BANGOR FAMILY PHYSICIANS

PAY FOR PERFORMANCE

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BANGOR FAMILY PHYSICIANS is a medical group practice located in Bangor, Maine. The practice has four family practice physicians and a medical support staff consisting of a practice manager, two receptionists, four nurses, two medical assistants, two billing clerks, and one laboratory technician. Data relevant to the practice are contained in Tables 11.1 and 11.2.

The practice is organized as a partnership, with each physician having an equal share. Although the practice manager has the authority to make the day-to-day business decisions, all strategic decisions regarding the management of the practice are made jointly by the partners. In addition, the practice uses a local accountant (CPA) to prepare and file its taxes and to act as a financial advisor when needed.

The current policy of the practice is to provide equal compensation to the physicians. Essentially, each physician is paid the same monthly salary ($12,500) and then, at the end of each year, any profits of the practice that are not needed for reinvestment in new assets are divided equally among the partners. Although this policy of "equal work for equal pay" has been in place since the practice was founded in 1986, there is growing discontentment among the partners regarding this compensation system. Not surprisingly, each of the physicians believes that he or she is working harder than the others and hence should receive greater compensation.

A recent survey by the Medical Group Management Association indicated that less than 10 percent of group practice family physicians

are compensated on a straight salary basis, while the majority is compensated on the basis of productivity. Of those compensated on the basis of productivity, about half are paid solely on that basis while half receive a base salary plus a "bonus" component based on productivity exclusively or on productivity plus other measures. (For more information on the Medical Group Management Association, see www.mgma.org.)

In an effort both to reward those physicians that are truly "working harder" as well as to create the incentive for all physicians to be as productive as possible, the partners directed the practice manager to assess the current compensation system and to recommend any changes that would improve the system. Assume that you are the practice manager of Bangor Family Physicians. As a start, you scheduled a meeting with the partners to develop some initial guidance. At this meeting, the partners agreed that any proposed system must have the following five characteristics.

1. The system must be **trusted**. The point here is that the physicians must trust not only the data that are used

TABLE 11.1
Bangor Family Physicians: Selected Annual Practice Data (2005)

	Physician Identifier				
	A	*B*	*C*	*D*	*Total*
Number of patients	4,023	3,567	3,966	4,244	15,800
Number of RVUs	4,667	5,055	5,475	4,967	20,164
Professional procedures	6,255	6,972	7,287	6,742	27,256
Gross charges	$527,820	$535,841	$602,675	$567,312	$2,242,648
Net collections	$422,256	$401,881	$421,872	$501,050	$1,747,059
Total support staff cost					$ 522,388
Total facilities costs					$ 298,351
Total supplies cost					$ 136,257
Revenues reinvested in the practice					$ 78,892
Physician base compensation					$ 600,000

Notes: 1. The RVUs listed here are work RVUs, which are only one of the three component RVUs used in Medicare physician reimbursement.
2. Over the past five years, the average annual amount reinvested in the practice was $80,000.
3. In 2005, each physician received a bonus of approximately $28,000.

TABLE 11.2
Bangor Family Physicians: Support Staff Salary Breakdown (2005)

	Number of Employees	*Total Compensation*
Practice manager	1	$ 75,168
Receptionists	2	48,652
Nurses	4	175,264
Medical assistants	2	52,615
Billing clerks	2	62,165
Laboratory technician	1	46,788
Other costs		61,736
Total		$522,388

Note: Other costs include accounting fees and other fees for outsourced services.

but also the integrity and competency of the individuals who administer the system. The compensation model itself may be sound, but a lack of faith in either the data or the administration of the system will lead to a lack of confidence in the entire system.

2. The system must be clearly **understood**. In the search for the perfect system, it is all too easy to create a model that is too complex, and hence the links between pay and performance cannot be easily identified. If the physicians cannot easily identify what performance is necessary to increase pay, the system will not have the desired results.
3. The system must be perceived to be **equitable**. If the physicians do not believe that the system is fair—that is, those physicians who contribute more are paid more—it is doomed to failure.
4. The system must create the proper **incentives**. A fundamental objective of any compensation plan is to maintain the financial viability of the organization. Thus, the model must create incentives that promote behavior that contributes to the success of the group.

