



# Health system sponsored physician employment: keys to success

*Part 2: Aligning incentives through physician compensation*

# Aligning incentives through physician compensation

Perhaps the greatest opportunity provided through health system sponsored physician employment is the ability to align physicians' and hospitals' incentives for financial performance and quality patient care through the employed physician compensation plan. A health system's flexibility in compensating physicians in private practice has been severely limited by federal and state laws and regulations. Hospital and health system employment offers certain exceptions and safe harbors under these laws when certain conditions are met.<sup>1</sup>

## Key legal provisions<sup>2</sup>

The statutory exemption and safe harbor for bona fide employment arrangements under the Stark Law permit hospitals to compensate physicians for services personally performed as long as the following conditions are met:

- Payment for such services is set forth in writing and clearly describes the services to be provided
- Compensation is set in advance for the term of the Agreement, which must be at least one year
- Compensation does not exceed fair market value
- Compensation is in no way related to the volume or value of referrals
- The arrangement is commercially reasonable even if no physician referrals of designated health services were made to the employer<sup>3</sup>

Even under these conditions, the fraud and abuse protections for bona fide employment allow for a compensation structure that is considerably more flexible and less risky than alternative compensation arrangements outside of the employment relationship. As a result, one major key to successful physician employment is the crafting of an employed physician compensation model that aligns physician and hospital incentives for long term success of the enterprise.

## The first priority of incentives – practice performance

Health systems employing physicians for the first time typically do so through acquisition of solo and small group private practices augmented by recruitment of new physicians out of residency training. In such start up scenarios, it is paramount to align incentives based on physician practice performance. The key elements of practice performance include physician productivity, cash collections and management of practice expenses. Health systems that employed physicians in the mid-1990s through salary-based arrangements encountered significant financial operating losses because the arrangements disconnected practice financial performance from physician compensation.

# The evolution of health system sponsored physician compensation

## Salary-based arrangements

When health systems first employed physicians, the arrangements were characterized by salary-based employment agreements. These were very specific in requiring of the employed physician a minimal number of office hours. They did not effectively link physician compensation to productivity, professional fee cash collections or practice expense management. The assumption was that the physician would continue to see the same number of patients as in the past, and that the health system would be responsible for practice management, thereby relieving the physician from the headaches associated with running the practice.

Salary-based compensation arrangements have sometimes been referred to as “Pay for Presence” since guaranteed compensation only hinged upon the physician meeting minimum office hour requirements. The arrangements did not require individual productivity, cash collections or practice expense management performance.

## Productivity incentives added

In response to significant reductions in productivity that occurred under guaranteed salary arrangements, hospitals instituted a second generation of physician compensation plans which became known as “base plus bonus” or “base plus incentive.” Typically, the bonus or incentive was tied to individual physician productivity. Early versions of these incentive arrangements tied compensation to gross billings, patient encounters, and Medicare relative value units

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## Acknowledgements

The author would like to acknowledge the invaluable assistance of Anthony D'Eredita, Randy Gott, Margaret Hoban, Peter Kindrachuk, Eric Passon, Sue Mackintosh, Vince Manoogian, and Dick Wright from Southwind Health Partners in the development and refinement of the concepts presented as well as their helpful review of the draft manuscript. In addition, Bob Vernon, Jennifer Newell and Joan Ronck at Southwind assisted in proofreading drafts. Peggy Naas, MD, of VHA provided helpful comments on the draft and has played a pivotal role in developing the Southwind/VHA collaboration leading to this co-branded publication. Any errors or omissions should be attributed to the author.

which reflected individual physician productivity but did not reward physician behavior that maximized professional fee cash collections or managing practice expenses.

Often the “base plus incentive” model had the effect of producing significantly higher health system financial operating losses, even while average group productivity improved. This is because some physicians ignored the incentives, being satisfied with the guaranteed base salary, while other physicians worked hard to achieve significantly higher

productivity. Higher productivity was measured by “billings,” relative value units or other metrics that did not take into account actual reimbursement realities and net earnings. Since productivity incentives are rarely tied to actual performance, bonus incentive payments often exceeded the dollars generated through higher productivity. These misaligned incentives often resulted in a segment of physicians never earning their base salary, while another segment never earned their bonus or incentive. The result, once again, was significant financial losses for the health system sponsor.

