HealthLeaders Media
A Division of hcPro

# Physician Compensation Report

**July 2007**
Vol. 8 No. 7

## INSIDE



A *HealthLeaders* Media publication

## MGMA surveys reveal importance of management

### Pediatric, anesthesia, and OB/GYN practices face different challenges but strive for efficiency

Whether it's an OB/GYN practice paying high medical liability insurance rates, a group of anesthetists employing certified registered nurse anesthetists (CRNA), or a pediatrician struggling to purchase vaccines, high practice costs are forcing most medical groups to operate on what MGMA President and CEO William F. Jessee, MD, FACMPE, referrs to as "razor-thin margins."

Most practices are staying within the margins by increasing revenue to offset rising costs, but Medicare payment freezes, and other reimbursement woes don't make that easy.

The key to success is efficiency, says **David N. Gans, FACMPE,** vice president of practice management resources with MGMA. Practices are doing more with less, which makes having strong, competent managers and leaders more important than ever, he adds.

"Good management can make the difference between a doctor who's fairly compensated for his or her work and a doctor that is being paid much less for working just as hard," says Gans.

However the economic challenges and top management issues vary depending on specialty—as illustrated by MGMA cost surveys recently released for pediatrics, anesthesia, and OB/GYN—and each manager, whether an administrator or a physician owner, will have different priorities for making his or her practice successful.

#### Anesthesia: Contract negotiation

Negotiating payer contracts is one of the key management issues for anesthesia practices, Gans says. At $254,053 in 2005, total operating costs—including nonphysician practitioner (NPP) costs—were relatively low for anesthetists compared to other specialties.

But poor reimbursement and payer-mandated contractual adjustments hindered practice revenue growth.

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>
> *—David N. Gans, FACMPE*

Anesthesia practices' payer mix included many Medicaid (10.3%) and Medicare (30.1%) patients, whose lower reimbursement levels added to problems of commercial payers discounting procedures from charged levels. Although anesthesia practices had high median gross charges per physician—$1,208,100—the fee-for-service collection rate was only 46.57%. In comparison, the average multispecialty group collects 60.62% of its fees.

"The issue for anesthesia is one of optimizing your contracts. You must make sure you're being paid fairly in the contracts you have, and that is a management function," Gans says.

Business management in general was the largest source of operating costs for anesthesia practices.

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## MGMA surveys

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General operating costs were only a median of $51,389 in 2005. Professional liability insurance made up $15,484 of that cost, and "billing purchased services" comprised an additional $19,956.

Despite the increases in certain operating costs, anesthesiology saw one of the largest compensation jumps of any specialty—10.34%, according to the 2006 *MGMA Physician Compensation and Production Survey.* **Suman Elizabeth Graeber, MHA, CMPE,** director for survey operations for MGMA, attributes the compensation increases in part to anesthesiologists expanding into outpatient facilities and ancillaries such as pain management, as well as effective management of CRNA support staff members.

"There's a tight correlation between costs and revenue," Graeber says. "Anesthesiologists have more luxury with their support staff costs, which tend to be larger with other specialties. They've been pretty effective at looking for other things to enhance their [traditional] sources of income."

### OB/GYN: Malpractice crisis

Medical liability insurance was the most substantial operating cost for OB/GYNs, who pay some of the highest rates of any specialty. At the median levels, groups paid $44,541 per full-time equivalent (FTE) physician in 2005, up from $42,364 the previous year. "[Rates] have been increasing year after year. This is the crisis that's been occurring in OB/GYN," says Gans.

Malpractice rates can vary significantly from state to state, depending on whether the state legislature has enacted caps for medical liability damages.

There isn't much practice management can do to counter this, short of picking up and moving to a state with more favorable rates—which some physicians are opting to do, says Gans. However, with medical liability being such an important cost in OB/GYN practices, patient safety becomes an even more important issue.

"Patient safety problems are more so systems issues than medical issues," he says. "Do you have the right training for your staff to do functions? Do you have the systems in place for medication management? Good administration has both benefits for practice efficiency and a patient care benefit."

Another major source of overhead for many OB/GYN practices is costs associated with equipment and personnel needed for ancillary services. Seventy-seven percent of practices provided ancillary services in 2005, according to the MGMA report.

