

Factors Impacting Physician Compensation

“People get what they deserve.”
—Folk Wisdom

The simple bit of folk wisdom just quoted may not apply to physician compensation in the current managed care environment. While physicians *should* get the financial compensation that they deserve, it is increasingly difficult to determine and provide “deserved” compensation because of the dramatic changes in reimbursement patterns.

These changes are a result of increases in the number of managed care payor contracts, consumer demands, merging and integration of group practices, and increases in government regulations aimed at reducing healthcare spending. All of these factors must be considered in developing physician compensation plans. As a result, compensation plans have become more complex as groups attempt to respond to and comply with market realities while striving to ensure that physicians get what they deserve.

Before a compensation plan can be developed, it is important to understand the concepts underlying the healthcare delivery system today, to know how it got here and to be aware of where it is going. Revenues drive salaries in any industry, so it is crucial to understand the various mechanisms by which physicians receive those revenues.

How should one begin to develop a physician compensation plan? We recommend a short review of the factors at work in the healthcare delivery system that impact physician compensation.

MANAGED CARE

Managed care—or “mangled care,” as many providers describe the system—is a healthcare delivery system that delivers healthcare services through contractual arrangements between providers and third-party payors. Prior to the mid-1990s, physicians provided healthcare services to patients under verbal contracts between physician and patient. The physician-patient relationship was built on trust. Services provided were rarely questioned as to the “medical necessity” and were paid at face value (fee for service).

As of year 2000, such arrangements are generally a thing of the past. Today physicians primarily provide services to patients under a contractual arrangement with a third-party payor or organization. The system attempts to control costs by employing reduced reimbursement and by controls over the quality and frequency of services provided. Among the payment methods included in these contracts are:

- Deeply discounted fee-for-service payments: This payment method reimburses providers for each service after the service has been provided (delivered) *minus* an agreed-upon percentage off the provider’s usual, customary, and reasonable fee or at a percentage of the Medicare fee schedule.
- Negotiated fee schedule payments: The managed care organization establishes a fee schedule, which may be based on discounting its usual and customary charges, or established fee schedules based on a relative value scale.
- Capitation, withholds, and risk/reward sharing: Capitation payments are made to providers in advance of the service at a predetermined per member, per month amount regardless of the level of service provided. These payments may, in turn, be reduced by a withhold, which is a reserve at the payor level to offset losses or pay out surpluses.
- Control-of-utilization methods: These reimbursement strategies seek to control costs in two primary ways.
 1. Referral and authorization requirements: Services must be approved by the managed care organization prior to the service being delivered or payment will be denied.
 2. Closed panels: The number of providers are limited by the managed care plans.

PRODUCT DEVELOPMENT

Previously, almost every patient was covered by some form of health insurance plan that paid the physician a fee for service set by the plan. No more. Today the managed care system is comprised of different types of health-care payment *products* and organizations, with new entities and products being developed daily to meet changing market forces. Physicians have little if any influence over the types of products that are sold in the marketplace. They are restricted by government regulations in their ability to develop organizations that address managing care in response to marketplace forces. The result is seen in the financial impact on the practice. Revenues have been reduced and expenses increased due to multiplying administrative responsibilities.

Payors determine product development in response to consumer demands. The following products and organizations that administer those products include:

- Indemnity plans: Traditional non-managed care products. Physicians are paid at the fee charged for a service provided by the insurance plan.
- Discounted fee-for-service plans: These operate through preferred provider organizations (PPO) or directly with physician(s).
- Capitated plans: These plans work directly with the provider or through an organization, such as a health maintenance organization (HMO) or independent practice association (IPA).
- Point-of-service plans (POS): These plans have contracts allowing for discounted fees for service at different rates for obtaining service outside the assigned network of physicians in a product.

FINANCIAL IMPLICATIONS

Physicians may receive payment from these products as individuals or as members of managed care organizations. Whether receiving payment as individuals or as managed care organization members, physicians will be impacted by the concept of “sharing financial risk,” which is included in most products. Sharing of financial risk is a complicated concept. Furthermore, it is uncertain how the physician can assist a payor in decreasing costs and creating profit pools to influence the impact of financial risk.

