

Feature Article #1

Three Common Physician Compensation Mistakes (and Potential Solutions)

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Introduction

Why does physician compensation matter? First, it's big. It is always the most significant operating expense for a physician group, in most cases making up 50% or more of total group practice operating expenses. Second, it is one of the two key factors (governance is the second) that will collectively define the culture of a physician group. An appropriately structured physician compensation model will encourage appropriate behaviors and strong operating performance. A poorly designed model will create a long list of unintended consequences for years to come.

Why focus on mistakes (versus solutions)? In a classic Seinfeld episode, one of the lead characters, George Costanza, concludes that all of his natural impulses are wrong and that, going forward, he will "do the opposite" of whatever his brain tells him do. This behavior change results in an unprecedented string of life successes including full-time employment with the New York Yankees. The message of this article is similar. All of the case study examples include an underlying "do the opposite" solution (or things to avoid at all costs). The best life lessons are often the ones learned from getting run over by the proverbial steam roller.

Some of the case study examples will appear to be over-simplistic or the work product of unsophisticated organizations leading readers to conclude "that could never happen here". However, most of the examples shared are from large integrated health systems across country and in many cases, could have been pulled from numerous health system/hospital examples.

Mistake #1: Unnecessary and Poorly Constructed Professional Services Agreements (PSA).

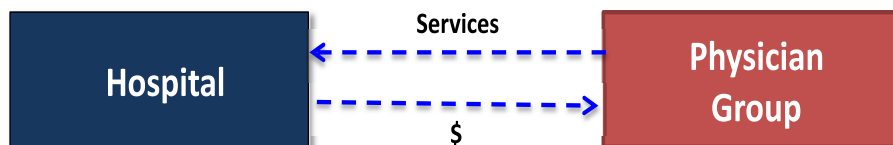
Professional services agreements, or PSAs, are an alternative physician-hospital alignment structure alternative to full employment where a hospital or health system typically purchases defined

services, usually physician professional services, from an independent physician group. Exhibit A below outlines a basic PSA relationship between a hospital and an independent group practice.

When done correctly, PSAs can be structured as a "win-win" relationship in which both the hospital and the physician group can benefit by effectively leveraging existing provider capacity or infrastructure. In the following example, the benefit for the hospital/health system is much harder to find:

- **Background:** Hospital A, which has historically generated significant contribution margin from electrophysiology (EP) services provided by an independent cardiology group, realizes a significant drop in EP related volumes when the independent physician group aligns with a competing hospital (Hospital B). In order to continue providing EP services, Hospital A develops a professional services agreement (PSA) with Hospital B to provide EP professional services and call/coverage.
- **What was purchased by Hospital A (from Hospital B)?**
 - 1.2 physician FTEs of cardiology-EP coverage defined as:
 - * Physician providers provide 24/7 on-call coverage for EP.
 - * Full-time EP clinical coverage on Hospital's premises from 8am-5pm, Monday-Friday.
 - * Consultative services on a 24/7 basis.
- **Who bills for what services?**
 - Revenue for professional services performed when the physician is physically in Hospital A is owned by Hospital A.

Exhibit A: Overview of Professional Services Agreement



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- Revenue for professional services performed outside of Hospital A (including the physician office building located next door) is owned by Hospital B.
- **Where are the mistakes?** At a minimum the list includes the following:
 - The wrong service was purchased. The type of 24/7 EP call coverage included in the PSA is unnecessary. Instead, Hospital A needed a defined level of EP physician services including both inpatient and outpatient services. For example, Hospital A could have purchased 100% of a 1.0 physician FTE that includes all office based and hospital professional services.
 - The PSA lacks a definition of how much clinical time was actually purchased. Instead, clinical time is blended together with the call coverage definition. Therefore, Hospital A is only receiving a fraction of the professional time (and professional revenue) of the PSA physicians resulting in substantial operating losses for Hospital A's EP physician practice. Time could have been defined by clinical shifts per week and minimum shifts/hours for office and procedural services.
 - The physician compensation rates paid through the PSA are very high and include some double-counting in the construction of the overall payment. While Hospital B would be expected to generate margin for providing services to Hospital A, a review by an external organization using current physician compensation market data would have highlighted the specific areas of the compensation model that were significantly above market.

Mistake #2: Compensating Physicians for Advanced Practitioner Clinician (APC) Work Effort.

A common health system trend over the past several years has been to aggressively add primary care provider capacity in the form of advanced practitioner clinicians (APCs), i.e., nurse practitioners (NPs) and physician assistants (PAs), in order to provide patient access for patient populations that are increasingly part of a value-based payer contracts. The trend toward adding APCs has also resulted in the following physician compensation examples which negatively impact hospital bottom lines:

- Example A. Cardiothoracic surgeons are supported by too many APCs in the OR resulting in work relative value unit (wRVU) production that is "super-charged" in comparison to industry norms. The model results in high physician compensation levels and under-utilized OR time (as a result of physicians hitting production targets and taking Fridays/Mondays off). This is a good example of another physician compensation contractual mistake, i.e., the failure to appropriately define work-week responsibilities (including clinic and OR time) for employed physicians.
- Example B. Medical specialists in an independent group practice have wRVU productivity that is 220 percent of national median levels. A detailed analysis reveals that the physicians are being credited with APC work effort for all services being provided in the hospital facility setting. The physicians are then compensated by the hospital for all wRVUs (including APC work effort) through a professional services agreement (PSA). To make matters worse, the hospital also compensates the independent group for all costs related to the employment of the APCs.