Interestingly, this hurt, rather than helped, physician compensation. Practices offering ancillary services had lower net income ($329,060 per FTE physician) than those practices that did not offer ancillaries ($375,853 per FTE physician). Gans says practices continue to add ancillaries because they offer several benefits:

1. **Patient convenience.** An ancillary service can pay off in the long-run by helping attract and retain patients. When you don't have to send a patient to a hospital for imaging, for example, he or she appreciates the convenience, Gans says.
2. **Physician convenience.** Ancillaries allow physicians to access the information they need immediately, helping them be more efficient. "The whole element of operating in today's limited reimbursement environment is cost efficiency," Gans says. "The most critical resource is doctor time."
3. **Revenue growth.** According to the MGMA survey, the median total medical revenue per FTE physician was $13,643 for bone densitometry and $67,217 for ultrasound, two of the most common ancillaries in OB/GYN practices.

### Pediatrics: Vaccine costs

Pediatricians' incomes are among the lowest of any physician specialty, in part because of high costs compared to the amount of revenue a practice can generate. Operating costs made up a median of 60.6% of total medical revenue for pediatric groups, compared to 52.5% for OB/GYN and only 12.5% for anesthesia groups.

The cost culprit for pediatricians is drug supply, which ranged between $28,352 per FTE at the 25th percentile and $73,906 at the 75th percentile. Most of that amount can be attributed to vaccines, which can have short shelf lives and low reimbursement rates, according to **Anne Francis, MD, FAAP,** a pediatrician in Rochester, NY.

When storage costs and other secondary costs are considered, some pediatricians don't break even on the costs of vaccines, but doctors continue to provide them because

## Practice operating cost per full-time equivalent physician

| Cost | Mean | 25th percentile | Median | 75th percentile |
|---|---|---|---|---|
| **Anesthesia** | | | | |
| Support staff | $23,727 | $868 | $15,725 | $37,683 |
| General operating cost | $59,423 | $33,905 | $51,389 | $72,330 |
| Total operating cost | $85,707 | $50,333 | $69,015 | $104,302 |
| Nonphysician practitioner (NPP) compensation and benefits | $181,409 | $62,275 | $153,074 | $296,245 |
| Physician compensation and benefits | $402,386 | $341,063 | $387,215 | $462,518 |
| **OB/GYN** | | | | |
| Support staff | $186,846 | $147,522 | $184,399 | $234,371 |
| General operating cost | $212,285 | $143,284 | $185,651 | $235,011 |
| Total operating cost | $399,132 | $284,864 | $359,948 | $491,816 |
| NPP compensation and benefits | $45,544 | $17,544 | $32,438 | $59,205 |
| Physician compensation and benefits | $337,838 | $251,730 | $323,662 | $411,307 |
| **Pediatrics** | | | | |
| Support staff | $150,190 | $107,379 | $146,595 | $179,523 |
| General operating cost | $177,995 | $131,491 | $168,428 | $212,752 |
| Total operating cost | $329,924 | $246,502 | $319,478 | $391,844 |
| NPP compensation and benefits | $30,700 | $11,822 | $25,248 | $44,676 |
| Physician compensation and benefits | $202,532 | $152,440 | $186,875 | $243,369 |

*Source:* MGMA Cost Survey for Obstetrics and Gynecology Practices, Cost Survey for Pediatric Practices, *and* Cost Survey for Anesthesia Practices. *Based on 2005 data. Reprinted with permission.*

they're necessary for quality patient care. "Newer vaccines are incredibly expensive. I think it's one of the things driving physicians away from pediatrics," Francis says.

Because pediatric practices have such a narrow margin for error, practice management is crucial to controlling costs, says Gans.

For example, because a flu vaccine is only good for one year, the practice must carefully estimate its volume requirement. "If you underestimate the amount of flu, you're going to have a patient care problem. But if you overestimate the amount of flu, you've paid for vaccine that you won't use and you don't get reimbursed," he says. Some practices are working with hospitals to purchase vaccines or utilizing "just-in-time" delivery so they only order vaccines when they need them. "But that's not everybody," Gans says. "Those are organizations that have good management and have been able to negotiate with suppliers."

### PCR *sources*

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# Legal restrictions hinder hospital-physician gainsharing

After the HHS Office of Inspector General (OIG) issued a series of advisory opinions granting limited approval to hospital-physician gainsharing arrangements in 2005, many industry experts predicted renewed interest in these projects, which were halted in 1999 after the OIG declared that gainsharing violated the Civil Monetary Penalties (CMP) statute. But renewed interest hasn't been enough to jumpstart a widespread gainsharing trend.