Depending on the product, the contract may provide for not only a discounted fee for service but also for withholds of a specified percentage. Under this scenario, the physician accepts a discount off the usual and customary charge and agrees to a percentage of reimbursement to be withheld from payments by the payor. These “withholds” represent a reserve to cover deficits or surpluses of the plan. Any “profits” or “surpluses” of the plan for each year are to be distributed to the physicians participating with that plan based on whatever method the plan develops. This policy obviously creates a financial unknown for the physician or group practice. In general, groups do not include in revenue projections any returns from this withhold. Discounted fee for service otherwise provides a traceable and somewhat predictable method of projecting revenues. However, as the number of plans in which a physician participates increases, the complexity of monitoring the revenues from those plans also increases. (Note: Revenue projections are discussed at length in Chapter 8 along with issues associated with physician incentives.)

Discounted fee for service has been a major factor in reducing reimbursement to physicians. The result has been that physicians are providing the same services for reduced rates while incurring higher costs for doing business. If the group practice participates in only indemnity and discounted fee-for-service products, determining the level of production the physicians need to maintain in order to realize a level of reimbursement that will cover overhead and result in a compensation package that is satisfactory to the physicians in the group is the primary issue in the development of the plan.

Increases in capitated prepaid revenue products have had a significant impact on physicians' compensation and add a new dimension to the development of the plan, as the incentives are different. Capitated payors typically compensate the practice, the practice network, or the integrated delivery system on an assigned per member per month (PMPM) basis irrespective of the actual number of patient visits. The PMPM is determined actuarially by the managed care payor or HMO. Capitated plans are based on a sharing-of-risk theory whereby utilization can make or break the providers of service.

Capitated plans do provide a benefit to the practice by providing a steady stream of income. If managed properly through efficient utilization, capitated arrangements can be profitable for both the practice and the physician employee. The key to profitability depends on the ability of the practice to secure an adequate PMPM reimbursement rate and its ability to control costs and manage utilization.

In a capitated plan, primary care practices typically are compensated a fixed monthly dollar amount based on the number of patients (covered

lives, members, or enrollees) assigned to the group practice or individuals in the group. Specialists may be paid a capitated PMPM amount based on the total number of patients in the plan or may be reimbursed on a discounted fee-for-service basis.

Managing utilization and resources in the practice provides the greatest challenge as groups move from a fee-for-service environment to capitation. In a fee-for-service environment, increased patient visits equate to increased revenue. The opposite is true in a capitated arrangement. Overutilization of services decreases the capitated profit margin. The physician group must provide the clinical management and protocols to ensure quality care while managing utilization.

In a capitated environment, the compensation system cannot be based on incentives that motivate the physicians to increase patient visits. Nor should incentives be included that encourage physicians to refer patients to specialists rather than continuing personally to provide continuing care. The key is to keep physicians productive by providing services at an efficient cost level. The system must be retooled to stress resource and utilization management. The underlying compensation plan philosophy must be one that encourages conservation of services while maintaining quality patient care.

In addition, prepaid revenues complicate the level of reporting necessary to provide the data for allocating revenues and expenses to the providers of service. Data will be needed on a per-plan basis; cost and utilization data within the group also are needed. Services provided should be tracked based on the group's fee-for-service equivalent charge. Doing so generally serves as the basis for determining the cost of providing patient care by individual physicians.

Although capitation plans have increased over the past several years as payors attempt to manage rising healthcare costs, in most practices the percentage of capitated revenues is still minimal. The *Cost Survey: 1999 Report Based on 1998 Data* by the Medical Group Management Association (MGMA) indicates that approximately 82 percent of the practices included in the survey have less than 10 percent in capitated revenues. Sixty-two percent have no capitation. The geographic area with the heaviest penetration of capitation is the western section, where 28 percent of the reporting practices had 11 to 50 percent capitation.

In a pure fee-for-service environment, many physician groups adopt an eat-what-you-kill mentality. Compensation models are designed to encourage physicians to maximize the number of encounters or procedures performed. Simply stated, the more the physician works, the more money he or she can expect to make. In a low capitation environment—where capitation represents less than 15 percent of revenue—the small percentage of

capitation rarely justifies a payment system that does anything more than encourage productivity with incentives.