**Table 1: Dynamics of base salary plus incentives tied to wRVUs\*, gross billings or encounters**

Physician category	Response to incentive	Cash compensation	Economic impact on sponsored medical group
<b>Low producers</b>	Work less; settle for minimum salary guarantee	Typically salaries were set at/near national median	Significant financial losses due to physicians not earning their salary
<b>High producers</b>	Work more to earn incentives	Salary plus incentives could reach levels well in excess of the 90th percentile of compensation	Significant financial losses due to physicians earning incentives exceeding actual earnings
<b>Overall impact</b>	Overall productivity not improved	Both types of physicians earning cash compensation in excess of national norms relative to productivity	Extraordinary financial operating losses – financially unsustainable

(\*wRVU's: work relative value units)

## The RVU model

Another physician compensation model, which hospitals began adopting in large numbers early in the new millennium, is based upon a payment per relative value unit. This approach has several advantages:

- Medicare's "work relative value units" are a standard measure of physician work effort (productivity) generally accepted by both health systems and physicians as a reasonable basis for physician compensation
- By eliminating the guaranteed base salary, low producing physicians were paid less and financial operating losses associated with below average producers fell
- Since wRVUs in no way reflect variations in payor mix or cash collections, institutions seeking to employ physicians who are "payor blind" and willing to accept any patient regardless of ability to pay are attracted to this approach
- From the standpoint of enhancing the attractiveness of the employment arrangement and the ability to attract and recruit physicians, the compensation per wRVU approach is attractive to physicians in its simplicity
- Unless payments are tiered such that higher producers are paid at a higher rate, high and low producers are paid at the same rate, while actual financial performance would reward high producing physicians at a significantly higher rate per wRVU
- From time to time, The Centers for Medicare and Medicaid Services revise the value of wRVUs, resulting in significant changes to physician compensation that may have unintended consequences for physician employment arrangements. One of these consequences is often significantly higher financial operating losses

For the reasons above, a physician compensation model based upon wRVU productivity does not go far enough to align incentives around cash collections performance and practice expense management. The result will likely be unsustainable financial performance.

There are, however, significant disadvantages of the compensation per wRVU approach:

- wRVUs do not provide physicians with any incentive to maximize professional fee cash collections
- wRVUs do not provide an incentive for a physician to be concerned about practice expense management
- Disconnecting payor mix from the physician incentive typically results in higher and unpredictable financial operating losses and, in some cases, can result in perverse practice patterns<sup>4</sup>

# Lessons learned from poor performing health system sponsored physician practices

The flaws evident in each of the models described above help illustrate a number of critical factors that must be considered in designing the optimal approach to aligning incentives through physician compensation. Effectively addressing each of these critical factors or key principles will optimize the financial performance and sustainability of the physician employment enterprise.

## Allocating financial risk

It has been said that “those who take the financial risk will be the managers.” A major flaw in the design of the first generation of health system sponsored physician practices was the concentration of financial risk with the hospital, based on the premise that the hospital was primarily responsible for management of the practice. However, there are a few – very few – existing examples of hospitals running physician practices as well as they run a department of the hospital. Absent direct involvement by physician leaders, and a capable, dedicated physician practice management infrastructure, the physician employment enterprise is doomed to failure, or at least, extraordinary financial operating losses and physician discontent.

On the other hand, a physician employment enterprise that is constituted as a physician led and professionally managed organization has a much better chance of achieving financial sustainability. This means two things. First, physicians must be given control over the day-to-day management of the practice (a governance concept). Second, they must be given appropriate

financial risk for practice performance (a physician compensation concept). In sum, the governance, management and alignment of incentives through compensation in a successful physician enterprise are inherently linked.

## Downside risk

As discussed above, guaranteed compensation arrangements may attract physicians who are unable or unwilling to be sufficiently productive to support their compensation level. Since physicians, like all humans, are more highly motivated by downside risk to their compensation than by upside bonus/incentive potential, those arrangements that have no minimum compensation level serve to attract and motivate more productive physicians.

## Professional fee cash collections risk

Often a physician will say, “Why should I accept financial risk for cash collections performance? The Hospital is responsible for collecting cash for the services that I bill...”

Simply stated, employed physician organizations where physicians are at risk for cash collections have significantly higher cash collections performance. This is true because cash collections performance is primarily a function of the scheduling, arrival, registration and charge capture activities that occur at the front desk of the individual physician’s practice site. The physician is closer to the staff performing these functions than the central business office or hospital staff. As a result, the physician is in the best position to focus attention on activities that optimize cash collections performance.

There are rare examples of success in situations where the cash collections risk rests with the physician enterprise as a whole or the sponsoring institution. Organizationally, a structure in which the front desk registration functions are directly accountable to a Central Business Office with established processes and set standards can achieve success. However, success in this approach remains the exception, as there is a

higher incidence of poor performance.

Absent dedicated and accountable infrastructure, which is characteristic of more mature health system sponsored physician practices, it is best to provide employed physicians with strong incentives to maximize professional fee cash collections. This is especially true for recently acquired practices where a front desk staff with long term loyalty to the physician will likely take their cues regarding policy and procedures from the physician and not from the new, centralized management bureaucracy.

