

Sustainable Physician Compensation Model Design Critical Success Factors for Building Productivity-Based Compensation Models



Live teleseminar with

Marc Halley, President and CEO of Halley Consulting Group
and author of

Owning Medical Practices: Best Practices for Sustainable Results

and

Will Reiser, Vice President of Product Development
and Decision Support

KEY POINTS

- 1) Time-tested critical success factors for building productivity-based compensation models that are truly sustainable
- 2) The vital role these factors play in facilitating financial viability for your owned medical practices
- 3) The way in which these factors will help you build your owned medical practice network so you are making significant strides toward market leadership

Success in the future will require physician compensation models that reward high clinical quality, high service quality, and high productivity.



Ralph Harding: Good afternoon, everyone. This is Ralph Harding, your host for this exciting one-hour seminar with our guests, Marc Halley and Will Reiser.

Marc Halley is one of the leading authorities in the nation on strategy and performance improvement for physician networks, and Will Reiser is our physician compensation model design and implementation expert at the Halley Consulting Group.

Today we will be visiting with Marc and Will about sustainable compensation model design and implementation. As a result of attending this seminar:

- You will learn the time-tested critical success factors for building productivity-based compensation models that are truly sustainable and play a vital role in facilitating financial viability for your owned medical practices.
- You will also learn how these factors will help you to build your owned medical practice network so you are making significant strides toward market leadership in the next 12 months.

The content of our discussion today is driven by the dozens of very thoughtful questions that you as healthcare professionals posed to Marc and Will during our ask campaign. We will be addressing just as many of your questions as we possibly can during this 60-minute broadcast; however, all of the questions submitted during our ask campaign that we do not answer during the broadcast will be answered by Marc or Will either by telephone or email.

First of all, let me call your attention to our handout for today's seminar. If you will look on the webcast page just below the "Ask Marc Halley" title, it says, "The following handout for the teleseminar is available for download." Just under that you will see a blue link that says "Physician Compensation Handout." If you will click on that link it will open a new window where you can view the handout. Please print the



handout and be prepared to follow along and take notes as we receive counsel from Marc and Will on this very timely topic today.

Before we begin the interview, let me provide you with a view of Marc's rich background in healthcare, and then I will ask Marc to introduce Will Reiser.

Marc D. Halley is President and Chief Executive Officer of the Halley Consulting Group. Marc has provided management and consulting services to medical practices for more than 25 years and has worked with a variety of specialties, including hospital-owned practice networks across the United States.

He has negotiated numerous contracts to acquire medical practices on behalf of hospitals in highly competitive environments, served as Senior Operating Officer of primary care networks, facilitated the financial turnarounds of hospital-owned medical practice networks, and worked with physicians to take primary care networks into risk-sharing arrangements, including carrier contract negotiations for a 100-physician primary care panel.

He also developed and implemented numerous models and tools to assist physicians and managers to track and improve medical practice operations. His supervisory training program has been taught to medical office managers around the country.

Marc is a frequently requested speaker, addressing governing boards, senior executives, physician groups, management teams, and national organizations. Marc's first book, *The Primary Care - Market Share Connection: How Hospitals Achieve Competitive Advantage* was released by Health Administration Press in March 2007. In December 2007, Marc contributed to a three-volume set titled *The Business of Healthcare*.



Marc was also a contributor and co-editor of *The Medical Practice Startup Guide* released by Greenbranch Publishing in August 2008. His newest book, *Owning Medical Practices: Best Practices for Sustainable Results* was released by the American Hospital Association's AHA Press in January 2011. He received his Bachelor of Science degree from Weber State University in Business Administration Management and his Master of Business Administration degree from Utah State University.

Marc, we are delighted to have you and William on the call. Will you please help our listeners to know more about Will's education and experience?

Marc Halley:

Thank you, Ralph. It's a pleasure to be here, and yes, I'd be happy to do so.

As you mentioned, Will Reiser is Vice President of Product Development and Decision Support at Halley Consulting, and has over 20 years of experience in healthcare consulting and management. Will has been actively engaged in consulting for independent healthcare providers and for health systems since 1990. Early in his career, he established a methodology to determine the value of medical practices for purchase by hospitals, health systems, and private practitioners.

He also directed the physician recruitment activities for a seven-hospital health system and structured physician recruitment packages including compensation to comply with federal regulations.

