How the Physician Gets Paid

A lecture to Foundations in Medicine
Thursday, October 13, 2011
By Dr. Richard Culbertson and Ben Azevedo

“Radix malorum est cupiditas”

Chaucer, Canterbury Tales
The Pardoner’s Tale
EVERY PERSON IN THIS ROOM CAN BE CONTENT IN THE PRACTICE OF MEDICINE

• But, your fulfillment is influenced significantly by the organization in which you choose to practice

• A perfect setting for some will be perfectly miserable for others

• The trick is to recognize the environmental conditions under which you will thrive
Notice this?

Let the games begin!

- $10
- $5
- $40
THE CURRENT SCENE

- In 2009, the percentage of US physicians practicing in groups or organizations of 3 or more members exceeded 50 per cent for the first time.
- It is speculated that as new payment systems and increased costs of practice (staff, electronic health records) take hold that this trend will accelerate.

Figure 1: ORGANIZATION OF THE DEPARTMENT OF MEDICINE

Smith, 1992
“After remaining stable through the early 90s, mean hours worked per week decreased by 7.2% among all physicians (from 54.9 hours per week 1996-98 to 51 hours per week 2006-08)”

The study authors conclude that “a steady decrease in hours worked per week during the last decade was observed for all physicians, which was temporally and geographically associated with lower physician fees” Staiger, et al, JAMA 2-14-10, pp. 747-753

Appears to refute controversial “Target Income Hypothesis” that states as fees are lowered, MDs will work MORE
Figure 1 and 3, combined

Mean Self-reported Hours Worked per Week

Inflation-Adjusted Physician Fees Between 1989 and 2006

SOLO PRACTICE

- Greatest autonomy and opportunity for entrepreneurship— you’re the boss!
- Retirement benefit through Keogh plans
- Ownership of assets and wealth accumulation opportunities
- But, Greatest risk
- Cash basis for accounting
- Problems of coverage; limitations on collective buying arrangements
- “HANDS ON” supervision required of staff
- Practice costs increasing with diminution of investment start up capital following 2008 recession
PARTNERSHIPS

• May be single or multi-specialty
• Reduce risk for individual; provide coverage during absences and may enhance referrals
• Size may range from 2 to 2000 plus physician members (Southern California Permanente Medical Group)
• A significant logistical limitation is the requirement for new partners to buy in and exiting partners to be bought out (Palo Alto Medical Group example)
• Little incentive for senior partners to reinvest
• Partnerships historically conservative in adding new members (working at full capacity and beyond)

PROFESSIONAL CORPORATION

• Single or Multi-specialty
• May achieve tax and limitation of liability benefits
• Able to accumulate reserves as capital
• May be organized as for profit or not-for-profit tax exempt entities (the latter requires governing board comprised of a non-physician majority)
• Governing bodies typically include some or all physicians
PHYSICIAN PRACTICE MANAGEMENT COMPANIES

• Still prominent as single specialty organizations, for example, in emergency medicine, radiology, pathology, anesthesia
• Ease of management and economies of scale are advantages
• Compensation formulae typically include production based bonuses

TRADITIONAL EMPLOYMENT MODELS

• Traditional salaried Employment:
• Veterans’ Health Administration
• Public health departments
• Military
• University tenured and tenure track faculty (declining from 60% of medical faculty 1980 to 40% in 2010)
• Corporations (railroads as an example, fell into disfavor as a result of AMA resistance)
RECENT EMPLOYMENT MODELS

• Hospitals-- 75% increase in employed physicians since 2000
  • Primary care
  • Hospitalists; intensivists
• Kocher and Sahni argue in the NEJM that hospitals lose $150000-250000 annually during the first 3 years of physician employment
• The employed model gained popularity in the early 1990s and was then widely rejected; will this happen again?


Percentages of Active U.S. Primary Care Physicians (PCPs) and Specialist Physicians Employed by Hospitals, 2000–2012.


ALTERNATIVE RECENT EMPLOYMENT MODELS

- Academic faculty practices
- Physician organizations themselves
- Group Employed medical staff Organizations (GEMS); ie, Mayo, Geissinger, Cleveland Clinic, etc.
Low Risk  REWARD  Low Risk

Compensation Model

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<th>Employment</th>
<th>Std</th>
<th>Group Based Production</th>
<th>Individual Incentive</th>
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Organizations of Practice

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<th>Std</th>
<th>Group Based Production</th>
<th>Individual Incentive</th>
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<tr>
<td>New</td>
<td>100%</td>
<td>20%</td>
<td>80%</td>
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<tr>
<td>Est.</td>
<td>0%</td>
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What’s your PERSONAL comfort zone?
COMPENSATION PLAN OBJECTIVES: GROSS CHARGES

STRENGTHS
• A measure of work volume

WEAKNESSES
• Depends on charge level, which may be heavily discounted by payers; not cash collected

COMPENSATION PLAN OBJECTIVES: COLLECTED REVENUE

STRENGTHS
• A measure of work volume and cash collected—direct value to the group

WEAKNESSES
• Focuses on revenue only and affected by the variation in payment levels between well insured and indigent care; also, the net value to the group may be largely offset by costs in generating revenue (Collection costs, cost of drugs, etc.)
### COMPENSATION PLAN OBJECTIVES