Hospitals enter into gainsharing agreements with physician groups to reward physicians for saving measurable costs while maintaining quality. For example, physicians may work together to standardize materials or wait to open disposable supplies until needed. As part of the agreement, the hospital shares with the physicians a portion of the cost savings that these actions produce. Although several hospitals have implemented the OIG-approved model, hospital-physician gainsharing has failed to become widespread, primarily because of remaining legal restrictions on how the agreements can be structured. The OIG advisory opinions set out fairly strict guidelines for setting up gainsharing arrangements, and hospitals risk penalties under the CMP statute, Stark law, and anti-kickback regulations if they deviate from the approved model.

Hospitals are often hesitant to jump through legal hoops only to face the prospect of penalties. "Having one more thing that you have to deal with from a regulatory standpoint may not be something a hospital wants to deal with right now," says **Rosemary Grandusky,** managing director and national supply chain leader with Navigant Consulting, Inc., in New York City.

## Physicians eager for additional income

Hospitals may be wary of jumping into gainsharing, but physicians are very eager for this additional source of income, says **David Harlow,** principal at The Harlow Group, LLC, a healthcare law and consulting firm based in Newton, MA. "The physicians have something to gain without many of the risks, so there's greater interest on the part of physicians perhaps than on the part of the hospital," he says.

Gainsharing, as it is currently defined, is centered on physician decisions, says **Joane Goodroe,** president of Norcross, GA–based Goodroe Healthcare Solutions, a consulting company that set up the gainsharing programs on which the OIG advisory opinions are based. Although hospitals organize the process, set up the contractual agreements, and face the negative consequences if the deal isn't set up correctly, a successful gainsharing program hinges on physicians making informed decisions about procedures and equipment on a daily basis and rewarding them financially for doing so. "Physicians are the ones that really have to drive it," she says. "[Equipment decisions] can't be hospital decisions, because they're not the experts. The physicians are the experts, and we've also got to recognize the work and effort to do that and compensate the physicians for doing that."

However, although gainsharing is an effective way to bring in additional revenue and boost physician compensation, the decision to enter into a gainsharing arrangement with a hospital may not be an automatic one for every physician practice. Physicians must generally dedicate a great deal of time and resources to upholding their end of the arrangement.

This typically involves staying up to date on the best practices for procedures while maintaining a focus on quality care—the OIG mandates that physicians provide medical support showing that cost-saving recommendations don't adversely affect patient care.

For example, 10 physicians can theoretically perform the same procedure on 10 different patients, all with excellent outcomes, but have 10 different processes and costs. Gainsharing provides physicians the financial incentive to engineer the processes to find the most efficient method of achieving excellent outcomes, and this can require a lot of work.

"Before ever signing the agreement, the physicians have to determine how they want to approach things. They have to spend time and energy studying how they're doing procedures right now and look at possible alternatives," says Goodroe. "They have to think differently about each case they go to do. You can't just show up for a couple of meetings and decide it's going to be done."

## Compensating physicians under gainsharing

How much many physicians earn under a gainsharing arrangement depends on how much they reduce costs for the hospital. The standard goal under Goodroe's gainsharing model—which is the model on which the OIG's safeguards

are based—is roughly a 10% reduction of overall costs in a targeted area, most commonly in a service line such as orthopedics or cardiology, which can have several million dollars in supply costs. For example, a hospital targeting its $3 million orthopedic medical device bill can save $300,000 or more, which is then split between the hospital and the participating physician group or groups. Success in reaching this target not only depends on physicians employing cost-saving quality measures, it also hinges on the hospital providing clinical, cost, and utilization benchmark data. "A particular site may not have access to data on which to base a gainsharing program. You need a reasonable baseline to measure future improvements against," says Harlow.

Under the Goodroe model, the hospital pays the money to the group rather than the individual physicians, so it's up to the group to allocate the money and integrate the funds into its existing compensation plan. The OIG recommends that participating physician groups "distribute their profits on a per-capita basis, thus restricting the incentive for individual physicians to generate disproportionate cost savings through these programs." Goodroe says most of the groups she has worked with lean toward a shared-revenue compensation model, so dividing the profits this way hasn't clashed with the existing group culture.

## Preparing for the future of gainsharing

With hospitals and physicians alike interested in seeing gainsharing becoming a viable option, the federal government is working to refine its stance on what is and isn't permissible. Two CMS gainsharing demonstration projects, one limited to hospitals and another across a broader continuum of care, have launched this year. The programs will run for a three-year period, after which the healthcare industry should have much clearer rules with regard to gainsharing arrangements, says Harlow, who has helped medical groups apply to participate in the CMS pilot projects.