Will is our content expert in the area of physician productivity compensation models, working with our clients to develop sustainable models that provide fair market compensation for both primary care and specialty physicians and groups. He developed and works to implement our firm's Financial and Statistical model, our Gap Dashboard, our Fee Analyzer, web



feedback surveys, and Will is the creative intelligence behind many of the Halley Consulting tools and models. He works with clients that include regional and national health systems, community hospitals, and private practice physicians. In addition, he oversees Halley Consulting's knowledge management operations and infrastructure.

Will received his Bachelor of Science degree from the University of Utah in Psychology and Anthropology, and a Master of Business Administration degree from Brigham Young University. He was also a contributor to the three-volume set, *The Business of Healthcare*, published in 2007 by Praeger, and most recently, Will and I wrote an article titled "Physician Compensation: Five Mistakes, One Solution," published in *hfm* magazine in July of 2011, and Will was also a co-presenter at the 2011 HFMA ANI in Orlando.

Ralph: Thank you, Marc, for that introduction. Will, we'd like to welcome you to the call and thank you for joining us today.

Will Reiser: Thanks, Ralph. It's my pleasure to be here.

Ralph: We would especially like to welcome over 150 healthcare professionals from every region of the country who have joined us today for this call. We're just delighted to have you here.

Marc and Will, we know that building sustainable physician compensation models is a key component of growing and sustaining hospital-owned medical practice networks, so let's get started by presenting the first question from one of our listening hospital executives. He makes this statement and then asks a very perceptive question:



“Our hospitals need to own medical practices to remain competitive in our local market. One of the most difficult challenges we face is that a very large percentage of the medical practices we own are not financially viable. How do you design an employed physician compensation model that is sustainable?”

Will, would you like to address this first question?

Will:

Sure.

There are several facets to this issue. First, those who have the responsibility for physician compensation need to ensure that the compensation models they have in place are structured to provide reasonable and sustainable levels of compensation.

Hospital executives will often tie their employed physician compensation models to some external measure or benchmark such as MGMA or AMGA, Sullivan Cotter and so on. The intent is to provide some level of objectivity to justify the compensation to the physicians and also to regulatory bodies. Yet, in doing so, they often lose sight of what compensation levels can truly be expected in a private practice setting in their community. And, of course, that private practice model is the gold standard for productivity and financial viability.

Second, hospitals don't place as much of the provider's compensation at risk because the hospital often maintains control over certain aspects of the practice that an independent provider may normally control, such as the billing office activities or staffing decisions and so forth. However, even when the hospital controls many of those operational aspects of the practice, it's still crucial that the provider's compensation be structured to have a high degree of variability based upon those measures that the provider *can* influence.



Ralph: Excellent response, Will. Thank you very much.

Listeners, let's turn to the handout on page two. Will has just given us the answer for the box at the top of the page, which is "private practice." "A private practice setting is the gold standard for practice productivity and financial viability."

Speaking of the private practice setting, Marc, this next question from one of our listeners is a perfect follow-up. She asks:

"Why is the private practice setting typically more conducive to promoting patient volume and practice revenue than the hospital-owned practice setting?"

Marc: This is a great question. In our experience, employed physician productivity is often 25 to 30 percent lower than their private practice counterparts in the same specialty.

The private practice incentives are clear. Every other Friday, private practice physicians get to meet a payroll. If there isn't enough cash, it's the doctors that go without. Now, that biweekly test of necessity motivates behaviors to generate and protect cash flow. In essence, physicians have to work to eat.

Employed physicians are just as smart and just as capable as their private practice peers of achieving those same levels of productivity and other behaviors required for practice viability if they have the right incentives and if the practice supports high productivity.

Ralph: Excellent. Thank you, Marc.



Listeners, please refer to your handout again on page two. The answer for the box at the bottom of the page is “necessity.” “Necessity motivates private practice physicians to generate and protect cash flow.”

Will, I’d like to direct this next question to you. This is a great question from one of our hospital executives. He says:

“As hospital executives, we view physician compensation as a complex problem. What are the initial questions that we should consider when developing physician compensation strategy?”

Will:

Well, this is a great question and I think when considering the compensation strategy, really six initial questions come to mind.

The first: How do our providers perform in terms of their absolute productivity relative to their private practice peers? And by absolute productivity, I mean in terms of the key metrics, whether it’s Work Relative Value Units, whether it’s patient encounters, etc. How do they compare to their private practice peers?

The second is: How much do we compensate our providers for that productivity? In other words, what is the appropriate compensation rate per unit of work?

The third: How does that rate compare to what private practice physicians in our community are able to achieve? And again, that is the ultimate indicator of a market rate of pay. What are those independent providers able to make within the community?

