part to fears surrounding running their own business. Others flock to private practice for the potentially higher financial gains, flounder under the pressures of business ownership, only to find themselves looking for
employment. What started as a simple, straight-forward compensation model can rapidly deteriorate to become a model that physicians fear.

If this model is introduced prior to establishing a healthy practice, profitability may be slow to achieve and this means month after month, a physician sees nothing but red on the profit and loss statements. This alone can discourage a physician, restricting the belief that success is possible, potentially stifling growth.

As with the revenue target model, the operating income model does have potential for mal-alignment. If safeguards are not in place and enforced against unprofessional coding behavior, practice patterns or both, it can create conflict with the hospital’s values and brand.

**RELATIVE VALUE UNIT MODEL**

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**WHEN TO USE THIS MODEL**

Models based on the use of Relative Value Units (RVUs) are primarily used to maintain a physician’s focus on production, while at the same time ignoring payer mix. Typically, Work RVUs are used in employment compensation models; however, Total RVUs can be used as well, but this is rarely seen.

In some cases, poor payer mix in the ambulatory setting may discourage physicians from accepting a particular health plan. This same health plan may be important to the hospital, either for volume, revenue or community branding. In order to avoid this conflict, hospitals will look to an RVU model that eliminates any downside risk to physicians for accepting a particular plan or treating those without any coverage, creating a system that is payer blind.
Large and small systems alike enjoy the benefits of benchmarking locally, regionally and nationally through Work RVUs. Work RVUs become a standard language to measure a physician’s productivity against peers. The Medical Group Management Association (MGMA) is a national leader in providing benchmark data to physicians and practices, and is seen as the leading resource for this information.

RVU models also work well when profitability is not the focus and may be unattainable due to how the practice is structured within the hospital’s organization. For instance, if an employed practice is subjected to purchasing requirements under a group purchasing agreement tied to the hospital, the practice expenses may actually be higher than that of similar groups not under a hospital purchasing agreement. This is typically tied to the purchasing of hospital-grade equipment and supplies instead of medical office equipment and supplies. Other hospital practices that affect profitability include pay rates, paid time off and other benefits. These line items are typically higher than that of a stand-alone medical practice. These inequities lead practices to use RVU-based compensation models to maintain a physician’s focus on production versus seeing red on profit and loss statements that the physicians likely cannot impact.

**Definitions and Applications**

\[ wRVU = \text{Work RVUs} \]

*This represents the time, skill and intensity required to provide the service.*

\[ pERVU = \text{Practice Expense RVUs} \]

*This represents the costs associated with maintaining the practice.*

\[ mRVU = \text{Malpractice RVUs} \]

*This represents the costs associated with maintaining professional liability insurance.*

\[ tRVU = \text{Total RVUs} \]

*This represents the total relative value of the service provided.*

\[ wRVU + pERVU + mRVU = tRVU \]
HOW THE MODEL WORKS

The application of Work RVUs into a compensation model can vary wildly. Some practices set a production target based upon the sum of Work RVUs in a given period. If a physician exceeds the target, a calculated incentive payment is generated.

Other practices use a conversion factor to translate Work RVUs into a dollar amount and then the dollar amount is applied to the compensation model as if it were cash. One method of defining the appropriate conversion factor is to use the median specialty physician compensation, divided by the median Work RVUs for that same specialty. MGMA annual salary and production survey data can be used for this purpose.

In this case, the Work RVU model is very similar to the net revenue target model except that instead of using dollars (cash collections or accrued net revenue); the Work RVU for each service provided is presented as the value of physician production per the CPT code billed. Regardless of the application, RVUs are calculated only when the service is documented as having occurred, which is the same for any revenue-based model. Merritt Hawkins, in their report: RVU Based Physician Compensation and Productivity, they provide 10 recommendations for RVU-based compensation:

1. Keep it simple.

2. Ensure administrators and physicians have a clear understanding of the system used by the practice to calculate RVUs and compensate physicians.

3. Stay informed of changes to the CMS Resource-Based Relative Value Scale (RBRVS) as it is this system that drives the RVU and it can be periodically updated.