As the percentage of capitated revenues to total revenue increases in the medical practice, the focus of the compensation system shifts proportionately from production to other factors, such as utilization management, patient satisfaction, and group performance. Compensation plans in this environment include a salary for the physician based on predetermined criteria and a performance-based incentive. Utilization management becomes a key factor and a strong contributor to group profitability in practices with capitated revenues in excess of 50 percent. Establishing quality protocols and monitoring clinical outcomes are key factors in managing care.

Financial incentives must be structured and aligned properly to drive and sustain the behaviors needed to prosper in a managed care environment. Capitation has a direct impact on the income available for physician compensation according to the MGMA's 1999 Report. As the percent of capitated revenue increases in specialty practices, the median compensation per physician drops substantially. For specialty practices with no capitation, the median income is \$296,595. As capitated revenues approach 10 percent of total revenue, median compensation for specialists drops to \$282,913. At 50 percent capitation, the median declines to \$212,750; at full capitation, specialists' median compensation drops to \$196,771.

The effect of capitation on primary care income is less pronounced. Median primary care compensation in practices with no capitated revenue is \$143,930. At 10 percent or less capitation, compensation declines slightly, to \$142,303. As capitation approaches 50 percent, median primary care compensation declines to \$135,000. Interestingly at full capitation, compensation increases to \$141,242.

Reimbursement techniques utilized by managed care products and organizations create the need for determining performance measures based on the provisions of each plan. Developing appropriate incentives to create the behavior necessary to result in profitable contract performance is an integral component of any compensation plan.

CONSUMER DEMANDS

Health-care reform initiatives have placed a great emphasis on quality of care and on fraud and abuse in the healthcare industry. While limited healthcare initiatives have been enacted by the federal government, discussion about them has prompted a shift in the patient/provider

relationship. Patients have become consumers of healthcare services. Armed with ammunition from the government, private insurance industry, and nonprofit organizations developed to further the quality of healthcare, consumers are prepared to question the qualifications of anyone participating in the provision of healthcare services to themselves, family, and friends.

President Clinton's Health Security Act of 1993 stated that "the American health care system, as a whole, is in deep crisis." It went on to say that "today's American health care system falls short of providing high quality care and choices for all Americans." The act identified numerous problems with the healthcare system. While most Americans had a general sense that all was not well with the healthcare system, the enumeration of its woes had a strong impact on consumer awareness and concerns. The following is a summary of some of the problems described in the act.

- **Lack of security:** The act stated that 37 million Americans have no insurance and another 22 million have inadequate coverage. Becoming ill or living with a chronic medical condition can mean losing insurance coverage or not being able to obtain it.
- **Rising costs:** Rising health costs mean lower wages, higher prices for goods and services, and higher taxes. As a result of rising costs, more and more Americans have given up insurance altogether because the premiums have become prohibitively expensive. In addition, many small companies either cannot afford insurance at all in the current system or have had to cut benefits or profits in order to provide insurance to their employees.
- **Quality threatened:** The act stated that no one is accountable for the performance of the healthcare system—not hospitals, physicians, other providers, or health insurers. While quality care should mean promoting good health, our system waits until people are sick before it starts to work. Furthermore, healthcare is biased toward specialty care and gives inadequate attention to cost-effective primary and preventive care. In addition, consumers cannot compare doctors and hospitals because reliable quality information is not available to them.

Moreover, the act asserted that healthcare providers often do not have enough information on which treatments work best and are most cost effective. Healthcare treatment patterns vary widely without detectable effects on health status. The act stated that our medical malpractice system does little to promote quality. Fear of litigation

forces providers to practice defensive medicine—ordering inappropriate tests and procedures to protect against lawsuits. Often truly negligent providers are not disciplined, and many victims of real malpractice are not compensated for their injuries.

As mentioned in the introduction, this act was not enacted. However, it stirred national debate. In addition, all of the issues addressed in the act have been considered in the development of products available on the market today and in legislation based on consumer awareness.

Both the government and private sector insurance companies are encouraging patients—the consumers—to ask more questions about their providers of care. In response to this movement, some physicians include in their compensation plans a component based on patient satisfaction or outcomes. Although patient satisfaction may be somewhat quantifiable based on surveys, outcomes measurement is a complex concept that is not easily determined.