Fourth: Do we have internal equity among our current employed physicians within and between specialties? And by this I mean, are there differences in compensation based on



specialty and personal productivity, or did some physicians just happen to negotiate a better deal?

And fifth: What are the local market forces affecting physician compensation? For example, are there strong competitors in the market who are artificially driving up the compensation for physicians?

And I think finally: Are we competing nationally for a particularly scarce specialty, making the compensation for that specialty much more costly?

Ralph:

Thank you, Will. Those are excellent foundation questions for our listeners to use as they develop compensation strategy, and you will notice, listeners, that we have listed those six questions for you on page three of the handout.

Marc, a number of our listeners submitted questions asking how to get the physicians on board when moving to a productivity-based compensation model. This next two-pronged question is representative of many that we received. He asks:

“How important are the attitude and engagement of the physicians in compensation model design? How do we make certain employed physicians are interested in financial as well as clinical performance?”

Marc:

Well, Ralph, this would be the proverbial \$64,000 question. In fact, in our experience, the answer to this question is the essence of successful hospital-owned medical practices staffed by employed physicians.

Physician and executive leaders must understand that the underlying motives and trends are forever changing the way



we deliver and finance medical care. Reimbursement has declined and will continue to decline. Regulatory compliance and other costs of providing care will continue to increase. The baby boom generation is placing—and will continue to place—unprecedented demand on primary care and specialty physicians and hospitals. This is the environment in which we all live, both physicians and executives and patients and everybody else.

The only way for providers to survive what we term this “perfect storm” is to work together to outmaneuver and outlast their competitors. We will need to, in our opinion, be much more aggressive in our performance expectations and much more rigorous in measuring our performance and changing the outcomes.

Now, in every successful practice, physicians and management will work together to achieve clinical quality, service quality, productivity, and financial viability. These four factors are like the four legs of a chair. If we miss even one leg, the result is suboptimal to say the least.

Physicians who have had to meet a payroll understand the significance of practice volume. If we don’t work, we don’t eat. That same attitude will be required if organizations are to survive over the next few years.

Those who experienced global capitation in the late ‘80s and early ‘90s understand that primary care practice volume is essential, even under risk models, perhaps even more essential because of the importance of patient access under risk and the ability to spread risk over larger population. The most successful specialists under a capitation model are those who are the most efficient and the most effective because they are busy in their specialty.

Success in the future will require physicians who have demonstrated a superb work ethic and are supported by systems and processes that promote and reward consistent



clinical quality, consistent service quality, and high patient volume. That success will require compensation models that reward high clinical quality, high service quality, and high productivity. Let your competitors hire the physicians who are not interested in working with you to achieve those critical objectives.

Ralph:

Thank you, Marc, for that outstanding information.

Listeners, on page four of the handout, let's fill in the answers with "performance" and "outcome." So the sentence there will read, "Measure performance, change the outcome."

Will, here is a question that you are well-qualified to answer. Our listener asks:

"What are the most common approaches and mistakes that you see in physician compensation contracts and how can they be avoided?"

Will:

Well, this is a question that I wish were posed more frequently because I think it's a critical one. There are several factors that come to mind.

First, as we mentioned earlier, many organizations link their local physician compensation to those national surveys. For example, executives often assume that a physician working at the 90th percentile in RVU productivity, for example, should be compensated at the 90th percentile in compensation per RVU. And oftentimes these executives are sorely disappointed when they sit down and do the math and realize that the logic just does not work.

As Marc mentioned earlier, he and I wrote the article about physician compensation; it was published in *Healthcare*



Financial Management in July of this year, and there is a section in that article that illustrates the danger of comparing Work RVUs actually produced with the rate of physician compensation per Work RVU, especially when you get out into the higher percentiles. It's interesting because it's often the lowest producers that yield higher rates per RVU when their low volume is compared to compensation! The best indicator of a market rate of physician compensation is found by looking at those local market realities. What's required to recruit and keep physicians in a particular specialty in our community?

The second is the failure to review compensation levels annually and to adjust compensation if needed. Oftentimes a failure to adjust compensation incrementally makes the work much more difficult down the road and the political risks of an unaddressed issue are significantly magnified. So again, you need to review and adjust that compensation annually if needed.

And I think the final factor is a failure to engage and communicate with physicians. Compensation is a sensitive issue. All compensation design work should have significant physician feedback and involvement at various points in the process. We call the forum for that engagement a "compensation committee." The committee process can help ensure that the management fully understands the physician pressures and perspectives, and at the same time, the compensation committee also helps to communicate to the physicians the financial realities and legal constraints facing the practices and the hospital. When there is a common knowledge for all of the parties, that ultimate tone of conflict is substantially reduced.