4. Don’t believe the myth that an RVU model will always pay physicians based upon the work performed. If an organization uses median salary information by specialty,
the conversion factor will vary between specialties and practice types (e.g., an internal medicine physician practicing outpatient medicine will likely be paid differently than an internal medicine physician practicing in an inpatient/hospitalist capacity.)

5. Consider hospital and physician alignment. The system is payer blind.

6. Include quality incentives as part of the overall compensation structure.

7. Be practical. The compensation plan must pay physicians fairly and be economically stable.

8. Consider having a tiered plan that allows rewards to increase once a threshold or baseline Work RVU is met.

9. Be aware of political risk associated with RVUs and the key entities influencing RVU values. RVU productivity will always have a certain level of uncertainty.

10. Remember there is a shortage of physicians and doctors are looking for stability and flexibility within the compensation model.

**CHALLENGES WITH THIS MODEL**

While using RVUs is a good way to level the playing field in terms of payer mix, it is not without its challenges. RVUs were derived from CMS as a way to calculate Medicare payments for services performed by physicians. To some, it seems logical to use the same system as a methodology to compensate physicians through an employment arrangement. However, the system itself can be very complex and mysterious to those who do not fully
understand what it is, how it works and most importantly – why it is being applied. Thus, the number one challenge with an RVU model is that of trust.

Once all stakeholders understand the goals and are able to support the methodology, the next challenge will be in the maintenance of the system. Typically, CMS provides a single major fee schedule update annually; however, CMS can and frequently does do minor updates mid-year to the fee schedule, including RVU tables. It is imperative that a practice clearly states how and when RVU tables will be updated or specify the version that will be used to calculate compensation. Some practices opt to only use major updates and other practices will apply all updates. Practices are encouraged to build in a time buffer that allows the practice a maximum number of days from CMS’s publishing of the fee-schedule updates to the date the updates will be loaded into the system used to calculate compensation. It is also important to distinguish if the CMS effective date will be used or the date loaded will be used in calculations. Expectations on the process and timing should be referenced in the employment contract, either directly or indirectly as a policy reference. There is greater flexibility when referencing the process is done via policy versus in the employment contract. This documentation is important in maintaining the relationship with the physician. As with the other models discussed thus far, the RVU model in and of itself, does not have any fail safes built in that would prevent abuse or manipulation of the RVUs through practices that conflict with the hospital’s brand or values.

### BALANCED SCORECARD

<table>
<thead>
<tr>
<th>WHEN TO USE THIS MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balanced scorecards can be used in mature, stable practices, in start-ups and everything in between. The premise of the balanced scorecard is that a healthy practice depends on all facets of the organization performing at optimal levels. The model is designed to</td>
</tr>
</tbody>
</table>
consistently measure each aspect of the business, drive the behaviors needed to improve the effectiveness of the practice and use the results to calculate incentive compensation.

Typically, this model is the hardest to implement simply because it takes considerable time and planning to build. It also requires significant care and feeding to be successful at driving the right behaviors. The model is built around a practice’s vision and rewards success in achieving the goals and objectives set forth in an annual planning process; therefore, the model is best used when the infrastructure is in place to allow the model to successfully drive behaviors.

Infrastructure is a fairly broad term and when it comes to building a compensation model, it’s important to have a clear definition of what specific components are needed to be successful and how each of those components support the model. Without a complete system in place, a balanced scorecard can become a shell game in the eyes of physicians, undermining the trust required for a long-term relationship.

Consider the following as pre-requisites to implementing a balanced scorecard model:

**The organization must have a simple, clear vision that all physicians and employees can support.** This is the “Big Idea” as Patrick Lencioni so eloquently calls it in his book *The Advantage*. By having a very simple and clear statement that all staff members can easily support, you gain alignment for a greater purpose. This vision is not the plaque on the wall; rather it is a simple and compelling reason for physicians and staff to come to work every day and every day make the organization just a little better.

**The organization must clearly define the components that are most important in achieving the vision.** At its core, the model conveys the importance of a healthy practice that includes all of Quint Studer’s pillars discussed in *Hardwiring Excellence*, or the “lanes”
discussed in *On the Mend* by John Toussaint, MD and Roger A. Gerard, PhD, or still better – the components defined by the organization that will employ their use. By defining these components, the organization sends a clear message that all are equally important and necessary to achieve the vision.