## Practice expense management

Employed physicians should also be given strong incentives to manage local practice expenses. In compensation arrangements that do not include such expense management incentives, it is likely that one of two scenarios will occur. In the first scenario, the health system’s centralized management aggressively manages practice expenses without regard to local practice site physician preferences. These arrangements are characterized by a high degree of physician angst and tension between the practice management team, local practice staff and the physicians.

In the second scenario, practice expenses are not well managed by the physician or the central practice management team, resulting in higher than appropriate practice expenses and the related excessive financial operating losses at the sponsor level.

In scenarios where physician compensation is disconnected from practice expense management, it is the duty of the practice management team to manage expenses regardless of physician preferences, resulting in a dynamic where it becomes the physician’s job to ask for incremental expenses (a new nurse, for example) and management’s job to say “no” to avoid a potentially unnecessary expense, thus creating conflict.

The best approach is to empower physicians at the local practice site to make expense decisions with information and guidance from professional management. In truth, physicians are, in most cases, the best judge of whether incremental practice expenses are necessary or whether certain expenses can be reduced. The key is to align incentives such that controllable practice expenses accrue directly to the physician through the compensation plan, and at full value. If, for example, incremental practice expenses were to accrue 50% to physician compensation, a rational physician will desire a higher cost structure to support productivity since the physician is not paying the full incremental cost.

In arrangements where the physician is accountable for the full value of incremental expenses and therefore holds the decision making authority, management's job is to provide good, sound information regarding how expenses compare to other practice sites in the physician enterprise and to other practices in the same specialty, regionally and nationally. Additionally, management should provide thoughtful analysis of how the expense increase or decrease will impact the physician's compensation, and/or the level of increased patient volume required to render a new practice expense a good investment.

**Table 2: Dynamics of expense management as it relates to physician compensation incentives**

Physician compensation plan	Response to incentive	Management team's role	Economic impact on sponsored medical group
<b>Physicians not at risk for practice expenses</b>	Seek increased practice expense without regard to financial impact; in models with productivity incentives, physicians typically seek more aggressively to add space & staff to enable higher levels of productivity	Management is responsible for expense management, often to the detriment of the physician/manager relationship	Significant financial losses due to failure to align expenses with practice revenues & volume
<b>Physicians at risk for controllable practice expenses</b>	Carefully evaluate practice expense structure to optimize physician compensation	Management serves as an internal consultant to the physician, responsible for providing benchmark data and financial analysis to assist physician in making the best decision	Financial performance is optimized

## Quality: the emerging focus of incentive alignment

Pending health care reform may signal changes in provider reimbursement with a new focus on adherence to best practice clinical guidelines and cost effective medicine. Much attention is being given to value based purchasing and bundled payments for a defined episode of care as a way to enhance measurement of quality and price transparency to the consumer. The flaws inherent in fee-for-service medicine are well documented. Still, in most markets today, practice performance is more a function of the volume of services delivered than of the quality or cost effectiveness of those services.

Health system sponsored physician employment offers hospitals the opportunity to take a leap forward toward aligning incentives with physicians to enhance the quality and cost effectiveness of medical care, with the added value of preparing for changes in government and third party payor reimbursement. For example, diabetes, heart disease, asthma and depression are chronic conditions that plague over 118 million Americans at a health care system cost of more than \$453 billion.<sup>5</sup> New payment systems that incentivize providers to improve the cost effectiveness of care for these diseases alone will have significant impact on the overall cost of health care in the U.S.

The assumption that all health care in America is delivered pursuant to a common standard has been disproven. According to the New England Journal of Medicine:

- 54.9% of recommended preventive care is delivered
- 53.5% of recommended acute care is delivered
- 56.1% of recommended chronic care is delivered
- 52.2% of recommended screening is delivered
- 58.5% of recommended follow up care is delivered<sup>6</sup>

It is only a matter of time before health systems are challenged by government and industry payors to manage chronic conditions more cost effectively and in line with proven treatment protocols in order to achieve optimal clinical outcomes, as well as cost-savings.

## Lessons learned about quality incentive programs

Lessons learned from early adopters of physician compensation incentives related to quality are several:

- Measures should be robust, reflect evidence-based national standards of care and be meaningful to consumers
- Financial incentives for physicians must be significant (more than 10% of total cash compensation) in order to be effective
- Measures should be relatively few in number and evolve over time – when optimum performance is achieved on basic measures, they can be replaced by new ones
- Care must be taken to adjust performance metrics for severity of illness so that physicians are not discouraged from caring for sicker patients
- Introducing quality incentives into a health system sponsored physician practice that is performing poorly and does not align incentives around practice performance can be counterproductive – quality incentives are best introduced once physicians have achieved optimum practice performance based on financial measures<sup>7</sup>

# Prospectively determining the health system's contribution

Health system executives overseeing physician employment put their jobs at risk when actual losses are at a significant negative variance from the business plan projections. Several of the physician compensation models described above (guaranteed salary, salary plus bonus/incentive; wRVUs) all have significant potential for unpredictable and undesirable financial results.