"The advisory opinions do not deal at all with the Stark issues, and that has been a significant issue for other folks eager to put a toe in the water," Harlow says. "They're unwilling to proceed without greater clarity on Stark law. The gainsharing demonstration project approvals are supposed to include exceptions on both the anti-kickback and Stark fronts. Perhaps once these approvals are released, providers will either feel more comfortable with the lay of the land or will seek Stark advisories."

### PCR *sources*

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## Gainsharing agreement safeguards

The HHS Office of Inspector General spelled out specific measures that make the hospital-physician gainsharing proposals acceptable, including the following (remember to consult with a healthcare attorney before jumping into an arrangement):

- Identify specific cost-saving measures
- Limit participation to existing physicians to reduce the likelihood that the arrangement will be used to attract new physicians to practice at the hospital
- Require disclosure of the agreement to patients, including the fact that the physician group is paid for its success in saving costs
- Cap potential savings derived from procedures for federally funded beneficiaries based on the prior year's admission numbers by physician group
- Limit the program to one year
- Monitor the referrals for changes in severity, age, or payer
- Distribute profits to group members on a per-capita basis
- Spell out particular actions encouraged to generate cost savings
- Set a floor level of savings, below which the physician group would receive no benefit
- Protect against service reductions due to product standardization by ensuring that individual physicians still have the same selection of devices available

# Median psychiatry comp nears $200K as physician pool shrinks

Median compensation levels for psychiatry are some of the lowest of any nonprimary care specialty—$189,409 annually, according to the 2006 *MGMA Physician Compensation and Production Survey.* Yet starting salaries over $200,000 are becoming more common as a looming shortage of psychiatrists becomes a reality in select facilities and regions.

Psychiatry is around the 13th or 14th most requested specialty nationally, according to 2006 data from search firms Merritt, Hawkins, and Associates and Delta Physician Placement. But demand for psychiatrists is much higher for temporary positions. Psychiatry was the third most requested specialty for locum tenens positions, according to Staff Care's 2006 *Review of Temporary Physician Staffing Trends.*

Rural areas also tend to have higher demand for psychiatrists than national averages, according to **Mickey Conner,** vice president for Horton, Smith & Associates, a recruiting firm based in Kansas. She ranks psychiatry as one of the top five difficult specialties to recruit in rural settings and says salaries start at $200,000 or higher.

## Facilities compete for psychiatrists

Any specialty experiencing a shortage of physicians is likely to see a slight bump in compensation as facilities try to one-up their competitors' compensation offers. However, psychiatrists work in a wider variety of settings than most physicians, creating sometimes fiercer competition.

Only about half of the more than 40,000 practicing psychiatrists maintain private practices, according to the American Psychiatric Association. The rest work in a variety of settings, including psychiatric hospitals, prisons and courts, nursing homes, hospices, rehabilitation programs, or even government or industry positions.

Those who do work in private practice tend to work part-time in other settings as well, perhaps taking call at a hospital or working on the staff at a clinic. As permanent employment becomes a more common compensation structure, some facilities are trying to turn these part-timers into full-time staff by offering guaranteed salaries.

Nonpractice settings also tend to have the most acute shortages of psychiatrists, with hospitals needing psychiatrists the most, followed by community and mental health centers, says **Sam Muszynski,** director of the American Psychiatric Association's Office of Healthcare Systems and Financing. Desperate facilities are forced to offer higher salaries to get by. For example, psychiatrists working in California's prison systems are regularly pulling in $250,000 per year or more, and county hospitals have been forced to raise salaries to stop the exodus of psychiatrists to the state's well-paying prisons.

> Psychiatry is around the **13th or 14th most requested specialty nationally.**

## Low reimbursement hinders growth

Although psychiatrists working in California's prisons are doing well, overall psychiatry compensation is growing only enough to keep pace with inflation, due to an adverse reimbursement environment. Psychiatry grew only by 3.6% from 2004 to 2005, and by an average of 5.1% per year between 2001 and 2005, according to MGMA data.

The problem is the payer mix, as well as low rates, Muszynski says. Many psychiatrists have a high proportion of Medicaid patients to add to poor reimbursement from Medicare and private payers. This is leading some in the field to seek alternatives, such as practicing out of network, he adds. "Because of unfavorable rates and because demand of psychiatric services is so high, a lot of people just practice outside of networks and can command higher fees. People who want the care are often going to pay for it," says Muszynski.