**The organization must have active participation in creating clear goals and targets that drive the organization closer to its vision.** Setting the vision gets all stakeholders looking toward the same point on the horizon. Defining the components demonstrates the values of the practice. Goal setting is about setting targets for each component that together, brings the practice closer to the vision. Targets should stretch the practice and push it to slowly evolve into a better, more effective practice. Goals and targets are also what define *winning* and *losing* to the team.

**The organization must have active participation when defining improvement activities that will allow the practice to achieve the shared goals.** Books on strategic planning or policy deployment as it is often referred to, speak of a practice called “catch-ball.” This is where the *need to improve* is created through the development of the vision and goals, but *how the improvement* is achieved is defined by those closest to the work. This process creates buy in and ownership among staff and physicians – both of which contribute a great deal in a balanced scorecard environment. This process also ensures a clear connection between each individual’s daily work and how that work contributes to the organizational goals and vision. Goals and targets must be specific, measureable, attainable, realistic and timely, or simply S.M.A.R.T.

**The organization must have clearly defined metrics that are shared in real time with staff and physicians.** Consider metrics as a scoreboard that informs what adjustments are needed to achieve the goals. At any given time during a football game, all
players can quickly tell whether their team is winning. They use the information on the scoreboard to adjust their game plan. A sports team would never consider playing a professional game without a scoreboard, yet many organizations do not see the value in real-time metrics. Using a scoreboard concept, organizations develop visual management systems that allow all stakeholders to quickly see whether they are winning or losing at any given time. If an organization is considering a balanced scorecard, there can be no surprises. Transparency and real-time metrics are “must-haves” for success.

The organization must have continuous improvement hardwired into the culture of every employee. While goal setting and improvement planning are important, organizations must remain nimble and react quickly to changes that jeopardize the targets. Hardwiring the need to continuously improve into every physician’s and staff member’s daily work is necessary to make these adjustments. The ability to hardwire continuous improvement directly ties back to which processes a physician can CONTROL, INFLUENCE or merely PARTICIPATE in. Physicians and staff must have the ability to at least INFLUENCE the processes necessary to remain nimble and continuously improve.

The organization must have a process in place for standard follow-up to be sure improvements are yielding results and that any roadblocks to improvement are cleared. Continuous daily improvement activities fall flat the day that follow-up ceases to exist. Improvement activities are called out as such because they imply improvement. However, the best laid plans do not always yield the expected results. Jim Collins described a process he called “autopsy without blame” in his book: Good to Great. The purpose was to enjoy the benefits of hindsight, constantly reflecting on activities, so positive results can be repeated and negative results can be avoided. This process of reflection is equally
important when implementing a balanced scorecard approach to physician compensation plans.

Considering the elements required to be successful with a balanced scorecard compensation methodology, it is important to ensure the practice has sufficient infrastructure prior to implementation. While daunting, the balanced scorecard approach is one that cannot help but drive the right behaviors among all stakeholders and thus yields the most favorable results.

**HOW THE MODEL WORKS**

The concept of a balanced scorecard was originally derived from a model that equally weighted four distinct components of a business: Financial, Customer, Internal Business Process, and Learning and Growth (Marr, Bernard. "What Is a Balanced Scorecard?"). In this case, strategy and vision are typically pictured in the center of the four quadrants. Applying a balanced scorecard approach to physician compensation rarely uses these same components, but does stay true to a couple of key attributes: 1) All components are equally weighted; and 2) All components work together to support the vision.

To create the model, a maximum score is assigned to each component. All components are weighted equally – thus creating balance. Within each component, there are specific goals and targets. In cases with a single target for each component, the maximum score remains the same. If the organization creates multiple goals within each component, then it is important to score each individual target, being sure to still maintain equality between components. For example, if the maximum score for each component is 5 points and a component has 2 goals, the maximum sum of the two goals cannot exceed 5 points.
Values can be set using a pass-fail methodology or using a scale that allows the physician to achieve an incentive based upon performance levels within a specific component. The scorecard itself can be comprised of a combination if this best serves the organization.