The optimum physician compensation plan should first consider the nature and level of health system support for the employed physician enterprise. Decisions regarding hospital subsidies of the physician practice should be prospectively defined and they should be specific.

Typical components of physician support include, but are not limited to, the following:

- **Centralized infrastructure** supporting the employed physician enterprise:
  - The multi-site physician practice management team
  - The information technology required to support the physician enterprise, including the physician practice management system and electronic health record
  - The central business office, responsible for back-end billing, collections, accounts receivable management and reporting
  - Centralized financial operations including accounts payable, payroll, general ledger accounting and financial reporting
  - Legal, marketing and other centralized services<sup>8</sup>
- **New physician support** A key advantage of the employment model is that it allows the sponsoring institution to underwrite new physician support for a limited time period (typically up to two years) without compromising the earnings of the existing employed physicians.
- **Excess facility expense** In order to support physician growth over time, practice site facilities must be developed that are large enough to accommodate future growth, without the cost of excess office space during the early years being supported by the existing physicians.
- **Teaching** Some institutions require all or a portion of their employed physicians to assume teaching duties in support of a hospital-based residency program.
- **Short-term disability** Any employment arrangement carries with it an expectation of some form of short-term disability benefit, to cover maternity leave or other illness or injury. The cost of short-term disability coverage can be estimated in advance.
- **Professional liability insurance** Particularly in markets without "tort reform" or where malpractice insurance costs are relatively high, it may be important for the institution to provide some type of support for malpractice coverage expense.
- **Indigent care** Many health system sponsored physician employment arrangements have as part of their mission to care for the underserved or the medically indigent. It is important when structuring physician compensation arrangements to define up front the extent to which the institution is able and willing to support the provision of physician services to the underserved.
- **Quality** Progressive institutions are allocating a portion of health system financial support to be devoted to efforts to enhance health care quality, including optimizing the performance of hospital operations, enhancing patient satisfaction, and adherence to best practice clinical guidelines and cost effective medicine.

# Aligning incentives through the net income model

The best approach for long term financial sustainability while attracting and retaining productive and high quality physicians is a compensation plan with two components:

- A base compensation arrangement based upon the net income model in which physician compensation is a function of professional fee cash collections less practice expenses
- A quality incentive that is tied to best practice clinical guidelines, cost effective medicine and patient satisfaction

## Net income model

A good example of a net income model works as follows. Physician base compensation is set in advance every three months based on the following formula:

	<u>prior 12 months professional fee cash collections</u>
<b>LESS (-)</b>	<u>direct practice expenses for the prior six months annualized, including office rent, staff, supplies, and professional liability insurance – all expenses within the four walls of the practice. Direct expenses are typically allocated among multiple physicians in a single practice site based on 50% FTE status and 50% pro rata professional fee cash collections to fairly allocate a portion as 50% fixed and 50% variable cost</u>
<b>LESS (-)</b>	<u>a fair allocation of centralized practice support costs,<sup>9</sup> including the allocated cost of the practice management information system and electronic health record system, central business office for accounts receivable management, the multi-site management team, accounting, payroll, accounts payable and financial reporting. Typically, centralized practice support costs are allocated on an FTE basis, as a percentage of professional fee cash collections, or as some combination of the two</u>
<b>PLUS (+)</b>	<u>a market adjustment factor, expressed as a percentage of professional fee cash collections or a fixed amount per physician FTE, that is required in order to achieve market competitive compensation</u>
<b>LESS (-)</b>	<u>physician benefits</u>
<b>EQUALS (=)</b>	total physician compensation

In the following section the essential elements of the above model will be described.

(\*FTE = full time equivalent)

## 12-month rolling average adjusted every 3 months

A common flaw in many physician compensation arrangements is that physician compensation is guaranteed for one or more years at a time, often resulting in a significant “cliff” at some point in the future when adjustments to compensation are required. Physicians value consistent earnings. Dramatic changes to physician compensation levels can often result in physician turnover or, at a minimum, disruption in the hospital/physician relationship.