All of these discussions have led to a search for the definition of quality. Bruce C. Vladeck, past administrator of the Health Care Financing Administration (HCFA), provided HCFA's definition of quality during his 1997 remarks at the National Roundtable on Health Care Quality sponsored by the National Institute of Medicine. He said: "Quality of care is the extent to which health care and health-related services result in desired outcomes and greater satisfaction with care for the populations and individuals we serve. . . . Our definition incorporates several other themes that reflect HCFA's mission . . . and it explicitly includes beneficiary satisfaction as part of the quality calculation."

In support of this mission, under Vladeck's administration, HCFA played a major role in developing and adopting the HEDIS 3.0 system. HEDIS stands for Health Plan Employer Data and Information Set. It is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues, such as cancer, heart disease, smoking, asthma, and diabetes. HEDIS provides purchasers and consumers with an unprecedented ability both to evaluate the quality of different health plans along a variety of important dimensions and to make their plan decisions based on demonstrated value rather than simply on cost.

HEDIS is sponsored by the National Committee for Quality Assurance (NCQA). The NCQA is a private, not-for-profit organization dedicated to improving the quality of healthcare. The organization's primary activities are assessing and reporting on the quality of the nation's managed care

plans. NCQA's efforts have led to partnerships and collaborative efforts with many states, the federal government, employer and consumer groups, and many of the nation's leading corporations and business coalitions. As of December 31, 1999, the states of New York, Ohio, Alabama, Tennessee, and Iowa all have established deadlines for health plans serving state employees to obtain NCQA accreditation. At the federal level, NCQA is working with the U.S. Office of Personnel Management on methods to provide federal employees with additional information on health plan quality to assist in the selection of health plans.

NCQA's mission is to provide information that enables purchasers and consumers of managed healthcare to distinguish among plans based on quality, thereby allowing them to make more informed healthcare purchasing decisions. Using information from NCQA's accreditation program in combination with HEDIS data, the most complete view of health plan quality is available to guide choice among competing health plans. Additional research and background information may be found at the NCQA web site: www.ncqa.org.

A federal effort is under way to measure and report physician outcomes. On May 7, 1998, the Department of Health and Human Services (DHHS) published in the *Federal Register* the Notice of Proposed Rulemaking (NPRM) for the National Provider Identifier (NPI). The NPRM recommended the adoption of the NPI as the standard healthcare provider identifier. The final rule is expected to be released in June 2000 with a compliance date of December 2002. Even though all physicians currently must have a provider number and unique provider identification number (UPIN) and must submit claims for payment using these numbers, a system is not in place to utilize these numbers to measure outcomes or performance in the numerous plans in which an individual physician may participate. Therefore, the National Provider Identification Number (NPIN) is being developed to use as a standard healthcare provider number to be used for filing claims under all health plans. This information combined with the NCQA and HEDIS data will provide a device for performance and outcomes measurement for physician services and healthcare plans.

On the private side, health plans are adopting "quality indexes." Pacifi-care Health System on a semiannual basis sends 1.5 million enrollees a report outlining how their clinic ranks compared with other clinics in the system. The "quality index" ranks medical groups in 28 indicators of care in three categories: clinical quality, service quality, and administrative services. The better-performing providers are rewarded with a higher capitation rate. Insurance companies have begun to use physician profiling not only in deciding who participates in a panel but also in contract negotiations and set-

ting payment rates. Profiling involves comparing physician performance on utilization of services, adherence to clinical guidelines, and other measures. The goal is to identify providers who are “outliers”—who use more services or have higher costs than other physicians—and urge them to make changes that lower costs. Physicians will need the information systems in place that provide these data to profile their own practices and include these “quality” indicators in their future compensation plans.

If there was any doubt about the linkage of quality of care to reimbursement, consider the remarks made by Nancy-Ann DeParle, administrator for the HCFA, on December 17, 1998. Speaking at an all-staff meeting on the HCFA Strategic Plan, she made the following statements:

“As our mission statement articulates what we do, our vision statement articulates how we want to be seen—leading the nation’s health care system toward improved health for all. This vision reflects our increasing appreciation of our role as the largest health insurer in the U.S. . . . As the largest health insurer in the nation and as a public purchaser of care, HCFA plays a leadership role in developing and reining payment systems, data standards, quality indicators and innovative ways of informing beneficiaries about health care choices. Like it or not, what we do influences the whole U.S. health care system. We must be intentional on how we use that influence.”