Consider the example shown in Figure 1:

**Figure 1: Sample Scorecard from Saguaro Physicians, LLC**

<table>
<thead>
<tr>
<th>Service</th>
<th>Patient satisfaction for the practice</th>
<th>Scoring</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>95% – 100% would definitely recommend to</td>
<td>Minimum response rate of 15% of total visits for the period to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>family/friends (3 pts)</td>
<td>qualify for the points.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>89% – 94% (2 pts)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>85% – 88% (1 pt)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt; 85% (No pts)</td>
<td></td>
</tr>
<tr>
<td>Quality</td>
<td>Mammogram compliance rates</td>
<td>&gt; 85% (3 pts)</td>
<td>Compliance based upon NQF #0031</td>
</tr>
<tr>
<td></td>
<td></td>
<td>82% – 84% (2 pts)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>75% – 81% (1 pt)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt; 75% (No pts)</td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td>Operating income vs. budget</td>
<td>110% of budget (3 pts)</td>
<td>* Baseline = 77.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% of budget (2 pts)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>98% of budget (1 pt)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt; 97% of budget (No pts)</td>
<td></td>
</tr>
<tr>
<td>Growth</td>
<td>Increase active patient panel (entire group)</td>
<td>&gt;30,000 (3 pts)</td>
<td>Active patients require at least one visit in the previous 24 months and current PCP on record to be part of the group.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>26,001 – 30,000 (2 pts)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>23,001 – 26,000 (1 pt)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>&lt; 23,000 (No pts)</td>
<td></td>
</tr>
<tr>
<td>People</td>
<td>Core staff turnover</td>
<td>&lt; 10% (3 pts)</td>
<td>Voluntary and involuntary turnover are counted. Transfers within the organization are not.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11% – 15% (2 pts)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>16% – 19% (1 pt)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt; 20% (No pts)</td>
<td></td>
</tr>
</tbody>
</table>

* Baseline = 23,516  
* Baseline = 23.8%
Once the maximum score for each target and corresponding components are set, the methodology to convert the score into an incentive payment is the next step. There are two main variations to achieving this. In order to maintain equity, some practices use the scorecard as a multiplier against an individual physician's productivity. See Figure 2.

**Physicians and Providers**

For physicians and providers on a production based incentive, the scorecard will be used as a multiplier to determine the incentive payout. Productivity incentives are calculated and then multiplied by the scorecard factor. Physician and provider bonuses will range from 75% of the productivity bonus to 110%.

<table>
<thead>
<tr>
<th>Points achieved</th>
<th>Factor for production bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 7</td>
<td>75% of eligible production bonus</td>
</tr>
<tr>
<td>8 – 9</td>
<td>90%</td>
</tr>
<tr>
<td>10 – 11</td>
<td>95%</td>
</tr>
<tr>
<td>12 – 13</td>
<td>100%</td>
</tr>
<tr>
<td>14+</td>
<td>110%</td>
</tr>
</tbody>
</table>

**FIGURE 2: PRODUCTIVITY MULTIPLIER FROM SAGUARO PHYSICIANS, LLC**

The other variation keeps all physicians equal and ignores individual contributions related to productivity. In this case, a dollar amount is assigned to each point. The calculation for the incentive is the dollar amount per point multiplied by the number of points received.

Even more variations of the scorecard approach have emerged as a direct result of organizations achieving unbalanced results. Consider the example in Figures 1 and 2. If the budget was exceeded (3 points), the practice was now caring for over 30,000 active patients (3 points), and all other components failed to improve above the baseline metrics, the physician would be eligible for 75% of the individual production bonus. This methodology would result in a paid incentive rewarding a physician despite critical failures in Service, Quality and People. These unbalanced results and the accompanying fear that results will
be short-term, have led practices to implement thresholds for each component, a minimum number of components with positive results or both as requirements to achieving an incentive. As the practice and the model mature, both goals and the application of the model will also mature, driving the right behaviors that lead to the right results.

A component often left out of a balanced scorecard physician compensation model is the staff members who support the daily practice operations. If the organization has a staff incentive plan in place or plans to add one, the exact same methodology should be used. In many cases, the same goals and targets apply and only the dollar amount per point varies. This practice ensures alignment throughout the entire practice. Cascading goals (smaller goals that support the physician goals) can also be used.