#### WORK RELATIVE VALUE UNITS

**STRENGTHS**
- A measure of work volume that is independent of variation in payer reimbursement levels; the PUREST measure of individual work; converted to collections credit by an average conversion factor across all payers; a good way of measuring work in a compensation system

**WEAKNESSES**
- RVUs are not cash; rewarding on the basis of RVUs will reward the development of low or non-paying practice, which can be a reasonable objective for a practice with a mission to care for the indigent; does not measure revenues or costs of providing care

### COMPENSATION PLAN OBJECTIVES—REVENUE MINUS EXPENSE

**STRENGTHS**
- A measure of net cash value of the work to the group; provides incentive for MDs paid on this net cash value to identify ways to both increase practice revenue and decrease costs

**WEAKNESSES**
- Tends to focus individual physicians on their individual financial performance and use of practice expenses; group leadership must find ways to value low or non-paying work outside of revenue collected to provide an incentive to do this work
WHAT IS VALUED?

ANY OR ALL OF THE FOLLOWING:
- Production
- Production adjusted for practice expense
- Quality collegiality
- Seniority
- Practice development—“rainmaker”
- Leadership (usually a formal position)
- Administrative time
- Teaching time
- research

How much $$$ does each specialty make?
### Median Compensation for Selected Specialties

**Selected Primary Care Specialties**
- Family Practice (without OB)
- Pediatrics
- Adolescent Medicine
- Obstetrics/Gynecology

**Specialty Care Specialties**
- Cardiology
- Cardiology: Invasive
- Dermatology
- Endocrinology
- General Surgery
- Gynecology
- Gynecology: Obstetrics
- Urology

* Represents specialties that are combined

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STAFF

- Who makes decision to hire?
- Expensive, staff expenses per US physician 4 times those of Canadians– Morra, et al, Health Affairs 9-2011
- Benefits can be complicated by ERISA requirement that retirement benefits for lower paid employees be reasonably consistent with retirement benefits paid to upper income employees (Physicians in this case)
- Nevertheless, staff can also enhance the productivity and quality of work life for physician
- Teaching– “My fellow; our resident; their medical student”

EXTERNAL CONTRACTORS

- Billing entities and revenue maximization specialists
- Compensation and Benefits consultants
- Practice management firms
- Information technology support
- Financial planning advisors (investments, tax)

- The key decision here is make or buy?
BENEFITS

• Retirement!
• Health insurance (average family of 4’s premium now exceeds $15000 annually!—Kaiser Family Foundation
• Dental
• Educational (Tuition; CME; Conferences and travel; time allocated for education)
• Auto
• Clubs—civic; social

THE FUTURE?

• Effects of Health Reform (PPACA 2010)?
• Intended and unintended consequences—
• Sweeteners for primary care; enhanced compensation
• Removal of the requirement for the annual infamous “Doc fix” in Medicare payments?
• Electronic health records and associated expenses to achieve meaningful use
• All of the above factors point to amalgamation of physicians into larger organized group settings!
FOR SPECIALISTS

- Will enhanced payments for primary care providers come at the expense of specialists given that PPACA reforms are actually to reduce health spending?
- Quality incentives
- Bundled payments – 4 experiments underway, one sum for all costs of illness paid to one source

BUNDLED PAYMENT EXAMPLE

Now: Current Payment Model

Table 1: Summary of Ms. Smith’s 90-day CHF Episode of Care

<table>
<thead>
<tr>
<th>Provider</th>
<th>Encounters</th>
<th>Invoice</th>
<th>Medicare Payment</th>
<th>Patient Payment</th>
<th>Total Payment</th>
<th>Difference Payment - Invoice</th>
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<tbody>
<tr>
<td>Physician</td>
<td>11</td>
<td>$5,908</td>
<td>$2,289</td>
<td>$365</td>
<td>$2,924</td>
<td>($3,084)</td>
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<tr>
<td>Hospital</td>
<td>1</td>
<td>$112,036</td>
<td>$66,019</td>
<td>$1,132</td>
<td>$67,161</td>
<td>($54,885)</td>
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<tr>
<td>Rehab</td>
<td>24</td>
<td>$3,740</td>
<td>$1,490</td>
<td>$374</td>
<td>$1,870</td>
<td>($1,670)</td>
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<tr>
<td>Total</td>
<td>35</td>
<td>$121,684</td>
<td>$99,774</td>
<td>$2,071</td>
<td>$61,845</td>
<td>($59,839)</td>
</tr>
</tbody>
</table>

The Future: Bundled Payment Model

- Medicare makes ONE payment (discounted at 3%) for Mrs. Smith’s 90 day episode
- Hospital acts as “convener” – bring together all providers involved
WHO IS BEST POSITIONED TO LEAD IN THE FUTURE OF ACCOUNTABLE CARE ORGANIZATIONS?

• YOU!

• Research demonstrates that hospitals led by MDs vs. MBAs achieve superior quality (increasingly valued in the future) because you understand the care process (the car guys vs. the suits) Goodall, A. "Physician Leaders and Hospital Performance: Is there an association? July 2011, IZA Discussion paper

Questions?
References


Contact information

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A tune to carry you out...
Extra