By adjusting compensation quarterly, based on a 12-month rolling average of professional fee cash collections, several objectives are met

- There is a significant productivity incentive
- There is alignment of incentives around cash collections performance
- There is relatively stable compensation, with fewer significant changes in compensation that may result from vacations or seasonality
- There is a gentle message of either improvement or deterioration delivered every three months, thereby encouraging the physician to closely monitor financial and operating performance, as any good business owner and manager would<sup>10</sup>

## 6-month rolling average direct expense allocation

Similarly, expenses are based on a rolling average over a shorter time period so that when new expenses are added, 50% and 100% of the economic impact on physician compensation will be realized in the first three and six months, respectively. This honors the physicians’ desire for relatively stable income while also ensuring that the results of expense changes are felt more quickly.

In local practice sites serving multiple physicians, a simple allocation of half of practice site expenses based on physician FTE and half based on pro rata professional fee cash collections mirrors the reality of practice economics. In this approach, high producers will incur a disproportionate share of operating expenses, yet low producing physicians incur equally with their peers that portion of fixed overhead which must be overcome in order to generate physician earnings.

More elaborate methods of expense allocation, such as a detailed accounting of resources assigned to individual physicians, achieve a substantially similar result yet require significant administrative accounting resources. For this reason, detailed accounting of assigned resources is less desirable unless a physician insists, against his colleagues wishes, on consuming a significantly higher level of resources (such as an additional dedicated nurse, for example).

Part time physicians face a challenge with the net income model when they are saddled with a full share of the fixed portion of overhead. However, in cases where a physician is productive at 50% to 80% of local site colleagues and consumes dedicated staff and office space, the allocation methodology breaks down. The solution to the part time physician dilemma is for less than full time physicians to arrange to share space and staff with another part time colleague with each being allocated an appropriate fractional share of fixed overhead.

## Allocating central support costs

As in the case of local practice site direct expenses, a significant portion of central support costs are fixed per physician FTE while another portion is indeed variable according to productivity. Fairness dictates that central support costs be allocated on a tiered basis such that higher producers pay a relatively lower percentage of their professional fee revenues for central support staff. A tiered allocation model for central support costs is also beneficial because it can fairly support a multi-specialty physician practice composed of both relatively low revenue primary care practices and high earning specialists.

**Table 3: Typical example of tiered allocation of central support expenses**

Annualized professional fee cash collections	Allocation of central support expenses as a percent of professional fee cash collections
< \$300,000	13.0%
\$300,000 - \$399,000	10.0%
\$400,000 - \$499,000	7.5%
> \$500,000	5.0%

## The market adjustment factor

As discussed above, sustainable health system physician practices are characterized by a predictable health system investment and the ability to attract and retain productive, quality physicians. This investment is often termed a “market adjustment factor.”<sup>11</sup> Its purpose is to increase the physician compensation level derived solely from net income so that total compensation is market competitive. Such an adjustment often accounts for the absence of ancillary services net income as a component of physician compensation.<sup>12</sup>

The market adjustment factor represents an investment of hospital funds into the physician enterprise and will vary by specialty. For example, since cardiologists in private practice typically earn as much as half of their compensation from in-office ancillary services (including nuclear scans, echocardiography and EKG stress tests), a significant market adjustment factor will be required to replace those earnings in a model

based solely on professional fee cash collections as its revenue source. On the other hand, primary care practices will typically require a more modest investment to cover the cost of EHR technology and a portion of centralized practice expenses.

The market adjustment factor is best set through a process of detailed financial modeling in which practice revenues and expenses are projected by the individual physician and the net income-based compensation is compared to national and regional benchmarks. For maximum protection from compliance violations in which physicians may be deemed to be compensated in excess of fair market value, it is a good idea to retain a qualified independent consultant to review the compensation plan, including the market adjustment factor, and render an opinion confirming that the resulting compensation is within the bounds of reasonableness and fair market value.

### Employing physicians with no ongoing subsidy?

Depending upon the nature of the managed care marketplace and the cost of professional liability insurance in the local market, it may be possible for health systems to support employed physicians with no prospective subsidy other than new physician support and the related excess facility costs involved where practice sites are sized larger than initially required to support practice growth.

For example, in major markets in the Northeast, third party payors have consolidated to only a few large organizations. Solo and small group private practice physicians are reimbursed at less than 90% of the Medicare equivalent reimbursement by these commercial payors. In such situations, a large health system sponsored physician enterprise may be able to negotiate as much as a 50% increase in reimbursement, thereby providing funds to cover what in other markets is a health system subsidy to cover practice management infrastructure, including management and information technology.

# Addressing the medically underserved

Not-for-profit hospitals have a mission and a legal imperative to provide charity care. Many institutions employ physicians to serve the medically underserved directly. The definition of “underserved” may vary but generally includes patients without private insurance or Medicaid coverage, although in some markets it may also include Medicare patients. As discussed above, RVU and other compensation models are popular, in part, due to their “payor neutrality.” These models remove the financial incentive for physicians to discriminate based upon payor mix.