The psychiatrists most likely to succeed in the harsh reimbursement climate tend to be the subspecialists, such as geriatric psychiatrists or child and adolescent psychiatrists. Whereas psychiatrists once trained only as generalists within the field, more of today's psychiatrists are opting for two-year fellowships in subspecialties that can net a substantial compensation increase.

Compared to the median compensation of $185,690 for a general psychiatrist, a child adolescent psychiatrist earns a median of $214,910, nearly a 16% difference, according to the 2006 *MGMA Physician Compensation and Production Survey.* Because it is a relatively new subspecialty, compensation surveys don't have comparable data for geriatric psychiatry, but Conner estimates that its levels are similar to pediatric psychiatry's.

## Psychiatry median compensation trends

| Compensation survey | 2006+ | 2005+ | 2004+ | % change 2005–2006 | % change 2004–2005 |
|---|---|---|---|---|---|
| AMGA *Medical Group Compensation and Financial Survey* | $186,786 | $177,000 | $167,375 | 5.5% | 5.8% |
| HCS *Physician Salary Survey Report* (salary data only)* | $157,588 | $155,000 | $152,010 | 1.7% | 2.0% |
| MGMA *Physician Compensation and Production Survey** | $189,409 | $182,799 | $162,572 | 3.6% | 12.4% |
| SCA *Physician Compensation and Productivity Survey Report** | $162,718 | $157,529 | $148,000 | 3.3% | 6.4% |

* Designated as a safe-harbor survey for calculating fair market value under Stark law.

+ Survey results are based on the previous year's data.

*Source: Data excerpted from American Medical Group Association, Hospital and Healthcare Compensation Service, Medical Group Management Association, and Sullivan Cotter & Associates compensation surveys. Reprinted with permission.*

The success of the subspecialties is in part due to greater demand, she says. Demand for child psychiatry has increased in recent years as physicians have begun treating previously undiagnosed diseases and new medications have been developed. And, like many other medical specialties, geriatric psychiatrists stand to benefit as the nation's demographics reflect an older population.

However, the growth of subspecialties has had some adverse consequences on the field, exacerbating the shortage problems by narrowing the scope of practice of the average physician and reducing the number of general psychiatrists available. "When you fraction that population into a fellowship in geriatrics, a fellowship in child, and you're basically splitting the same population of psychiatrists you always had into three different areas now," Conner says.

### Psychiatrists triage their workload

Psychiatrists are using every resource available to meet patient demand and bring in additional revenue; this often involves utilizing nonphysician workers, such as psych technicians, rehab therapists, social workers, and psychologists.

"More and more you have small group settings that are not necessarily multispecialty, but they are multidisciplinary," says Muszynski. "And clearly cases are triaged according to an assessment of medical oversight needed."

For example, to maximize efficiency, today's psychiatrists tend to focus on medication management and complex psychiatric cases, delegating psychoanalysis to psychologists or other support personnel.

The common conception of a patient reclining on a couch discussing problems with his or her psychiatrist may be a thing of the past.

Some psychiatrists are even using other physicians to help prioritize patients.

For example, **Fred Horton,** president and CEO of Horton, Smith & Associates, worked with a group practice that set up an education system for primary care physicians, teaching them to manage lower-level mental health problems without referring patients to a psychiatrist.

This helped alleviate the demand on the region's psychiatrists, allowing them to focus more on higher-level cases.

### PCR *sources*

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# Focusing on overhead can cost practices revenue, compensation

To cut costs, one physician fires his office manager and hires his untrained spouse. Another denies health coverage to employees and wonders why she is unable to fill positions. Yet a third spends more time finding ways to allocate overhead to a new partner than seeing patients.

When it comes to reducing overhead, all three of these are common mistakes that **Randy Bauman,** a physician practice consultant with Delta Healthcare in Brentwood, TN, has grown accustomed to seeing during his interactions with physician practices.

Many physicians, particularly those working under a "revenue minus expenses" compensation model, obsess about overhead, because it's an easy target, he says. But the compensation pool in a private practice can be increased by either bringing in more revenue or slashing overhead, and many of these physicians are focusing on the wrong area. They could be losing compensation as a result, he says.