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In almost all cases, the practice of crediting APC work effort to physicians is not intentional but instead driven by system or process limitations. Regardless of the cause, correcting the situation can be difficult given that it will lead to significant compensation decreases and agitated physicians.

Mistake #3: Failure to Adjust Compensation for the Lack of Physician Call Responsibility.

Medical staff bylaws typically include language that allows physicians that meet a set of criteria to drop out of the call rotation for their respective specialty. While the medical staff leadership may approve the petition of the individual physician, in the past it was the physician's partners in independent practice who ultimately decided whether to allow the physician to drop from the call rotation, and if they did, whether the physician would also have his/her compensation reduced as a result (given that the remaining physicians in the call group would now need to share a higher call burden).

As more specialty groups have become employed by a hospital, the responsibility for determining how (or if) to adjust compensation for

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the senior physician who doesn't take call has shifted to the leadership of the employed group practice. Too frequently, the physician who drops out of the call schedule does not have their compensation reduced (or the corresponding reduction in compensation is far less than the true value of call from a physician perspective). In the worst cases, the reduction in the number of physicians on call forces the hospital to compensate the remaining physicians in the call group for excess call (on a per shift basis) or to contract for additional call coverage at very expensive rates. The financial impact of a failure to reduce compensation and simultaneously paying for excess call coverage almost always results in practice operating expenses that are significantly above national comparisons.

A simple approach used by some hospitals is to have the physicians internally determine the value of call for their specialty, i.e., the annual compensation reduction taken by the physician dropping out of the call rotation that will be instead allocated to the physicians picking up the extra shift of call. Exhibit B below summarizes the difference between how call responsibility valued when using external sources (national survey data) versus when physicians internally determine the value of call for their specialty. In the example below, the survey data resulted in an estimated call value for one physician of approximately \$73,000 on an annual basis. The final model developed by the cardiology physicians and implemented by the hospital resulted in a call value of \$160,000, a difference of \$87,000 per year!

Exhibit B: Breakout of Estimated Cardiology Compensation by Call/Non-Call Work Effort

Work Effort Description	Compensation by Type of Work		
	Internal Method	External Method	Difference
Non-Call Related Work	\$ 440,000	\$ 527,000	-\$ 87,000
Call Responsibilities	\$ 160,000	\$ 73,000	\$ 87,000
Total	\$ 600,000	\$ 600,000	\$ -

Wrap-up

There is no short answer on how to avoid physician compensation mistakes and a more detailed discussion is beyond the scope of this article. However, the following short list may assist leadership in minimizing missteps along the pathway to developing high functioning physician groups:

1. *Pursue a comprehensive approach.* Physician compensation design should almost always be addressed as part of a more comprehensive process that also includes group decision-making and organizational structure.
2. *Address physician call responsibilities head-on.* For a high number of physician specialties, call and coverage issues are an increasingly significant portion of the overall compensation model. To the extent possible, call issues should be addressed within larger specialty groups, i.e., cardiology versus subspecialty groups. For example, a large cardiology group may have one EP physician who shares general call responsibilities with the larger group (instead of looking at EP as a standalone specialty for call/coverage purposes).
3. *Understand what the national survey data is and isn't.* There are multiple survey sources for physician compensation and production data and there are some differences in how the data is collected and compiled as well as in the types of organizations that respond to the surveys. There are also some data issues that some of the large surveys sources share that should be understood by health systems prior to developing some specialty specific plans including medical oncology and rheumatology.
4. *Avoid "one size fits all" approaches.* While compensation models for different specialties may share some similar components, a single approach applied across a high number of specialties is usually problematic.
5. *Monitor and adjust on an ongoing basis.* Physician compensation design work should be ongoing and include frequent monitoring and, if needed, changes to the model. Periodic reviews/analyses by external expertise can be helpful in affirming the strengths of the current model as well as identifying potential issues.

Physician compensation design is one of the three legs of the stool (the other legs being organizational and governance structures) necessary for developing a high functioning, hospital aligned, physician group practice. The future physician compensation success stories will most likely come from organizations that successfully move toward an integrated physician group model and in many ways, steal the best practices currently used in successful independent group practice models.

Author note: This article includes a sampling of the materials presented at the MGMA 2017 Annual Conference in Anaheim, California titled "Physician Compensation: Ten Common Mistakes (and Four Solutions)". Feel free to contact me at cpederson@insighthp.com with any questions or for a complete copy of the MGMA presentation.