CITRINCOOPERMAN

Attest & Assurance | Tax Compliance & Research | Specialty & Consulting

Physician Compensation: A Brave New World

The new medical landscape and trends that determine how physicians are paid.

Contents |

Once upon a time, there were medical practices here, and hospitals there, and traditional indemnity plans covered the bulk of their fees. And it worked.

Then, everything changed. In a brief 20-year span, managed care supplanted indemnity plans. Rules surrounding Medicare became more stringent. Health insurers became the rate setters and reimbursement dictators. And the pendulum of power — and compensation — swung away from physicians.

A recent survey by The Medicus Firm, a national physician recruiting firm, found that physician income growth stalled from 2009 to 2010. Over 30 percent of respondents attributed the lack of income growth to declining reimbursements, and 61 percent expressed dissatisfaction with their 2010 income. Today, it's a brave new world of physician compensation. The medical profession is still coming to grips with it, and trying to decide what its next move might be.

In light of that, it's prudent to take a look at the new medical landscape and the trends that are determining how today's physicians are paid.

Size Matters

There's no denying one inescapable trend: small practices are going the way of the buggy whip. With insurance rate schedules constricting physician reimbursement, traditional fee-for-service practices have found it difficult to stay profitable. Doctors have responded by realizing that the best (and perhaps only) way to preserve their bottom line is to enlarge their practices.

The trend from small to large practices began about 15 years ago. The primary method of doing so: forming a medical group by aggregating several small practices into a large one. Some of these groups are managed by physicians; others are bought by private equity groups and are professionally managed. (To comply with state laws, which prohibit medical practices from being owned by non-physicians, private equity groups typically establish medical service organizations, or MSOs, which contract with physician groups to provide practice management for a fee.)

When a 5- or 10-doctor practice expands to 50 or 100, two important goals are achieved:

- Consolidating overhead expenses (admin, back office, etc.) by creating economies of scale; and
- Leveraging the resulting increase in the patient population to negotiate more lucrative contracts with health insurers.

It certainly didn't take long before hospitals caught wind of the medical group trend — especially as these groups began building their own surgery centers and ancillary service clinics. Hospitals responded to the potential threat by forming their own in-house medical groups. It made perfect sense, given that physicians are the prime feeder sources for hospital beds, ORs, and ancillary services.

Today, physicians who realize that small-practice profitability has become elusive — if not impossible — to achieve generally have two choices: join an independent medical group or a hospital medical group.

The question is: How should physicians be compensated in each of these scenarios? In response, the industry has developed a bevy of innovative, and somewhat complex, compensation formulas. Let's take a look at some of the components of these equations.

Independent Medical Groups

A decade or two ago, when there was ample profitability in medical groups, profits were divided equally. But as both Medicare and private insurance reimbursements have declined and the revenue pie has shrunk, doctors have focused on once-overlooked discrepancies and inequities in the value-to-compensation formula at these practices. As a result, in the last decade, new compensation formulas have been crafted to account for differences in productivity among a group's physicians. And today, across 20 different practices, there may be 15 different ways of allocating compensation.

Many are based on relative value units ("RVUs"), a measure of value used in the medicare reimbursement formula for physician services. For each service or CPT code, a total RVU value is determined based on the time, skill and cost of delivering the service.

There are many ways to develop an RVU-based formula. In a homogeneous group of doctors — all cardiologists, for example — the formula may be based entirely on the work component RVU: the harder you work, the more you earn.

The formula gets more complicated in heterogeneous medical groups. If, for instance, a dermatology group includes general practitioners as well as a Mohs surgeon who generates substantially more revenue, a simple allocation formula would be inappropriate. While the Mohs surgeon generates more income, and may receive the lion's share of that income, it's also more costly to run a surgery practice than a general dermatology practice, what with nursing, biology, equipment and supplies costs, and higher malpractice insurance. For such cases, a formula can be developed utilizing the practice expense RVU component, i.e., "How much does it cost the practice to actually perform that procedure?" This component can be used to compute and compare the real costs of the surgeon's services versus a general dermatologist's.

In many practices, one portion of profits may be individual productivity-based, with another portion split equally among practitioners to encourage teamwork. This is particularly applicable to a multi-office practice in which one office is in a lower-income, Medicare-heavy area and another is in a wealthier area where private insurance pays perhaps 140 percent of Medicare reimbursement. In such a same-services/different-reimbursement scenario, a team-based component ensures that physicians are not penalized for working in lower-revenue locales.

There are other variations in productivity formulas. In many cases, partners may share equally in the profits of associates, employed physicians, and/or ancillary services such as labs, pathology and x-ray services. Or, in a mixed group of primary care physicians (PCPs) and specialists, a formula may be crafted to recognize that PCP office visits generate the majority of ancillary services. All of these allocations can be split equally based on receipts, an RVU-based formula, or a combination in some production-based formula.

Physician services rendered. Employed physicians. Ancillary services. These are the variable components that may factor into the overall compensation design for a medical group. And every one is a little bit different.