"It's easy to obsess with overhead, because everyone understands overhead. Everyone knows how to balance a checkbook," Bauman adds. "Revenue is more complicated to understand; it's extremely complex compared to just cutting costs."

For example, Bauman recently worked with a group that blamed its poor performance on overhead being too high, but a more thorough assessment revealed that the real problem was a majority of physicians producing below the 30th percentile compared to national production surveys.

The bottom line, he says, is groups with higher overhead generally report higher physicians incomes.

## The costs of cutting costs

The quest to reduce overhead isn't always as extreme as the above three examples, but Bauman says physicians unfamiliar with the long-term aspects of financing a practice often cut corners unnecessarily. Cutting costs is feasible to an extent, but a doctor needs to take risks to get results.

"The ability to control cost is limited, but the ability to generate revenue is unlimited," says Bauman. "Revenue is the most important part of business, and generating it is sometimes as simple as adding another ancillary service."

Bauman says simply negotiating with payers or improving collection of copays—an underappreciated source of revenue—can make a big difference in practice finances and add to the compensation pool. "As much as half of the revenue a doctor receives from a routine visit can be the copay, and some are obsessing about the long distance bill instead," he says. "Negotiating better contracts with payers and improving collections is vital."

> "The ability to control cost is limited, but **the ability to generate revenue is unlimited.**"
>
> *—Randy Bauman*

Many practices are misled by data on overhead percentage, a number that obscures the path to increasing revenue, because it is easy to forget that it is composed of both overhead and revenue. Bauman recalls working with a group of surgeons who almost backed out of a deal to merge with a group of internists, because the internal medicine practice had 60% overhead, compared to 40% for the surgical group. "The surgeons said 'You're too inefficient,' but got real quiet when I pointed out that, in terms of real dollars, the overhead of the two groups was virtually identical—it was the revenue that was different." says Bauman. "Overhead is important, and ignoring it is a huge mistake, but you need to focus on what you're getting for that percentage. You need to make sure you're not offering a service at a loss." In other words, if you increase your revenue, your overhead percentage goes down, although your actual costs don't.

Another common mistake physicians make is to shuffle overhead around and forget that it is a piece of a finite pie. Allocating the overhead to a new partner in the practice not only fuels tensions, it ignores the real problem. In most medical practices, the overhead is fixed, so adding or subtracting a provider doesn't significantly diminish it. Doctors considering adding a provider should do so because they are seeking to boost revenue and not lower operating expenses.

## The big picture of rising costs

The problem isn't just physician attitudes; healthcare facilities across the country have endured a combination of higher operating costs and declining revenue over the past

decade, which is pushing many physicians to slash overhead expenses in the face of financial adversity, says **Peter Lucash,** CEO of Digital CPE, a training and consulting firm based in Charleston, SC. "Not looking at the big picture, not being able to separate themselves from the business, and thinking 'what is this costing me,' are three of the biggest mistakes doctors are making," he says. "Physicians aren't making as much as they did in the heyday of the 1970s and 1980s, and reimbursement rates are sliding, but you need to invest before you can enjoy a return on the investment."

As demand for service increases, physicians must move away from the traditional nine-to-five business model, Lucash says, and focus more on patient satisfaction. Further, he says, the United States spends more money per person on healthcare than any other nation in the world, but the outcome is worse. As technology increases the speed of transactions, patients expect more for their money and become frustrated when they feel their needs aren't being met.

"Patients want to see that the $2 trillion being spent is making a difference. If people call a doctor's office and they can't get a doctor, an appointment, prescription, or referral, the doctor is going to lose that patient," he says. "I need to get a human being the first time. If I call at 9:30 a.m., I don't want a call back at 5 p.m. Patients will go somewhere else. Emergency rooms make hundreds of dollars in claims because the patient didn't get a call back."

Physicians unable to hire an additional receptionist should consider an e-mail answering service instead, for example. Doing so allows the patient to reach the doctor easily, and the doctor to retain a patient. The patient also doesn't need to pay an expensive copay to have a question answered, and the doctor saves time to do what he or she does best—treat patients. "Physicians are selling their time, so the more they can make in an hour, the better," Lucash says. "For example, there's a high cost in doing a test with diagnostic equipment, but the profit margin brings in more money per hour or per day because it's such a big-ticket item. A 10% profit margin on something making you $1 million annually is better than a 50% margin on something making you only $10,000 per year."

**Neil Baum, MD,** a urologist in New Orleans, has been practicing for 29 years. During that time he has seen 25–30 patients daily four days a week and has charts for 27,000 patients total. One of the most valuable investments he made was also the most simple.

