

Physician Compensation in a Managed Care and Stark II World

Traditionally, many medical groups have compensated physicians based on “productivity.” Productivity meant the more that physicians billed and collected, the higher their compensation. This approach worked well enough as long as insurance companies and Medicare were paying on a fee-for-service basis. In a capitated, managed care world, however, the same compensation formula could prove disastrous. Medical groups need to rethink physician compensation in light of the shift to capitated managed care, and the impact of the new “Stark II” law restricting physician self-referral for ancillary medical services.

Why the compensation formula needs to change

The concepts of compensating medical group physicians based on how many services they render or order and the group receiving capitation payments—a fixed amount of money per plan member assigned to the group no matter how many services are provided—clearly are incompatible. In purely economic terms, the physician who does the most may be the least productive as far as group profits are concerned.

To address that conflict, medical groups need to reconsider how they measure “productivity.” To do so, the group must first determine what objectives they want to achieve through their compensation formula. In both fee-for-service and capitated environments, the primary goal should be to maximize the group’s net income. As with any other goods or services sold for a fixed price, profit results from increasing sales volume (here, the number of enrollees assigned to the group) and reducing the cost of sales, that is, the group’s direct and indirect expenses. Groups participating in managed care need to ensure that their physicians deliver the same or even better care to keep patients and payers happy and enrollment up, and at the same time maximize the efficient use of the group’s human and other resources to keep costs down.

To maximize the group’s profits, the compensation formula should be designed to accomplish a number of things: enhance quality of patient care; encourage efficient use of in-house and outside providers and resources, by cutting back on ancillaries, referrals to specialists, hospitalization, and patient visits whenever possible; motivate physicians to see managed care patients; increase patient and third-party-payer satisfaction; make prevention and health promotion as important as providing care; stress the success of the group as a whole rather than emphasizing individual physicians; and reward “good” physician behavior.

When exploring a new approach to compensation, groups should realize there is no one “right” compensation formula; every group is different. Factors such as the group’s particular “culture,” and whether the group is primary care only, single specialty, or multispecialty are critical. In addition, the group may need to upgrade and expand its systems for gathering and processing medical and financial information to better measure utilization of group and outside resources, and to

develop and monitor compliance with practice guidelines and track and evaluate outcomes data measurements. Furthermore, the “right” compensation formula, while a powerful tool for reshaping physician behavior, cannot stand alone. Rather, it should be one important element of a multifaceted, strategic plan for the group’s survival in a managed care world.

New compensation approaches

There are a variety of possible approaches to physician compensation, including:

Modified fee-for-service: Under this approach, physicians, in effect, bill the group rather than a third-party payer; pursuant to an agreed-upon, discounted fee-for-service schedule. This allows for continuation of the familiar, productivity-based compensation system. The problem, however, is that if utilization is not carefully controlled, the “charges” billed to the group could exceed the capitation income available for payout to the physicians. To reduce this risk, some groups withhold 10 to 20 percent or more from the agreed fee schedule and reward more efficient physicians with bonuses.

Another approach is to use a “floating multiplier.” That is, the fee-for-service rate is based on work units, such as those measured by McGraw-Hill’s *Relative Values for Physicians*, multiplied by a dollar figure for medicine, surgery, and other professional services. At the end of each month, all of the physician charges pursuant to the agreed fee schedule are compared to the funds available after deducting the overhead of the group, not including physician salaries. If the physicians’ charges exceed the available funds by 20 percent, for example, the multiplier is reduced by 20 percent. The obvious problem with even a modified fee-for-service approach is that it does not directly penalize a physician for excessive utilization or reward a physician who is efficient.

Salary plus bonus: Many groups now set a base salary for physicians. The base salary does not need to be the same for each physician. In addition to the salary, the physician is eligible to receive a quarterly or annual bonus that might add 20 to 30 percent or more of the base salary amount to his or her total compensation. The bonus can be based on several factors, often assigned points and weighted, including the following: number of patient visits, referral patterns to specialists and to ancillary service providers, rate of hospitalization and length of stay, outcomes measurements, patient satisfaction, use of “physician extenders” such as nurse practitioners and physician assistants, seniority, and time devoted to group administration and marketing. By paying a fixed salary, the incentive to overutilize is greatly reduced. At the same time, the availability of a bonus pool allows the group to recognize and reward individual physician effort and contribution to the financial health of the group.