It is apparent from the remarks of both Vladeck as HCFA administrator in 1997 and DeParle as HCFA administrator in 1998 that the mission of the federal government is to include quality in some manner as a component of reimbursement. Defining the quality assurance components of a compensation plan will be specific to any one practice or specialty. Defining the measure of the quality assurance will be a dilemma. Defining the weight that these measures have on total compensation will be a greater dilemma.

Today a very small percentage of physician practices include patient satisfaction and quality as components of compensation plans. In the coming few years, the compensation plans of virtually every practice will have to include these components based on the actions of HCFA and state governments in coordinating performance measures with the HEDIS and NCQA surveys.

MERGER AND INTEGRATION OF PRACTICES

Everything should be made as simple as possible, but not simpler.

—Albert Einstein

The merger and integration of practices has impacted physician compensation models significantly. In 1965 there were 4,000 group practices, while to-

day the number exceeds 19,000. The numbers and size of these groups makes compensation plan analysis, design, and revision essential. Underlying this process is the need to keep compensation plans as simple, understandable, and equitable as possible while addressing all the emerging regulations and shifting requirements of the practice and its members. The compensation plan designer walks a fine line. Einstein's advice to keep it as simple as possible should be heeded, tempered by the wisdom of King Solomon: Don't share your baby in such a way that you no longer have a baby—that is, don't try to meet the needs of each physician member at the expense of the overall practice.

Solo physicians who merge with others are faced with the issue of how to share income and expenses that previously was totally theirs. Typically, compensation plans developed as a result of mergers between one or more solo practitioners will result in the eat-what-you-kill mentality in an attempt to mirror premerger operational results.

Issues may soon surface concerning the allocation of expenses, however. The division of overhead becomes especially sensitive in mergers of solo practices where the physicians have significantly different levels of patient visits, case mix, payor mix, and/or provide different subspecialties of medicine. As the practice matures, payor mix considerations may arise in the scheduling and allocation of patient visits. As mentioned previously, pure productivity formulas are not effective in a heavily capitated practice.

As with the merger and integration of solo practitioners, group practice mergers also raise a host of compensation issues. When groups merge, the new entity must face the task of bringing together diverse plans into a new combined plan that will achieve the objectives of the combined group. Most likely each of the merging entities will utilize a different methodology for sharing income and expenses. At a time when the merging practices are dealing with significant operational changes, revisions to the compensation models can be particularly stressful and increase an already existing level of anxiety and tension.

The first step in compensation plan design for merging groups is for the group to establish a strategic plan and mission. The group must decide its direction and goals in order for incentives to be established in the compensation plan to achieve those goals. The plan should be analyzed to determine if it complies with the mission statement and fosters the group mentality regarding practice operations, quality of care, and hours worked. As the merging practice matures, incentives can be adjusted as strategies and requirements of the organization change.

The key to long-term group success will depend on the ability of the practice to align individual behaviors with the goals of the practice. To

achieve this goal, the compensation system must reward appropriate behaviors with incentives. Issues related to compensation that must be addressed include but are not limited to:

- Production
- Capitation
- Call coverage
- Administrative compensation
- Seniority
- Other physician compensation such as pension contributions

To proceed with a merger, many times groups postpone dealing with compensation issues. A delay in dealing with compensation, however, can be the death knell for merging groups. The wise practice will address compensation head on and reach a consensus on a combined compensation plan before the merger. If the combining group cannot reach consensus, the best alternative is to postpone the merger. Disagreements over compensation can lead to group breakups, which can be financially devastating for all involved.

In an attempt to deal effectively with managed care, more and more multispecialty practices are merging. Specialists have sought alliances with primary care physicians in an attempt to preserve their referral sources and “gatekeeper” relationships.

However, mergers between multispecialty groups can present additional problems. Multispecialty merger conflicts can arise purely over cultural issues. Historically specialists have occupied elite roles in the medical field, in some cases, commanding compensation far in excess of their primary care counterparts.

To illustrate the compensation disparity, consider that the median compensation for primary care physicians is \$139,244, as reported in the MGMA 1999 Report. The median compensation reported for specialists was \$231,993.