Side Bar

Be aware of a Stark truth

The Stark Law, named for U.S. Congressman Pete Stark (D-Cal.), who sponsored the initial bill, prohibits physicians from referring a patient to a medical facility — such as a laboratory, pathology center, etc. — in which he/she has a financial interest, be it ownership, investment, or a structured compensation arrangement. In addition, the Stark Law prohibits any direct correlation between a physician's referrals to in-house ancillary services and that physician's compensation.

Hospital Medical Groups

Due to increasing competition to control the almighty medical referral, hospitals are attracting and integrating physicians and practices into their own hospital-owned medical groups. To attract these doctors, hospitals are employing an array of tactics. Multiple factors can enter the negotiating process, including who pays practice expenses and/or employee benefits, and where the practice will be housed (in the hospital or a freestanding office location). In addition, to protect themselves, physicians often ask for and typically receive a multi-year guaranteed contract.

When constructing physician compensation formulas in hospital medical practices, other variables come into play, including the much-stressed-about three-letter acronym: FMV, or fair market value. In the quest to lure physicians into their in-house medical groups, hospitals would like nothing more than to pay their physicians handsomely. However, the Stark Law and other anti-kickback statutes prohibit hospitals from paying doctors a salary above fair market value. In response, hospitals have had to get creative with compensation formulas to attract practices they covet.

One such creative formula is to base compensation as a ratio of current earnings to current work RVUs. For example, if a doctor is earning $320,000 a year while generating 8,000 work RVUs, the hospital may offer to assume all practice expenses — payroll, rent, malpractice insurance, etc. — while compensating the doctor at the same level (or more) as long as they generate the same number of work RVUs. For an agreed-upon integration period, say two years, compensation would be guaranteed as long as annual RVUs were within a reasonable range of base RVUs. After two years, the 8,000-RVU mark would be used as a base; if that milestone is not reached, base compensation may be proportionately reduced. If the milestone was exceeded, compensation would be proportionately increased, thus providing incentive for effort.

If a hospital wants a physician or practice badly enough, it may use more aggressive recruiting incentives. To lure a “rock star” doctor, hospital management may look for imaginative ways to push the salary envelope and negotiate a valuation of reasonable compensation that fits within fair market value parameters. One tactic: In addition to base compensation, a directorship may be offered — essentially a stipend of $25,000 to $150,000 annually for overseeing a hospital program. Assigning a Chief Cardiologist title to a physician, for example, may add an extra $85,000 a year to his or her compensation. These directorships must carry real responsibility and commitment, and the stipend must be fair market value for the services provided.

The Shrinking Revenue Pie

Amid all the aforementioned maneuvering by doctors to fit into the new healthcare compensation paradigm, a sobering fact is unavoidable: The overall revenue pie is shrinking.

The result: Most believe that the past two decades' steady and inexorable decline in physician reimbursement revenue will continue, and even worsen. (Is it any wonder, then, that the Association of American Medical Colleges is projecting a shortfall of 91,500 physicians by 2020 and 130,600 by 2025?)

As the Affordable Care Act begins to ramp up and be implemented, even more pressure will be placed on the country's medical infrastructure. Shortages of primary care physicians will require groups to consider adding physician extenders including nurse practitioners and physician assistants, which will have an impact on physician compensation.

All of the above factors have thrown the medical profession into flux, leaving physicians and provider organizations alike to explore compensation levels in an environment that is exerting downward pressure on reimbursement. The right answers can be elusive; there are no cookie-cutter solutions.

A medical practice is one of today's most complex businesses, with business models and compensation formulas that are both diverse and creative in an industry beset by encroaching regulations, rising costs and ever-tightening revenues.

About the Authors

Alan G. Badey, CPA, is the Managing Partner of Citrin Cooperman's White Plains office and Practice Leader of the firm's Health Care practice. For over 20 years, Alan has provided accounting and consulting expertise to leading healthcare providers. The author of numerous articles, he is also a sought-after presenter and moderator on business panels.

John P. Bryan, CPA, is a partner based in Citrin Cooperman's White Plains office and is a member of the firm's Healthcare practice. He has more than 25 years of public accounting experience. A significant portion of John's practice is devoted to the healthcare industry, with an emphasis on physician groups including single and multi-specialty practices. His areas of expertise in this field include structuring compensation, improving efficiencies, billing procedures, and mergers.

ABOUT CITRIN COOPERMAN

Citrin Cooperman has worked with the healthcare industry for over 20 years, serving physician practices, medical groups, hospitals, and other providers.

Citrin Cooperman is the 25th largest accounting firm in the United States, providing attest and assurance, tax, business advisory services, and valuation and forensic services to clients in New York, New Jersey, Pennsylvania, and Connecticut.

Citrin Cooperman has deep experience in a number of industries, and areas including healthcare, architects and engineers, construction, real estate, not-for-profit organizations, entertainment, staffing and executive search, professional services firms, restaurants, technology, and funeral. The firm, founded in 1979, is an independent firm associated with Moore Stephens.