Provider Compensation: No “One Size Fits All” Solution

Case Study

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Physician practices, whether independent or hospital employed, struggle with finding the right compensation model for physicians and mid-level providers. According to the MGMA Operations Management Book of Knowledge, “compensation of physicians and other key clinical providers is critical to the ongoing success of a medical practice.”¹ As reimbursement models continually change, practice administrators continually struggle with finding the right balance between ensuring a financially successful practice and keeping the providers happy. This manuscript aims to provide thoughtful insight and questions to ask while determining provider compensation arrangements.

By definition a medical provider is “A person—eg, doctor, nurse, nurse practitioner, or institution—eg, hospital, clinic, or lab, that provides medical care.” Physicians, Physician Assistants, and Nurse Practitioners all have different scopes of practice and each of them add value to a practice when their skill level is fully taken advantage of. This manuscript will restrict the focus to physician compensation since this is the area in which most practices struggle.

Physician compensation trends have dramatically changed in the past 5 to 10 years. In the early days of physician employment, most groups paid physicians a base salary without a requirement for production or even number of hours worked. It was the unspoken expectation that the physician would round on hospital patients before clinic and after while maintaining an 8-9 hour clinic workload 5 days per week. In the 1990s very few hospital employed physicians had a productivity requirement tied to compensation. As a new generation of physicians emerged into the workforce along with a different work ethic, physician compensation began to change. Physicians realized their time was valuable and thus began demanding a higher salary for the grueling work that was demanded of them. Employers, as a means to try and tie productivity to compensation, began trying to shift physician arrangements to different compensation models. Today there are a multitude of physician compensation models to choose from to help leverage and provide financial stability to the practice, however, federal statutes and regulations now play a big part in determining how a physician can be compensated.

In 1989 Congress passed, as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), a set of provisions known as the Stark Law restricting certain types of physician

compensation arrangements. In 1993, the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) expanded the Stark Law to include even more monetary restrictions between physicians and other healthcare related entities. Under the Stark Law, named for now retired Congressman Pete Stark, the law “prohibits physician referrals of designated health services (“DHS”) for Medicare and Medicaid patients if the physician (or an immediate family member) has a financial relationship with that entity. 42 U.S.C. 1395nn. A financial relationship includes ownership, investment interest, and compensation arrangements.”2 The Stark Law does contain several exceptions, one of which is bona fide employment arrangements that are within fair market value. Section 1877 of the Social Security Act is known as the physician self-referral law (the “Stark Statute”). The Centers for Medicare & Medicaid Services (“CMS”) have publicized three sets of rules to implement Section 1877, generally referred to as Phase I, the Phase II Interim Final Rule, and the Phase III Final Rule, which was published in the Federal Register on September 5, 2007. According to the Phase II Interim Final Rule:

“Fair market value means the value in arm’s-length transactions consistent with general market value. ‘General market value’ means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party; or the compensation that would be included in a service agreement as a result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition or at the time of the service agreement. Usually the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.”

On July 9, 2015, the Office of Inspector General of the U.S. Department of Health and Human Services (the "OIG") released an alert to physicians titled “Physician Compensation Arrangements May Result in Significant Liability”3 where the OIG warned physicians they were personally liable for certain types of compensation arrangements. This alert along with recent

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2 https://en.wikipedia.org/wiki/Stark_Law
OIG settlement cases would lead the prudent Practice Administrator to be cautious when developing physician compensation arrangements.

A variety of physician compensation models exist and are as unique as the provider. According to the Advisory Board, 90% of medical groups revenue is determined by provider productivity and accounts for 50% - 60% of group expenses. A variety of physician compensation models exist and are as unique as the provider. For the purposes of this article, we will review with historical examples the pros and cons for three main compensation models: straight base salary, base salary with productivity and/or quality incentive, and straight productivity compensation. Each of these compensation models come with a multitude of pros and cons as it relates to use in a physician practices both in the employed setting and in the private practice model.

Many practices will offer a straight base salary to newly hired physicians or physicians who work a fixed schedule. A straight base salary allows the Practice Administrator to accurately know the salary expenses for a practice in a given month but offers little incentive to the physician to increase productivity. It is the physicians work ethic that will determine whether this model is successful or an albatross for the practice.

In the first case study, two independent internal medicine physicians practiced an eat what you treat model of compensation. Each physician’s collections were totaled but at the end of the month, each physician would take an equal split of the remaining money after paying staff salaries and overhead expenses. Neither physician monitored their productivity nor was it tied to their monthly income. One physician saw 5-8 patients more per day than the other one. As overhead and staff salary expenses grew, the remaining revenue shrunk. The one physician who worked more hours and saw more patients began to grew impatient with the 50/50 monthly split. Eventually the physicians had a falling apart and had to enlist the help of their accountant to develop a revenue sharing agreement in order to keep the practice together. This fraction between the physicians never healed and has resulted in numerous other practice problems throughout the years.

In this instance several problems led to the final result. First the practice did not employ a full time Practice Administrator or office manager. Secondly the straight salary agreement was based on the assumption that both physicians were working equally hard and productivity was

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nearly the same. Third, the practice was not monitoring their reimbursement and expense changes from year to year. They failed to anticipate the changes to practice reimbursement and expenses which ultimately changed the level of income both received.