Sub-capitation: A third approach is to “sub-capitate” each physician in the group, that is, pay each physician a “per patient per month” amount for providing agreed-upon “covered services” for those patients assigned to the physician. To determine compensation, the expenses attributable to the physician are deducted from his or her sub-capitation income.

Expense allocation can be done in a number of ways. First, all of the group’s expenses can be divided into at least three basic categories: fixed expenses such as office rent (usually allocated equally); expenses that vary and are allocated in accordance with patient volume, such as staff salaries and supplies; and “individual” expenses directly attributable to particular physicians, such as

continuing medical education and automobile allowances. Or expenses could be allocated according to the RBRVS units generated by each physician. For example, if physician "A" generated 40 percent of such units, physician "B" 25 percent, and physician "C" 35 percent, expenses could be allocated accordingly. A third, less precise approach would be to calculate the group's overall overhead percentage (total overhead divided by total revenue) and deduct this same percentage from each physician's capitation revenue.

Two formulas: Groups that are not fully or even predominantly being paid by capitation could devise two compensation formulas: one for traditional fee-for-service income, and a second for capitation income using one of the approaches previously described. The potential problem with this approach is that it could encourage physicians to have different practice styles depending on the patient's form of insurance. Groups should be careful not to send a mixed message to the physicians regarding what behavior is appropriate.

Stark II's impact on physician compensation

Effective Jan. 1, 1995, the so-called "Stark II" law (42 U.S.C. Section 1395nn) makes it unlawful with respect to Medicare and Medi-Cal patients for physicians in a medical group to divide up income from such ancillary revenue sources as X-ray, lab, and physical therapy directly according to which physician ordered the ancillary test or service. This new law will force most groups to develop a new formula for allocating such income. Unfortunately, it is far from clear what new formulas are legal, and physicians and their attorneys hope this will be addressed by future legislation or regulations. In the meantime, the following approaches seem to comply with the new law:

- ! Divide the ancillary income equally among all group members.
- ! Divide ancillary income into one or more pools based upon seniority or other factors, and allocate equally among physicians in each category.
- ! Allocate the income based on each physician's percentage of the total billing or collections of the group, not including ancillary services.
- ! Allocate income based on other measures of "hands-on" physician work, such as patient visits or RBRVS-based work units.
- ! Apply ancillary income first to pay overhead.
- ! Combine several of the aforementioned approaches, such as by dividing 50 percent of the ancillary income equally and the balance according to each physician's relative billings or collections for non-ancillary services.
- ! Use one of the foregoing approaches for Medicare and Medi-Cal patient ancillary income only and continue to use a productivity-based formula for all other ancillary income.

Finally, please note that physicians can continue to allocate ancillary income derived from the professional, as opposed to the technical, portion of such services based on individual physician effort. Thus, physicians who read the X-rays they ordered can receive the whole professional fee; the technical fee, however, would have to be distributed in accordance with the restrictions described previously.

Developing a new compensation formula

If your group determines that it needs to modify its current compensation formula, we recommend that the group develop a working sub-group or committee to study the problem and make recommendations. This group should include one or more physicians, the practice administrator and, if necessary, outside consultants. The committee would then:

- ! Determine what the practice hopes to achieve or support-such as efficient use of resources and patient and payer satisfaction - through a modified compensation formula.
- ! Assess how well the group's current compensation formula meets the goals and objectives.
- ! If the current compensation formula is inadequate, develop a new formula that incorporates sufficient physician input from the group's other physicians to the committee. All the physicians should thoroughly understand the proposed new formula and how and why it was developed.

Once the new formula has been approved by the group, as proposed or amended, it needs to be implemented, which could involve modifying physician employment agreements or a group partnership agreement. Finally, the group needs to carefully monitor how it and its physicians are performing under the new formula and, if problems occur, make adjustments to the formula.

A sensitive undertaking

Changing a medical group's compensation formula can be a very sensitive undertaking for all concerned. Although a new formula might significantly increase the group's ability to survive and thrive, the "wrong" compensation system could lead to the dissolution of a group. Like a pharmaceutical company seeking FDA approval for a new drug, a group constructing a new compensation formula should strive to meet the tests of being "safe and effective" before it is adopted. To be "effective" it should appropriately reward "good" and penalize "bad" physician behavior. To be "safe," the physicians must perceive the new formula-and the process to develop it-as being fair. To have a successful outcome, the group must achieve both.

*

*

*

Mr. Miller is a Los Angeles attorney who specializes in medical practice issues, and Ms. Askanas is a CMA attorney.