"Before I switched over to electronic medical records, I was spending $1,000 a month on transcription, and some transcriptionists cost up to $35,000 plus benefits," he said. "After stamps, time spent, and so on, it could cost anywhere from $12 to $15 to transcribe a letter. Now it costs pennies."

Electronic medical records allow Baum to fill in the diagnosis, medication, and treatment fields on a form so that the information is able to keep up with the patient. Coding electronically allowed Baum to switch from undercoding at level two and three to a level four and five. The result of the switch boosted his income by more than $50,000 annually.

## The dangers of ignoring overhead

Lucash and Bauman aren't suggesting that practices ignore overhead altogether, however. There are times, according to both experts, when a doctor running any practice should be concerned with overhead. "A physician should be paying attention to overhead on a monthly basis. It's important to look at your profit as a percentage of your revenue," says Lucash. "A primary care physician might have a profit margin of 2% or 3%, while the group might have a margin of 10%. What you're trying to achieve is the overall health of your business, and you look at that by determining the return on your investment."

Using existing staff members for regularly scheduled tasks avoids the hassle of bringing on another part-time employee. It may not reduce overhead, but it can reduce the burden on other members of your team. Assigning one staff member to be in charge of office supplies not only saves time for other employees, it also eases the workload in the office.

"Putting one person in charge of reordering supplies will keep supply costs down," says Bauman. "It doesn't have to be a full-time hire. Good practices aren't afraid to make changes on a continuous basis. You always need to be mindful of overhead, and at the same time you have to create a culture of not wasting money, but it shouldn't be your singular focus."

### PCR *sources*

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# R – E + S: Subsidize hospital-employed physicians to reap the benefits of the private practice compensation model

*by Max Reiboldt, CPA*

In nearly all private practices, the compensation model starts with the basic algebraic equation, "R – E = C" (revenue/collections minus expenses/overhead equals the total compensation pool). However, in a hospital-employed setting and some private groups employing physicians (nonpartners), the formula and incentive model takes on an additional variable, changing to "R – E + S = C," in which "S" represents subsidies required to make the formula work. In other words, the formula tries to emulate a private practice compensation formula, but because of factors inherent in hospital employment settings, it is simply not possible without a subsidy.

Hospital-employed physicians these days are often asked to work and be paid in an environment very similar to a private practice, and there are many variations of the private practice formula that can be considered in such a setting. Some focus on individual productivity, whereas others attempt to emphasize both productivity and expense control.



Although the latter is preferable, one of the realities of this structure is that it is difficult to make ends meet, and as a result physicians' effect on expenses within the hospital-employed physician setting is limited without a subsidy.

## Expenses in hospital settings

The standard rebuttal from many physicians in a hospital setting is that they have very little to do with controlling costs. The reality that somewhat refutes the viability of the basic R – E model is that hospital expenses are derived from varied sources. For example, within a hospital there may be a network infrastructure of management with certain allocated costs. Whether all these costs are to be allocated and applied against the revenue as overhead within the R – E model typically varies based on the individual situation.

Another reality is that many hospitals incur expenses that are not common to the private practice, or, if they are, the cost is typically lower in a private practice. For example, many IT systems are applied to network practices in conjunction with the purchase of an enterprise-wide IT application. These vendors and resultant software and hardware applications are of much greater volume (and, of course, cost) than any private practice would be able to incur or justify on their own. However, the additional overhead is clearly existent and must be charged somewhere.

## The benefits of R – E

Even with uncontrollable costs that make it difficult for hospitals to apply the R – E model, there are still many positives for utilizing such a model, even if it requires a subsidy. First, the R – E formula provides incentives for physicians to both maximize revenue and control some expenses. Even though physicians don't have control of certain costs, it's important for them to be aware of these variables and how they affect compensation. Moreover, several of the line item expenses can be controlled by the physician, and therefore are extremely applicable for the physician control within this model.

When the total compensation pool is calculated, leaving a specific amount of funds available to be distributed to the physicians, that amount can then be allocated based upon

several variables. This could be both individual- and group-based, allowing the hospital employer even more opportunities for aligning the culture and practice incentives among all of the providers within the network/group.

For example, a portion of the pool of funds could be allocated directly to the physician provider, based upon his or her productivity or percentage of total productivity to the total; another portion could be allocated equally, promoting more of a group mindset. Moreover, if ancillaries are a part of the network, the easiest and certainly most legally compliant methodology for allocating those ancillary profits to the physicians would be equally. Again, this would be derived from the pool of dollars after determining the R – E = C derivative amount.