The other side of the equation however, is that RVU and similar approaches to physician compensation leave the health system at risk to compensate physicians for providing care to the medically underserved. Since there is no limitation inherent in these models, the annual financial operating loss borne by the sponsor will be variable, unpredictable and potentially unlimited. The result is often an unsustainable financial operating loss.

Using the net income model as the basis for compensation, there are ways to prospectively define the extent to which funds are used to underwrite physician services for the medically underserved. The following are examples of how this might work:

- **A limited per visit supplement subject to a cap**  
The difference between net cash collections for medically underserved patients and a higher standard (such as a percentage of the Medicare fee schedule, for example) can be defined in advance. As a part of the physician compensation plan, the hospital agrees to fund up to a fixed amount per patient visit for physicians with greater than a predetermined percentage of medically underserved patients (for example, physicians with

self-pay and Medicaid payor mix greater than 7%). The total amount payable to the physician is subject to a cap to ensure that funding levels do not exceed available funds.

- **Payor mix off-set** Another approach that works well for large health system sponsored physician practices is to (1) measure uncollectible fees for each physician (defined as self-pay fees and Medicaid contractual allowances, for example), (2) stratify physicians in the group practice from highest to lowest dollar value of uncollectible fees, and (3) determine a fixed amount that would off-set the highest one-third of those physicians with the most adverse payor mix.
- One group of 200 primary care physicians in the Midwest determined, for example, that the total amount of uncollectable fees for the highest one-third of the physician group with adverse payor mix was, in total, \$1 million. The health system agreed to contribute \$500,000 and the physicians themselves agreed to contribute a percentage of net cash collections equal to \$500,000 (about 0.5% of cash collections) to a compensation fund. This fund was distributed such that no physician in the group practice had a payor mix that was any worse than the 67th percentile, or the high end of normal for that group.

In either of these two approaches, the key success factor is that the hospital contribution to care for the underserved through the employed physician practice is determined in advance, is predictable and is part of a business plan that is financially sustainable.

# Aligning incentives for effective new physician recruitment

Using a net income physician compensation model, it is possible to create incentives for new physician recruitment by the health system through a one time underwriting of a new physician's income during the initial two years of practice. The following table illustrates the impact of a new physician recruit on a three physician practice site, where Drs. A, B and C are low, median and high producers, respectively.

In this example, direct practice expenses are allocated 50/50 between an equal share per full time equivalent and a pro rata share based on cash collections. The new physician during the first year of practice only produces \$200,000, less than half of the median producer, Dr. B. This new physician is allocated a fair share of practice expenses using the 50/50 formula

(50% equal; 50% based on cash collections pro rata) resulting in a contribution to covering fixed expenses of \$27,000. This contribution benefits the existing physicians and helps cover the incremental expenses associated with any additional staff and supply costs that the new physician incurs.

The hospital's cost to underwrite the new physician during the first year is \$89,000. Without considering any potential cannibalization of the pre-existing practices, Drs. A, B and C will each experience a \$9,000 improvement in their annual income, which, together with an improved call schedule, provides significant incentive for growing the practice by agreeing to add a new physician.

**Table 4: Example of new physician underwriting for existing three physician practice site (in thousands of dollars)**

	Total	Dr. A	Dr. B	Dr. C	New
Individual cash collections	1,460	336	420	504	200
Direct expenses (50/50)	(580)	(139)	(156)	(173)	(112)
Docking station (12%/cash)	(175)	(40)	(50)	(60)	(24)
Market adjustment (\$15k)	60	15	15	15	15
Physician benefits	(125)	(29)	(33)	(35)	(28)
<b>Total base compensation</b>	<b>640</b>	<b>142</b>	<b>196</b>	<b>251</b>	<b>51</b>
<b>Total 1st year support - physician guarantee</b>	<b>640</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>89</b>
<b>Existing physician compensation change</b>	<b>27</b>	<b>9</b>	<b>9</b>	<b>9</b>	<b>N/A</b>

# The quality incentive

The previous sections summarize the essential elements of the net income based compensation model which represents the foundation of the leading practice physician compensation plan. In addition to base compensation tied to practice performance, there exists the opportunity to have a quality incentive tied to any one of a number of quality related criteria. The most common quality incentive criteria include the following:

- Patient satisfaction
- Adherence to best practice clinical guidelines
- Cost effective health care delivery
- Patient safety
- Medical record documentation
- Citizenship

Some institutions will choose to fund the quality incentive directly by the institution or health system, while others will insist that the physicians themselves fund the quality incentive through a deduction from their base compensation. In either case, the opportunity is for significant (at least 10% and up to more than 20% of total cash compensation) incentives tied to a relatively limited number of quality metrics that will drive improved performance in the health system sponsored medical practice.