Ralph: Thank you, Will, most valuable.

Listeners, Will has provided the information you need for your handout on page five. The answer there is "local market



realities.” “The best indicator of a market rate of physician compensation is found by looking at local market realities.”

Marc, we had multiple questions come in expressing concerns regarding expense control. One of our listeners asked:

“What are the most important factors we should pay attention to as far as revenue enhancement and expense control are concerned?”

Marc:

Thank you, Ralph, and thanks for that question. This is a great one.

The most successful private practices, again, have always been those with higher volumes. Physicians in these practices are satisfied because they can do a lot of what they were trained to do. They are rewarded for providing higher clinical quality and higher service quality to a larger number of patients. Yes, they do control expenses, but that is not the key to their success. The key to success lies on the revenue side of the income statement.

Not surprisingly, the most successful hospital-owned practices have the same characteristics. They produce enough revenue because they have enough volume, which is largely a function of physician productivity. Their employed physicians are rewarded for providing high quality care and caring to a large number of patients. In fact, we like Work RVU models that reward clinical quality and service quality by adding potential dollars to the compensation rate per Work RVU. And why not? The doctors seeing larger numbers of patients are providing outstanding clinical care and service more often.

Ralph:

Thank you, Marc, for that insightful answer.



Listeners, we are now on page six of the handout and the answer Marc has given us for box at the top of the page is “revenue.” “The key to success of both private and hospital-owned practices lies on the revenue side of the income statement.”

Will, another topic that was frequently brought up by our listeners during the ask campaign was Work RVUs. This next question says:

“Hospital executives that are focused on fixing faulty physician compensation models often view Work Relative Value Units as the key component in constructing a sustainable compensation model. What advice would you give us about wRVUs as a tool in constructing compensation models?”

Will:

That’s a great question, and as you’ve probably been able to surmise so far, we really do have a preference for Work RVU models, and we usually recommend that Work RVUs are the models we put in place for physician compensation. They even work in a private practice setting.

Now, in a hospital-owned practice setting, Work RVUs do have some significant advantages even over other models such as a bottom line model and so on. But like any tool, RVUs can be misused, and regardless of the model used, the following principles are particularly important in an employment situation.

First, employed physicians should have a high degree of control over the measures that drive their compensation. And again, Work RVUs meet this requirement particularly well because even in an employment setting the physician still has a lot of control over his or her personal productivity or style of practice and over the services that they provide and the procedure coding that supports those services and the documentation as well.



The Work RVU model also tends to avoid some of the problems associated with employment, such as payer mix philosophy and central billing practices where the physicians may not control those elements.

The second point is that it really is in the best interest of employed physicians and the hospital that the compensation per unit of production be sustainable over the long term. Otherwise, the practice loses money and consumes precious capital that would otherwise be used for the long-term success of the integrated organization. Sustainability is largely a function of the local practice volume and a well-managed cost structure, rather than a pay rate determined using those national benchmarks, which may have nothing to do with that local reality.

Just a quick side note, you've probably all noticed that the national surveys are currently experiencing a real fluctuation in some of the long-standing metrics as increasing numbers of physicians opt for employment. So we need to be cautious that basing compensation on those fluctuating metrics can be a very risky process.

The third point to make is that we recommend that our clients invest the time to understand the impact of a compensation model beyond the static illustration. All too often, hospital executives will structure a compensation with multiple tiers and thresholds based on a fixed point of productivity, and the math looks good for that one example that they've put together. But of course, the actual productivity will vary, and so it's absolutely critical to test the compensation structure using various scenarios and differing levels of productivity in order to see how it performs across the spectrum.

I've often encountered models that were so broken that the practice lost substantial amounts of money on every additional patient visit that they happened to see, simply because it had an unintended escalator up on the high end, and of course, you're not going to make up the losses in that type of a situation based on volume.



The fourth point is that our preferred compensation approach includes a base pay component calculated as 50 percent of the prior year's actual Work RVUs multiplied by the rate per RVU for that physician specialty. The other 50 percent of the physician's compensation is driven by the productivity component, which may include, as Marc had mentioned earlier, a clinical quality and service quality bonus component that's factored into that rate per RVU as well.

And the fifth point to make is we recommend that productivity compensation be paid to the physician monthly rather than quarterly or annually. And this is a very important point because when you pay that compensation out monthly, the physician is always engaged and always receives that feedback on their level of current productivity.