The emergence of managed care has, to some extent, caused a role reversal as the position of “gatekeeper” for primary care physicians has become established. Specialists are now dependent on primary care physicians for referral reimbursement. According to the Medical Group Managers Association survey, specialists are willing to pay for this alliance. Specialists in single-specialty groups reflected median compensation of \$299,648 while their counterparts in multispecialty groups earned a median of \$201,312. Con-

versely, primary care physicians reported median compensation of \$137,716 in single specialty practices, whereas the median income increased to \$139,591 for multispecialty practices.

Combining cultural differences in multispecialty practice mergers is nothing short of forming a United Nations group. Add to these differences the combination of compensation systems and you may create World War III. Developing a system of revenue and expense sharing in these groups presents multiple problems. Combining compensation plans in a multispecialty practice is an extremely delicate undertaking, due to the differing group styles and operational practices. For example, assume a family practice group joins forces with a surgical specialty. Allocating overhead may become a key factor due to the differences in utilization of office facilities and supplies.

Should an anesthesiologist in a multispecialty group pick up expenses based on a percent of collections? Obviously this specialist would not utilize resources within the clinic setting for patient visits. The specialty does, however, generate a higher level of collections than a primary care physician. By using collections as a measure of resource utilization, the anesthesiologist would be allocated an unreasonable amount of expenses.

GOVERNMENT REGULATION

The numerous laws that affect income distribution further complicate developing compensation systems for physician organizations. The list of those laws includes:

- Antikickback law
- Stark I and II
- Tax-exemption rules contained in the Internal Revenue Code
- Tax-exempt bond financing rules
- Corporate practice of medicine
- Antitrust laws

In a group practice owned 100 percent by the physicians providing services, the Stark laws (Ethics in Patient Referrals Act of 1989) provide the greatest challenge to the development of compensation formulas. Stark prevents physicians from receiving compensation based on the value or

volume of designated health services (ancillary income). Stark can have a traumatic effect on existing groups as well as merging practices as they revise and design compensation plans to comply with the law's regulations. Chapter 4 is dedicated to the issues involved with Stark laws in determining compensation systems. Each of the above-listed laws is also discussed in later chapters regarding both their implications to group practice and, to a limited basis, the concerns of physician organizations with nonphysician capital partners.

The tempo of change in healthcare is likely to become faster-paced in the years ahead. Managed care, mergers, integration, and regulations are expected to take on new faces in the new millennium as the cost of healthcare services continues to rise. Medicare reimbursement regulations will continue to change on a daily basis. Payors will continue to merge and restructure products to meet the demands of society.

Cost will be one of the factors setting this stepped-up tempo of change. For the first time since the early 1990s, large employers are now encountering a double-digit increase in their healthcare costs, according to the annual *Towers Perrin Healthcare Cost Survey*. The most recent survey, which was released January 10, 2000, projects that health benefit plans' costs will increase by approximately 12 percent in 2000. The survey finds that employees will contribute an average of \$40 a month (21 percent of the total cost of their coverage) in 2000 for employee-only coverage. At least 90 percent of respondents expect double-digit increases in healthcare costs for the next several years. These figures are based on responses from survey participants, who were asked to provide their 1999 and 2000 per capita premium costs for insured health and dental plans and premium costs for insured health and dental plans and premium equivalents (i.e., estimated benefit and administrative costs) for self-insured plans.

The Towers Perrin survey reports that the large upturn in healthcare costs is a complex problem with several causes. The rising costs of prescription drugs due to increased demand, higher utilization of healthcare services by a gradually aging population, and Medicare cutbacks that shifted costs from the government employers are believed to be key factors in the rise. As the insurance industry and government debate the issues and reform their policies and practices to provide beneficiaries with care at the lowest cost, it is clear that providers, physicians, and suppliers of healthcare services need to revise their strategies as a means of survival.

Physicians and their management teams must constantly be aware of all these activities. Even Einstein's insight has limitations and is subject to revisions. The "simple as possible, but not simpler" compensation plan of today may be inappropriate tomorrow.

The information provided in this book is intended to serve as a basis for generating discussion and ideas for developing a compensation system that meets the objectives and goals of a group given a set of circumstances at any given time. Changes in the market and group infrastructure will require further analysis and research.