The quality incentive is the strategic element in the health system sponsored physician practice compensation plan. It enables the physician enterprise to leap ahead of the local market competition and ahead of the payment practices of third party payors. The quality incentive focuses the organization on identifying, measuring, monitoring and developing robust positive and negative incentives around best practice clinical guidelines, cost effective medicine and other qualitative elements that will undoubtedly form the basis for differential Medicare and other third party payor reimbursement in the future.

By proactively focusing the physician enterprise on quality ahead of both government and private payors, the institution and its employed physicians position themselves to define health care quality for their community. There are excellent examples of institutions being successful by setting the standard of what will be measured and to what the incentives will be tied. By organizing to measure, monitor and reward based on common quality criteria across multiple payors, the integrated health system is best positioned to engage physicians in quality improvement.

# Let time be your friend

It is important to take stock in where the health system sponsored physician enterprise lies on a continuum of physician practice maturity. On one end are new, start-up enterprises composed of a mix of acquired private practices and newly recruited physicians. On the other end is a large, sophisticated, physician led and professionally managed enterprise demonstrating adherence to best practice clinical quality and cost effective medicine.

In the early stages of development, aligning incentives around the basics of professional fee cash collections, physician productivity and practice expense management is paramount. As the enterprise develops management infrastructure and reporting systems to monitor practice performance, and as the employed physicians optimize their individual practice economics, it will be time to increase the focus through new compensation incentives on best practice clinical guidelines and cost effective health care delivery.

For example, institutions in the early stages of development will likely have a 95/5 mix of compensation tied to practice performance vs. quality, while more mature organizations will likely have a mix of 80/20 or even 70/30. The key is to align incentives based on where the physician practice enterprise exists on the development continuum. Over time, move toward strong incentives tied to appropriate quality metrics while maintaining sustainable practice performance.

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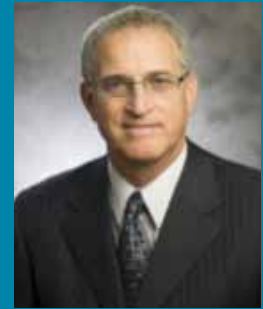
## Case Study



# Aligning incentives through physician compensation

**Sentara Medical Group  
Hampton Roads, Virginia**

**David R. Maizel, MD, vice president and executive medical director, Sentara Medical Group, explained the medical group through its vision statement: “Sentara Medical Group, Hampton Roads’ preferred multispecialty group practice, will establish and guide the clinical quality, practice performance and service excellence standards for the communities we serve. We champion innovative care coordination, endorse medical education, participate in clinical research and assure that our patients receive an extraordinary customer experience. Our interactions with other divisions contribute to the achievement of Sentara Healthcare’s strategic imperatives.”**



**David R. Maizel, M.D.**  
Senior Vice President  
and Medical Director  
Sentara Medical Group

## History

In 1995, Sentara Medical Group started with 63 physicians in eight practice sites and Sentara Health Plan, a staff model HMO, consolidated into SMG. In 1998, Tidewater Medical Group merged into SMG adding 33 primary care physicians and seven physician assistants/nurse practitioners. In 2005, another 23 primary care physicians were added when Williamsburg Community Medical Group joined SMG. 2006 brought 12 physicians and nurse practitioners from the practices owned by Obici Hospital. 85 additional physicians and midlevels joined as high profile general surgery, vascular surgery and urology practices were acquired.

## Today

In 2009, SMG employs almost 400 physicians, 105 mid-level providers representing 55 percent primary care and 29 different specialties at 100 practice locations. SMG is now able to selectively recruit both primary care and specialists to meet the needs of the communities in which they serve. Their strategy is to maintain financially stable practices that are cash flow positive with “break even” profit and loss statements. They continue to pursue innovative care delivery models: expanded role of physician extenders, hospitalists and intensivists (first in the nation with eICU, now with 120 wired beds), “medical home”. As group practices are acquired, clinical integration through common soft ware applications, exchange of information and therefore the “ease of doing business” is important and part of the strategy.

## Vision Focused on the Future Sentara 2006 Strategic Plan

### Physician Alignment

1. Be regional best and aspire to national top 10%.
2. Transform care through innovative solutions and the adoption of the Institute of Medicine 6 Aims of Care.
3. Pursue growth; adding tangible value to the communities we serve.