The variations in the application of this model speak directly to the need for compensation models to be organically grown by the organization to fill a specific need or gap. The options are bound only by the infrastructure of the practice to maintain the system.

**CHALLENGES WITH THIS MODEL**

The challenges with this model can be significant:

- Failure to set a clear vision for what success looks like and relentlessly sharing that vision can lead to ambiguity and confusion.
- Alignment among physicians, administrators and staff is critical to the success of the model and the practice.
- Each and every stakeholder must understand the connection between his or her individual daily work and the organizational goals.
- The inability to identify gaps in performance and actively share information as to whether those gaps are closing can become a critical failure point. Physicians are rarely excited about surprises when it comes to their compensation.
Considering the complexity of a balanced scorecard model, organizations must be prepared to seek out experts not only in practice management, but also those skilled in leading continuous improvement to lead the medical practice. Without this ability, the scorecard becomes one-dimensional to those using it, and it loses its purpose. The model is designed to consistently measure each aspect of the business, drive the behaviors needed to improve the effectiveness of the practice, and use the results to calculate incentive compensation.

CONCLUSION

The goal is to create successful, long-lasting partnerships between physicians and hospitals. Compensation models are used to keep the relationship on track and keep each party accountable for the results. Compensation models are not selected – they are organically grown to meet the specific needs of the organization.

Successful relationships are built upon a foundation of trust. When physicians question the “fairness” of a compensation plan, this is a clear indication of lack of trust and likely lack of participation in the development of the compensation plan and/or the strategic goals.

EMBRACE THE PAST

Prior to building a compensation model, reflect on lessons learned. If the hospital or physician has previous experience with employment models, take the time to reflect on what worked well and what gaps remained. Use the opportunity to build a model that closes those gaps.

Take the opportunity to learn from others. As stated by Sir Isaac Newton (1643 – 1727), “If I have seen further it is by standing on the shoulders of giants.” Do not underestimate the power of reflecting on the learning of others.
CLEAR DESTINATION

Organizations need a clear picture of what success looks like. Without the clarity, it will become impossible to maintain course and the organization will likely suffer from shifting priorities and nebulous goals. It will be impossible to define the gaps in actual versus expected performance. The stability required for a lasting partnership will not exist.

Creation of the vision will lead to the creation of the business plan that becomes the road map for success. Relentlessly sharing that vision and road map ensures alignment at all levels of the practice. This becomes the seed from which the compensation model will be born.

Share the goals. This will ensure all stakeholders know how the practice will get to the destination and it connects each individual’s daily work to the vision. Even if all staff members are not compensated through incentive plans, they will likely perform better if they understand the connection between their daily work and the success of the practice. Acknowledging this connection demonstrates respect and fosters a desire to continually improve among team members.

BUILD THE MODEL

Create a compensation model that helps the practice grow closer to the vision. An effective model is a vehicle used to reinforce expected results and drives behaviors that lead to success.

Define practice guidelines, both clinical and non-clinical, to ensure the practice remains aligned with the hospital’s values and brand in the community. Share facts and data with physicians on their adherence to these standards.

HARNESS THE POWER OF GPS
Global Positioning Systems, or GPS, is a satellite-based navigation system to let navigators know exactly where they are and help them stay on course. The first step is creating the vision that serves as the destination. The business plan, including specific goals and targets, becomes your road map. Actively measuring where a physician is in relation to these goals and targets is the only way for physicians to know where they are and what corrections need to be made. This feedback loop becomes the GPS for the practice.

The simpler the plan, the simpler it is to share information. If information relating to specific goals is only available monthly or quarterly, it will be important to find other metrics that can be used as an early-warning system to keep physicians on track and to maintain a strong relationship with the hospital. Transparency is critical to long-term success.

While GPS is a great tool, it is only as effective as the navigator. If the navigator fails to acknowledge the GPS warnings and make course corrections, the result will be failure to reach the desired destination. Sharing real-time metrics is also just a tool. In order to drive behaviors, the practice must be led by an individual or team who uses the data to constantly improve the operations.

Creating business plans, designing compensation models and building out proformas or budgets used to predict the success of the relationship are all tactical and necessary – but monitoring progress towards the vision and continuously improving is where the real work is done. It is this work that makes the relationship last – it is not the compensation model.