Our preferred model also uses a three-month moving average to determine the productivity pay for the individual physician, and it makes that payment usually on the second pay period of the following month. Again, so there's immediate feedback! That immediate feedback really does help to reinforce the productive behaviors, and it alerts the physicians when their productivity may be dropping.

Ralph:

Thank you, Will. Outstanding information.

Listeners, in the box at the top of page seven of the handout, the answers are "local practice volume" and "cost structure." So that box will read, "Sustainability is largely a function of local practice volume and a well-managed cost structure."

Marc, here is an excellent question that I'd like to direct to you from one of our listeners. She says:

"Some of our compensation model engineers would like to add various components into the compensation equation such as clinical quality, service quality, expense control, personal



behavior or other factors. What is your opinion of the effect this could have on the sustainability of the model?”

Marc:

Well, Ralph, given the current trends in reimbursement, this is another great question.

Some payers are already requiring demonstrated clinical quality and service quality in order for organizations to receive full reimbursement. We see some physician and executive leaders, as a result, assuming that volume measures will become a thing of the past. Not so, at least in successful practices.

Those of us who lived through global capitation in the late 80s and early 90s, as I mentioned, remember that the most successful organizations were those with large primary care patient panels that had great access to their primary care physicians. A primary care practice is the most cost effective place to treat most common ailments. It is the best place for integrated organizations to manage the health of a population and to coordinate specialty care referrals to fewer of the most effective and efficient specialists, which is the basis for an effective patient-centered medical home. The larger the patient panel, the more effectively an organization can spread its risk, and the busier are the preferred specialists as they practice their evidence-based best.

Now, as I mentioned earlier, successful compensation models of the future will, of necessity, maintain a hefty bias toward high productivity. In fact, we anticipate that we'll see clinical quality and service quality bonuses again reflected in additional compensation per RVU or whatever the productivity measure since busier physicians have to provide high quality care and caring more frequently to more patients.

In terms of rewarding personal behavior, there are certain conditions of employment that apply to all of us, regardless



of our education level. Paying licensed professionals extra to practice good medicine or to keep up on their charts or to participate in routine ambulatory call coverage or to behave respectfully seems, frankly, a bit ludicrous.

Those who fail to meet the basic standards and norms should be fired, even if they're a hard to recruit specialist. Now, the hidden costs, remember, the *hidden* costs of tolerating a "C" player—behavioral "C" player or otherwise—are most evident in the frustration of our "A" players. So we strongly advise our clients against using the compensation model to fix bad behavior. Correcting that behavior is a governance and management issue. Compensation should reward the behaviors that produce the desired results.

Now, expense control is certainly a legitimate component of the ultimate risk and reward compensation model found in private practice settings. Unfortunately, as Will mentioned earlier, in a hospital ownership setting, physicians do not have the same control or the ultimate risk or reward they experienced in private practice. Factors such as central billing, hospital employee benefits (which are more expensive), payer mix objectives—again, some mission-based payer mix objectives—certainly loss of ancillary income which is stripped out of some owned practices, and other factors like those change the rules of the game for employed physicians.

So instead of focusing on the bottom line with a compensation approach, we prefer to engage physicians and management at each location to work together to achieve practice viability as a governance and management issue, using both revenue enhancement and expense control tactics.

Again, this is an operational governance and management issue, not a compensation issue. Practice financial viability becomes the minimum standard for acceptable performance; that is, when we count all the revenues and only the expenses found in a private practice setting—that gold standard we've talked about.



Ralph:

Thank you, Marc. Excellent information.

Listeners, in the box at the bottom of page seven we can fill in the blanks with “high productivity.” “Successful compensation models of the future will maintain a hefty bias toward high productivity.”

Then let’s turn to page eight and look at the box at the top of that page. It should read “Physicians and management should work together to achieve practice viability using both revenue enhancement and expense control tactics.” So again, those answers are “revenue enhancement” and “expense control.”

Will, here is another great question for you to answer. Our listener asks:

“What are the critical success factors in developing and implementing physician compensation plans that will lead to financially viable medical practices?”

Will:

You’re right, it is a good question, and there are a couple of thoughts that come to mind as I consider this.

The first is that both physicians and management need to understand that changing a compensation model should and will take time. It takes time to properly engage physicians in moving to a new compensation model that may make more sense going forward, and such engagement is not necessarily an easy process, but it really is an essential element of that process.

