Integrating Physicians: Compensation Modeling, Budgeting, and Reporting Are Key to Post-Reform Success

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Physician integration will be critical to achieving the quality and cost goals of the emerging value-based healthcare system. In many areas of the country, hospitals are establishing new hospital-physician structures, acquiring practices, and employing physicians. Many physicians are also proactively seeking employment or other formal engagement options with hospitals.

Compensation Modeling to Aid Decision Making
Integration can and should yield benefits for hospitals, physicians, and other providers, but compensation arrangements need to be different from those of the 1990s, which often resulted in significant financial losses for hospitals. Compensation programs must support organizational goals and provide physicians a fair and stable income.

A critically important principle is to apply compensation standards and metrics consistently across physicians, locations, and specialties, where applicable. But all standards are not equal in weight. Because clinical work effort often represents up to 95 percent of community physicians’ time, productivity is the primary metric for incentive-based compensation programs, with quality, access, and strategic alignment thresholds incorporated, but to a lesser extent. Productivity-based compensation methods include compensation: per work relative value units (wRVUs); as a percentage of gross charges; as a percentage of net collections; and per encounter, among others.

Physician employment contracts are structured in many different ways. Solid information systems are required both to effectively project future operating performance and to monitor ongoing performance in many domains. Revenue generation, compensation, and productivity by specialty and practice are highly relevant criteria.

Hospitals that do their homework before employing physicians will model alternative arrangements. Modeling enables executives to understand the financial impact of numerous compensation methods before practices are acquired or other arrangements are secured. Based on the results of such modeling, executives can select those arrangements that best meet physician and hospital financial goals, and then rigorously budget, report, and monitor progress, making adjustments as needed.

Kaufman Hall’s Budget Advisor® provides each of these capabilities, and does so on a provider-specific, clinic/practice-specific, or organization-wide level. This helps organizations find the right balance between offering multiple compensation options and maintaining some consistency of arrangements across practices and facilities.

Managing Employed Physicians through Best-Practice Budgeting
As hospitals invest in physician strategies, the management of revenue, productivity, and costs related to integrated physician practices and their employed physicians will be mandatory. Organizations most likely to succeed in the next decade will define indicators of success, measure performance against these indicators, and devise and implement plans to respond to less-than-anticipated performance.

Unlike what occurred during the acquisition frenzy of the 1990s, detailed budgets should now be developed by hospitals and health systems prior to practice acquisition or employment. Physician compensation, as well as wages and benefits of nonphysician personnel, should be included.

Budget Advisor’s physician budgeting model integrates three types of data that enable organizations and physician practices to accomplish such budgeting (Figure 1):

• **Provider volume** data, which draws data from the practice’s general ledger or billing system and may include encounters, work RVUs, total RVUs, gross charges, contractual allowances, and bad debt.
• **Provider compensation** data, which is often based on work RVUs and includes compensation data by provider. It covers physicians and mid-level providers, such as nurse practitioners and physician assistants. The model also allows inclusion of “add-on” pay for other services, such as directorships, legal consultations, honorariums, and other compensation sources. FICA and other benefits calculations are also included.
• **Other expenses** data covers costs related to professional liability, continuing education, clinic staff salaries, clinic supplies and expenses, and any billing fee allocation for each physician location.

Budget Advisor supports many different compensation methodologies for physicians and their mid-level staff. These include salary or hourly rate arrangements (which traditionally are used for mid-level providers), guaranteed income (which may be used for physicians in the first years of hire), and volume-driven methodologies. Tiered alternatives that support volume-driven compensation include arrangements based on a physician’s:

• total work RVUs for the year
• volume of work RVUs over the course of a contract year
• annual volume, with one rate up to a maximum volume, another rate for any volume over the maximum, and a third rate if the physician’s volume falls below a minimum level

The software also supports other compensation models. This flexibility enables organizations to compare multiple sets of compensation arrangements to identify the impact of one over the other. This is particularly useful when the organization is transitioning or considering a transition from one compensation model to another.

Monitoring and Reporting Progress Going Forward
As the practice is integrated with the hospital, productivity, total revenue, physician compensation, non-physician staffing and
compensation levels, physician revenue cycle performance, supplies and expenses, overhead management, and other costs should be monitored and managed on a regular basis. To achieve results, the organization’s financial systems must be able to link compensation to specific productivity and quality/outcomes metrics. Budgetary review, monitoring, and real-time reporting are imperative.

For example, to improve productivity, an organization may need to drill down and analyze income statements of specific physician clinics on a comparative basis, looking at detailed information regarding volumes, salaries, and supply costs at each. Distribution of budgets and performance reports will enable physician leaders and managers to identify and address key budget variances. Standard budget reports, available within Budget Advisor, allow users to compare the performance results by physician or practice.

At Mercy Health System in Janesville, Wisconsin, a three-hospital system with nearly 300 employed physicians, Budget Advisor has transformed a manual spreadsheet process for provider production reporting to an automated one, taking half the time to complete. “With our old process, the job involved in completing almost 250 production reports for physicians each month left no time for us to review the reports in a significant way prior to their distribution to directors and physicians,” describes Renae Holloway, Coordinator-Budget/Production Reporting.

Budget Advisor’s reporting capabilities enable the creation of monthly production reports for each physician in a streamlined and accurate manner. Figure 2 is a tailored production report for one physician. Chargeable units reflect the aggregation of services by CPT code, based on data extracted from the practice’s billing system. The final column on the right provides information about whether the physician’s production revenue is “over” or “under” the amount needed to cover his or her salary draw. Eliminating manual data entry, this number is also saved to the database for the monthly journal entry to the general ledger for the bonus accrual.

“Physicians receive their production reports via email much quicker than they used to. This is helping them improve their practice productivity,” says Holloway. “Also, finance staff is able to spend less time inputting numbers and more time analyzing the data. Budget Advisor also gives us more detail for the budgeting process because we have a multiyear history for each provider’s volumes and revenue and can more accurately budget going forward.”

**Meeting the Goals of the New Business Model**

Physician integration is central to healthcare’s new business model and to the achievement, or not, of quality improvement and cost reduction goals. Under the new payment system, hospitals and health systems must be able to determine if they are delivering services to quality targets at the lowest possible cost, in accordance with specified benchmarks. Cost metrics will need to be “managed to”—in other words, met or exceeded. Budgeting on a much higher level, accompanied by rigorous operations management and reporting, will be particularly critical. If lowest-possible costs are not achieved as budgeted, hospitals will have to identify and eliminate operational inefficiencies that stand in the way. Statistical data related to multiple domains (strategic, operating, productivity, etc.) must be integrated from disparate sources, such as general ledger, payroll, and billing systems.

Hospitals will need the very best tools to meet rigorous cost and budget planning, monitoring, and reporting requirements. Executives and managers must be able to manipulate, monitor, and report on information at the unit and consolidated level. Analytic capabilities, which transform data into actionable information, are needed. Budget Advisor offers the operational control points and feedback loops that are required to reduce operating costs and manage the transformation from a volume-based payment system to a value-based system.

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