## Adding 'S' to the equation

There is no universal rule for determining the subsidy, and it may vary depending on the preferences of each hospital. One option for determining the subsidy is to calculate all costs, regardless of the amount of control the physician has over them. Thus, it would be the result of an accurate assessment of the hospital network's true performance. Conversely, if certain costs are not considered part of the overall evaluation and measurement process, this can be taken into account during the calculations.

Suffice it to say that the subsidy should be measured consistently and within defined and understood parameters, and then measured accordingly within the overall network organization, typically on a per-physician basis.

The concept of a subsidy is essentially based on accepting a certain amount of losses, but once a method for calculating the subsidy is developed and consistently applied, the organization should constantly work toward reducing its losses. Just because you're adding an expected level of loss to the formula doesn't mean you shouldn't strive to reduce that loss on an ongoing basis, measuring improvement from one year to another.

## Acceptable loss in private practices

In some instances, we call the subsidy an "acceptable loss" per physician. This is a result of the matters noted above relative to cost allocations, as well as the overall value of employing the physicians in a hospital setting (i.e., downstream revenue).

In a private group, a subsidy isn't as necessary when the physicians are employed primarily because of the downstream revenue they help generate. Further, the availability of ancillary services and resultant revenue/profit is not as prominent within a hospital-employed physician setting as it is in private practices.

Usually employed physicians in private settings are individuals who are either part-time or early within their tenure and not yet partners. Sometimes they are paid a subsidy under a similar model as that outlined above. Ultimately, however, they should be on a partnership track or at least applicable to the partners' compensation structure and realize that they must produce at levels that justify their compensation (i.e., no subsidy). ✚

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# News in brief

## Hospital CEOs concerned about physician and nurse shortages

More than two-thirds of hospital CEOs view physician shortages as a serious problem, and more than three-quarters view nursing shortages as a major issue, according to a survey of more than 400 hospital CEOs conducted by the Council on Physician and Nurse Supply.

Significant findings from the survey include the following:

- 86% of hospital CEOs surveyed are currently recruiting physicians
- 89% are currently recruiting nurses
- Of those recruiting physicians, 80% are seeking primary care doctors, and 74% are seeking specialists
- 94% of responding CEOs said recruiting physicians can be both difficult and challenging
- 86% indicated that recruiting nurses is difficult and/or challenging

Only 2.4% of responding hospital CEOs said that there is no shortage of physicians in the United States, and less than 1% said that there is no nurse shortage.

## Report: U.S. healthcare ranks last among wealthy nations

Americans pay more but receive less when it comes to healthcare compared to their counterparts in Germany, Britain, Australia, and Canada, according to a report from the Commonwealth Fund. The report ranks U.S. healthcare last based on comparisons of quality, access, efficiency, equity, and outcome.

Germany received the highest ranking, followed by Britain, Australia, New Zealand, and Canada. Per-capita healthcare spending in the United States in 2004 was $6,102, whereas Germany spent $3,005, Britain spent $2,546, Australia spent $2,876, New Zealand spent $2,083, and Canada spent $3,165.

The most notable way the United States differs from other countries is the absence of universal health insurance coverage and slow adoption of IT. However, one of the areas in which the U.S. healthcare system outpaces those in other countries is preventive medicine, the report says. Another is the short wait time for elective, non-emergency surgery, such as cataract procedures or hip replacements.

However, 61% of U.S. patients say it is somewhat or very difficult to get ER care on weekends or evenings, whereas 25%–59% of those in the other countries say the same.

## AMA backs students in California tuition lawsuit

The AMA and the California Medical Association have filed an amicus brief asking a state appellate court to uphold a ruling to refund former students of the University of California's professional schools.

The March 2006 ruling by a trial court judge resulted from a lawsuit filed in 2003 by students who accused the University of California of breach of contract for repeatedly raising tuition and fees for its professional schools despite promising not to do so. The AMA claims the increases negatively affected medical students' financial and career paths. On March 2, 2006, a judge awarded the students more than $30 million in damages and granted permanent injunctive relief.



**Physician Compensation Report** (ISSN:1530-342X) is published monthly by HCPro, Inc., 200 Hoods Lane, Marblehead, MA, 01945, 781/639-1872, *www.hcmarketplace.com*. 