Second, management needs to understand that a change in the compensation model may result in an increase in total compensation costs in the beginning as the high producers are transitioned into a new compensation model that may be



advantageous for them, and the lower producers are given a little bit more time to elevate their productivity and get into this newer compensation methodology. So it may cost a little bit more on the front end, but in the long run, you'll see those increased volumes and increased viability down the road.

Finally, most importantly, physician and executive leaders need to acknowledge that a compensation model that is not sustainable is a bad deal. A short-term win for the doctors at the expense of the hospital, or vice versa, is just that—it is short term. Relationships will sour as the losses mount and fingers begin to point, and capital won't flow as freely to the practices that aren't viable, and that throws good money after bad.

It's to be expected and anticipated that there will be operating losses on a new physician practice to the community, but those established practices—those around 24 months in operation—those really should be at break-even levels of productivity, and they should ultimately offer physicians the opportunity to earn a market competitive rate of pay.

It's far better, ultimately, to structure a compensation model based on sustainable levels, adjust it periodically, and then ensure that all the parties understand and openly discuss the dynamics that are at play. Making sure that we have the best paid physicians in town because they legitimately earn it, that is ultimately in everybody's best interest.

Ralph:

Thank you for that great information, Will, and I wanted to let our listeners know that those three important points that Will just explained to us are listed for you at the bottom of page eight.



Marc, here's another very thoughtful question from one of our listeners. She asks:

“How important is the clinical setting to the sustainability of our physician compensation model?”

Marc:

Well, of course—and I know the person who posed the question realizes this—the compensation model is absolutely and inextricably tied to the sustainability of the medical practice.

Physician compensation is by far the most significant element in the practice cost structure. Compensation is also, perhaps, the most significant factor in recruitment and retention of quality physicians, most of whom have other local or regional opportunities. The compensation model, then, is the most important factor in motivating personal productivity. So all of those factors are driven by that compensation model.

Now, at the same time, the clinical setting has a significant affect on the physician's ability to achieve optimal performance, regardless of the model. Providing adequate support staff, for example, so the physician does what only the physician can do, is critical to optimizing productivity.

What we call “highest and best use staffing” includes making sure that the clinical assistant is at the exam room door every time the physician leaves the room. Better yet, the alert clinical assistant knows when the exam room visit has gone beyond the norm for the patient's chief complaint, and essentially rescues the physician from what has likely become a social call. The nurses can take over the discussion at a much lower cost and actually increase patient satisfaction.

We frequently refer to the facility itself—to the “productivity zone”—in an ambulatory setting, which includes the examination rooms, the nurse's station and the doctor's



work station. That zone must be free of anything that would detract from a positive patient experience or from the productivity of the physician and the clinical assistant. Clutter of any kind is a huge distraction. Clean counters, conveniently located supplies and equipment make a big difference in little ways when they are repeated 20 to 40 times a day, four to five days a week, 48 weeks a year. Consider the fact that a barrier in the hallway that adds a minute of inefficiency to each patient visit can cost two patient visits a day.

Ralph:

Outstanding, Marc, thank you. That is just very valuable information.

Listeners, please note that the key points Marc just reviewed with us are listed on page nine of the handout.

Will, this next question is one that you will be particularly adept at answering. Our listener says:

“We have heard both Marc and Will speak about Work Relative Value Units as being a best practice for hospital-owned medical practices. Please share with us the potential advantages and disadvantages of this approach.”

Will:

There are a couple of key advantages of RVUs, and one of the primary advantages with Work RVUs is that they provide that direct measure of the work effort that the physician provides. This can ultimately provide a precisely targeted metric upon which to base the compensation. The physician, through appropriate coding and documentation can control the ultimate compensation level. RVUs also flex with the complexity of patients and so on, and so it really does help to just target in on that direct effort that the provider happens to provide.



Also, while it may not necessarily be realized by most providers, I think most administrators understand that many payers structure their reimbursement for billed charges based upon an RVU scale. So when you compensate physicians based upon the Work RVUs, there is a degree of alignment between services rendered and billed and the compensation paid, again, as long as you ensure that those rates per unit are appropriate and not exorbitant.

But RVUs aren't all rosy, either; there are some challenges. Basing compensation on Work RVUs can require some degree of creativity when you're dealing with specialties or practices which have a high cash-based component to the services. For example, some cosmetic procedures may not have RVUs associated with them, and so there may need to be some creative methods to deal with that type of a service mix.