Sentara Strategic Imperatives

## Compensation program history

Initially, physician compensation was straight salary guarantees with no incentive to either increase productivity or to manage expenses. The salary was linked to availability. Then the plan changed to a percentage of collections with tiered incentives which increased productivity but had no risk for expense management.

Currently, the comp plan is based on revenues less expenses with quarterly reconciliation if a physician underperforms their draw. The physicians at a single practice site have flexibility to determine the allocation methodology for revenue and expense. The current plan does not specifically reward quality, citizenship or performance towards strategic imperatives. The future inclusion of such elements is possible in the future.

In Sentara's marketplace there are some pay-for-performance programs for primary care providers and Sentara is working with some of the payors for programs for specialists. Physician quality reporting initiative reporting by specialty has been introduced to prepare providers for the upcoming CMS changes. The electronic medical record is being implemented with the goal being real time indicators for clinical dashboards by specialty and patient registries. 360 degree reviews for all providers include a patient satisfaction survey. To link hospital activities, services and the specialists, clinical service lines structures are being developed. Sentara currently has six.

## Lessons learned

Compensation plans drive physician behavior. Compensation by whatever methodology needs to be linked to the achievement of successful organizational strategy. The hospital and the physician health care organization have to share a common profit and liability statement to tightly align physician compensation to the net system success. Management of both productivity and expense is a key success factor in a compensation plan. RVUs are utilized more as an income distribution guide rather than the currency of compensation. Physician leaders must be accountable for the development and recommendation of the compensation plan. The dynamic situation of regulatory and compliance changes and expectations are leading to the unwinding of previous successful models of "per click" arrangements, joint ventures and co-management agreements. Dr. Maizel recommended an annual fair market value and Stark assessment.

For Sentara Medical Group, physician alignment success leads to the organization achieving its three Strategic Imperatives. Valued medical providers are attracted and retained to provide needed and valued care in the community. Proactive provider succession planning avoids any deficiencies in provider resources in the community. Patients receive coordinated care through an integrated multispecialty group with "unencumbered access to services: right care by the right caregiver at the right time." Physician leadership is nurtured in a planful way. Innovative care models are piloted and then successful ones deployed. The investment in the Sentara Medical Group is linked and managed to measurable benefits or desirable return on investment.

This case study is summarized from comments by David Maizel, MD, on April 28, 2009 as part of the 2009 VHA CEO Affinity Group Teleconference Series.



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**Peggy Naas, MD, is a board certified orthopedic surgeon working with physicians and hospitals as they work together to serve the needs of patients and communities.**

# End notes

1. Walton, Leigh, et. al. "Hospitals Employing Physicians: A Practical Guide for Buying Physician Practices and Compensating Employed Doctors", February 17, 2009; at the 10th Annual Conference on Emerging Issues in Health Law, Orlando, Florida.
2. Neither Southwind Health Partners or VHA provides legal advice. The legal concepts presented here reflect generally known legal requirements and fundamental legal principles relating to the design of a physician compensation plan for physician practices sponsored by not-for-profit, tax exempt institutions. The authors recommend that institutions seek legal advice from qualified legal counsel when establishing or restructuring a health system sponsored physician practice.
3. 42 U.S.C. 1320-7b (b)(3)(B) and 42 U.S.C. 1395(e)(2).
4. For example, a surgical specialist paid based on RVUs without regard to payor mix may perform unnecessary elective procedures in order to optimize compensation.
5. Schroeder, S., *New England Journal of Medicine*, 2007; 357:1221-1228.
6. *New England Journal of Medicine*, June 26, 2003.
7. Nussbaum, M.D., Samuel J., "Pay-for-Performance," Presentation to Medical Group Management Association Academic Practice Assembly in Orlando, Florida, March 28, 2008.
8. The author refers to this dedicated, centralized infrastructure as "the Docking Station," reflecting that this infrastructure encompasses everything supporting the physician practice outside of the four walls of the local practice site and also represents the primary vehicle to connect the practicing physicians to the health system sponsor, in the same manner as the Apollo/Soyuz mission relied upon a "docking station" to connect the two country's space craft while in orbit around the earth.
9. "Docking Station" expenses.
10. A critical component of success in operating the net income model is the organization's ability to deliver CRATR™, or consistent, reliable, accurate, timely and relevant financial and operating information at the individual physician and practice site level on a monthly basis. CRATR™ is the subject of a future chapter in this series where it will be more fully discussed.
11. Also, this has been referred to as a "physician productivity incentive" when expressed as a percentage of professional fee cash collections.
12. As discussed earlier in this chapter, in no way is it permissible for health system sponsored physician practices to tie physician compensation to the volume or value of physician referrals to the hospital or to other ancillary services. Furthermore, total physician cash compensation must be at fair market value.