The second common compensation model for physicians is a salary with incentive, productivity and/or quality. This model helps to incentivize the physician to not only perform his or her job but to be productive and provide high quality of care. This model is most often found in practices hospital employed models since it encourages high performance. Practice Administrators should be cautious when using this model due to the risk of greater salary expenses than practice volume or quality reimbursement. If not calculated correctly, the physician can earn more than he or she brings to the practices thus creating a negative economic effect on the practice. Best practice models of this compensation arrangement call for a renegotiation of the terms of the contract every two years to ensure the productivity and/or quality standards still meet the practice reimbursement.

In the second case study, a hospital employed a specialty physician with a compensation model of a base salary with a productivity bonus. This productivity bonus was based on the billed work relative value units (wRVUs) each month and measured quarterly against MGMA benchmarks. The wRVUs were then paid out at the negotiated per wRVU bonus over the threshold. The hospital used an outside billing company, which was partly owned by the physician, to bill for and calculate the wRVUs. The incentive motivated the physician to work hard which resulted in a large wRVU bonus each quarter. After the first year the Practice Administrator realized an ominous trend for the practice, the physician was accumulating more incentive payments than revenue was being collected. Upon further investigation the Practice Administrator found that the case mix of the practice showed the physician saw a large portion of the practice as no-pay patients which meant the physician was given credit for the productivity but there was no revenue generated as part of those patient visits. For the next three years the clinic profit and loss was upside down due to this physician’s compensation model. At the end of the three years, the physician decided to leave hospital employment and return to private practice thinking they could make the same salary. Since his previous compensation was based on a flawed model, the physician found themself four months later making half as much as before without an understanding of why.

In this case the hospital failed to set up the compensation arrangement such that it would be viable long term. The aggressive dollar per wRVU payment coupled with the tough payor mix
set the clinic up for financial distress from the start. The physician was given a false sense of
success by their compensation and was amazed when they returned to private practice at the
financial stress the compensation model put on the practice.

In the final compensation model, straight productivity salary is most commonly found in
private group practices where partners earn an “eat what you kill” model. In this compensation
model physicians are usually paid a percentage of the revenue or wRVUs they generate. This is
by far the most risk adverse model in physician compensation plans. This puts the onus on the
physician to work in order to earn compensation. Hybrid models of this arrangement also exist in
which physicians base salary is modified monthly, quarterly, or annually based on their
productivity during the previous timeframe. Many successful health systems are adapting this
model as a means to control physician salary costs and encourage productivity.

In the third case study, a specialty physician was compensated based on a percentage of
the previous quarters wRVUs. They would be paid $X times 95% of the monthly average based
on the previous quarters wRVUs. This model motivated the physician to work hard but also
provided relief to the practice when the physician failed to produce during the previous quarter.
The physician enjoyed this model because it provided both semi immediate reward for hard work
as well as allowed them to know what their compensation would be in the upcoming quarter.

The right solution may not be a one size fits all approach for a medical practice but rather
a step-by-step process to determining the strategic goals of the practice, the financial
reimbursement model, and finally how each provider fits into the equation. Each compensation
model is vital to determining the success or failure of a physician practice. Not only will it have
financial impact on the expense side but it will help determine how your practice is able to adapt
to reimbursement changes in the healthcare industry.

Practice Administrators should always begin with the end in mind when developing
physician compensation arrangements. What is important to the practice? What market forces –
either reimbursement changes or new market payors will impact the practice in the coming years?
MGMA dedicates an entire chapter in the Operations Management Book of Knowledge to
physician compensation arrangements. Being able to foresee to the end of the physician
compensation contract is key to developing the right compensation model.

Practice Administrators must also be able to support the proposed physician
compensation model through a financial pro forma. What sources of revenue will these physician
generate? With 50%-60% of a medical group’s expense coming from physician compensation, how will the physician generate enough revenue to cover both his salary but also other group expenses? Chapter 5 of the MGMA Book of Knowledge Financial Management goes into detail as how to budget for a medical practice. This is the most important skill a Practice Administrator can have. Without a knowledge of budgeting and forecasting changes to reimbursement, a practice can easily go bankrupt in a very short amount of time.

Setting expectations and communication of the compensation plan are other vital pieces of a successful physician compensation plan. The managing partners or Board of Directors of a practice along with the Practice Administrator must set the right expectations with physicians when agreeing to a new contract. Two way communication is vital so that all parties understand the goals of the contract along with the compensation plan so that going forward there are not any misaligned expectations. Physicians are not taught in medical school about wRVUs or other productivity measures leading many of them to learn on the job. It is recommended that Practice Administrators gauge the understanding of the physicians knowledge of productivity measures when negotiating physician arrangements. This is quite easily the most overlooked part of a physician compensation plan. It is important that a Practice Administrator explain the financial implications both in terms of costs to the practice but also the sources of revenue needed to cover such costs. Having both parties on the same page will prevent problems going forward as the contract is executed.

Choosing the right physician compensation model is a tough decision fraught with consequences. With the rapid change in healthcare reimbursement along with the legal requirements, it gives even the most seasoned Practice Administrator a headache when deciding how to structure physician contracts. With an awareness of the changing healthcare landscape, beginning with the end in mind, along with developing a solid financial pro forma, these are all keys to success for practice administrators. Each physician contract will be as uniquely different as their fingerprint. To gain buy in, practice administrators will have to demonstrate a solid financial plan backed by benchmarking data linking it all to the practice’s goals in order to persuade physicians regarding their compensation plan.