And also, I think it's very important that special care be taken when you're dealing with surgical specialties to ensure that the billing system will appropriately adjust the accumulated Work RVU values assigned when multiple procedures are performed. Medicare and other payers will frequently reduce the reimbursement for the second and third surgical procedure performed as part of the same surgical case, and if you fail to appropriately adjust the Work RVUs for those cases with multiple procedures, you can result in an overstating of the Work RVUs, and that, of course, would then lead to an excessive compensation.

Ralph:

Thank you, Will. Again, outstanding information for our listeners.

Listeners, if you will please turn to page 10 of the handout, let's go over the answers for the two boxes there. The answer for the first box is "direct measure." "RVUs provide a direct measure of the work that the physician provides."



And then in the second box, the answer is “payers.” “Most payers structure their reimbursement for billed charges based upon the RVU scale.”

Marc, listen to this very perceptive two-pronged question from one of our listeners. He asks:

“Why do you believe there is a seeming resignation by board members, hospital executives, and physician leaders to accept financial losses as a cost of doing business in hospital-owned medical practices? What do you recommend as a way to change this thinking?”

Marc:

What a great question! This thought process is certainly perplexing, especially when there are viable private practices in the same specialty in the same community. What’s even more confusing to me are the lengths to which some executives go to rationalize those losses rather than fixing them.

We hear arguments about downstream revenue, which is, by the way, the same revenue received from private practice physicians without having to supplement those practices. More importantly is the fact that most downstream revenue is consumed as a cost of doing business, leaving relatively little downstream capital overall—the money that we can actually reinvest. We certainly understand the concept of contribution margin, but at some point, hospital-owned medical practices need to quit draining precious capital to cover operating losses when that capital should be used for strategic purposes.

In our experience, the most effective advocates for changing this mental model are actually the employed physicians who used to meet a payroll every two weeks. They know how to do it. Working with these experienced physicians, most of the common mistakes hospitals make when they acquire and operate medical practices can be overcome. Engaging senior



hospital and health system leadership with those doctors in learning and applying the principles for success in the medical practice business is essential.

Many of the principles that we espouse are available in our publications, particularly our most recent book titled *Owning Medical Practices: Best Practices for Sustainable Results* published by the AHA Press earlier this year. Based on correct operating principles for medical practices, not hospital departments, senior hospital leadership must be willing to sponsor a performance standard that is equivalent to private practice when compared apples to apples.

Ralph:

Thank you, Marc. Those are absolutely critical concepts for our listening audience.

On page 11 of the handout, listeners, we have listed the recommendations that Marc just provided to raise expectations for the performance of hospital-owned medical practices.

This next question will be appropriate for Will. Our listener asks:

“How can you make a productivity-based plan equitable for all providers when you are dealing with some providers who have administrative and GME teaching responsibilities as well as clinical responsibilities?”

Will:

It is a great question, and we frequently see hospitals address these types of situations in a number of ways. Many will deal with the perceived complexity by not addressing it. They may elect to compensate the physicians on a fixed salary because that’s easier and because they can’t determine how to value the time the providers dedicate to the non-clinical component of their day.



Others may elevate the rates paid per unit to adjust for the fact that providers are only spending a portion of their time in productivity or RVU-generating activities. So, for example, those particular physicians may have a higher rate per unit than their simply clinic-based peers. And that can create several challenges when it comes to the implementation and the perceptions of the providers.

But we think that the best practice in these types of situations is actually to address the administrative or teaching responsibility separate from the productivity component. The administrative or teaching role is provided an appropriate stipend or hourly compensation, and the compensation for the clinical work would be at a rate that's appropriate and sustainable given the work that's performed at rates that are similar to your full-time clinical providers.

By dealing with these two distinct roles separately, you can ensure that you're compensating appropriately for each role, and you avoid the confusion that often occurs when elevating clinical productivity-based rates of pay to adjust for non-clinical activities. You end up paying an appropriate teaching stipend and an appropriate rate for the clinical productivity as well.

Ralph:

Great answer, Will. Thank you.

Marc and Will, I know that each of you have some critically important thoughts that you wish to share with our listeners before we conclude the seminar this afternoon, and so with that in mind, I believe we have time for one more question before we hear final thoughts from each of you.

Marc, our next listener asks:

“How long does it take to effectively address most of the challenges common to hospital-owned medical practices in order to create financial and operational viability?”



Marc:

Thank you, Ralph. I'm glad we had time for this question.

Hospital-owned medical practice networks break even one practice at a time. That's very important to understand. They don't break even as a network or as a large group; they break even one practice or one department at a time, if it's a multi-specialty group setting.

We've seen some client practices achieve that private practice equivalent within just a few months; however, we usually recommend an 18-month time frame to achieve the private practice gold standard. Now, that allows enough time to:

- 1) Establish the operational governance that engages employed physicians as partners in performance improvement.
- 2) Develop a competent team of implementers among the management ranks.
- 3) Implement performance reporting that supports rigorous measurement and a culture of accountability.

Performance improvement is usually visible within a few months, and those practices and physicians that will not make the grade fairly quickly become evident.

Ralph:

Thank you, Marc.

Listeners, we are now at the top of page 12 on the handout, and Marc's recommendation was allowing an 18-month time frame to achieve the private practice gold standard.

Marc and Will, before you share your very vital concluding thoughts with our listeners, I want to thank you for responding to the excellent questions posed by our listening healthcare



executives, and by doing so, teaching us the time-tested critical success factors for building productivity-based compensation models that are truly sustainable and play a vital role in facilitating financial viability for our listeners' owned medical practices.

Thank you also for presenting our listeners with the formula to use these factors to build their owned medical practice networks so they are making significant strides towards market leadership in the next 12 months.

Marc, what's the best way for our listeners to contact Halley Consulting to arrange for an organizationally-specific analysis of their health system, hospital or group practice?

Marc: Ralph, there are two ways. First of all, we have a website www.halleyconsulting.com, and then we have a toll-free number, and that number is 1-866-706-5373.

Ralph: Great, thank you, Marc and Will both for joining us today and providing these most excellent insights, which I know will be so valuable for our healthcare professionals. Would you now both please share the very vital parting thoughts you would like our listeners to remember as we conclude this event today?

Will: Thanks, Ralph.

There are a couple of key points that I think I'd like to reiterate, and the first is to understand that there really is no magic bullet. Compensation design is complex, and it's often emotionally charged, and although the mathematics of the compensation model may be really quite simple, it ultimately is the transition—getting from where you are to where you



ultimately want to be—that takes the real effort. I often state that it is the *transition* that makes or breaks a compensation model design effort. We need to recognize that change does take time, and changing the practice patterns to succeed in a different compensation structure takes time and requires that clear communication with the providers.

This next point is a really critical one: if you are engaging in a compensation redesign initiative, try to approach it from the perspective of aligning productivity with compensation, not as a reduction in compensation. I often see hospital executives say, “Our compensation is too high. We need to reduce the compensation.” But really, what you need to do is get the productivity to a level that supports the compensation, and it’s a subtle difference, but that message is very different when you’re communicating that with your physician. Then, if at all possible, you need to provide the physicians with a shadowing period where they can familiarize themselves with the new compensation model without there being any financial impact. Providing the physicians with sufficient time to adjust their productivity, if needed, and to regain any potential compensation reduction.

Marc:

Will, thank you. Let me add just a few parting thoughts as well, Ralph. Will’s comments were outstanding.

One of the fundamental mistakes hospitals made during the first cycle of physician employment, this 1985 to the late 1990s, was overpaying for practices they purchased through significant goodwill payments, many of which were amortized over then five years.

Today we don’t see as much inappropriate use of goodwill. Instead, we see hospital executives and physicians make the mistake of building compensation models that pay physicians more than they made in private practice. Now, this is a more insidious mistake which can’t be amortized and will ultimately have to be addressed as reimbursement continues to decline.



We realize, because we help cut these deals, that there are competitive factors in certain markets forcing deals that may not violate fair market value if you find the right benchmark, but which are not sustainable in the short or long term. There is such a temptation for physicians to maximize their income, and such a temptation for executives to justify the deal to capture market share or to maintain a service line. In our experience, however, this mistake always, and I mean *always* comes home to roost for both the physicians and management.

If all the parties will adhere to correct compensation principles, they can work together to make sure that the physicians have an opportunity to earn a market competitive income while maintaining their relationships and the long-term viability of their partnership or integrated organization.

Ralph:

Thank you, Marc and Will both for the sage counsel we have received today, and most especially, thanks to all of you healthcare professionals who have invested your time to both provide us with wonderful questions to answer and then for joining us for this seminar today.

For your convenience and the convenience of your colleagues who may not have been able to attend, a recording of this seminar will be available on the Halley Consulting Group website along with a written transcript for your use. We will give you notice as soon as the information is available so you can visit the Halley site at www.halleyconsulting.com and access this most valuable information.

Until then, our most kind regards and appreciation for the opportunity to be with you today.