5. The system must be **affordable**. The costs of implementing and administering the system must be reasonable. Furthermore, the total amount of incentive compensation paid must not impair the ability of the practice to cover its operating costs, replace existing assets, or acquire new assets.

Even with this general guidance, the task of assessing the current physician compensation system and making recommendations for change seemed daunting. After all, there are many physician compensation systems available, each having its own strengths and weaknesses. To gain a better appreciation of the possible choices, you next met with the group's accountant (Jennifer Wong) to learn more about alternative systems. After several meetings, you concluded that there are only a few alternatives that would be appropriate for Bangor Family Physicians.

- *Revenue Model*. This model rewards physicians solely on the basis of revenue generation: the greater the revenue generated by a physician, the higher the compensation. The metric used could be actual revenues or some proxy for revenues such as work relative value units (RVUs). (Work RVUs are discussed in detail later.)
- *Net Income Model*. In this model, the physicians are held responsible for both revenues and costs: the greater the revenue generated and the lower the costs incurred by a physician, the higher the compensation. The advantage of this system is that physicians would have the incentive to be both more productive (generate more revenues) and, at the same time, reduce the costs associated with operating the practice. The biggest challenge in instituting this system is the ability to allocate practice costs to individual physicians. Although cost allocation can be roughly accomplished, it will be difficult to convince the physicians that the allocation has true economic meaning. With limited data at hand, one possible solution is to divide the total costs of the practice into fixed and variable components, then allocate the fixed component equally to all

four physicians and allocate the variable component on the basis of some measure of resource utilization.

- *Base Salary Plus Productivity Model.* Here, productivity (measured either by revenue generation or net income) is applied to only a portion of physician income. For example, each physician might receive a base salary of $6,000 per month. Then, the remaining compensation is based on some measure of productivity.
- *Multiple Factor Performance Model.* This model recognizes that physician performance extends over many dimensions, rather than just financial ones. For example, patient satisfaction plays an important roll in the reputation of the practice and hence in its ability to both retain patients and attract new patients. In addition, such factors as amount of committee work (both internal and external) and participation in continuing education programs contribute to the well-being of the practice. Thus, compensation in this model is based both on economic and noneconomic factors. Table 11.3 contains physician data related to noneconomic factors; however, there is no established method to measure the value of these factors.

Of course, any combination of the above approaches could also be used. Thus, even though the number of systems considered is relatively limited, a wide variety of solutions is possible.

TABLE 11.3
Bangor Family Physicians: Noneconomic Productivity Data (2005)

	Physician Identifier			
	A	*B*	*C*	*D*
Average patient satisfaction score	91	93	90	87
Number of committee meetings	12	16	8	4
Continuing education credits	15	12	10	18
Professional association leadership	1	2	0	0

Notes: 1. Patient satisfaction scores are on a scale of 100.
2. Professional association leadership reports number of leadership positions held.

In addition to defining possible approaches, you also learned from Jennifer that another group practice she works with recently adopted a system where revenues are proxied by RVUs. RVUs form the basis of physician compensation for Medicare services. Under this system, each physician service (procedure) has three relative value components: (1) physician work, (2) practice expense, and (3) malpractice expense. For each RVU component, there is a geographic practice cost index that reflects the local cost of each component relative to the national average. To determine the Medicare reimbursement amount, each RVU component for a particular procedure is first multiplied by the matching geographic cost index. Then, these products are summed. Finally, the total geographic-adjusted RVU amount is multiplied by a nationally uniform dollar-value conversion factor.

Armed with the above information, you held another meeting with the partners to gain some additional insights into their views regarding physician compensation. All agreed that the physicians that contribute most to the practice should receive the highest compensation. However, there was no agreement on how to define "contribute the most." Although one physician strongly believed that revenues were the best measure of productivity, another countered that if the high revenues were generated at the expense of high costs, then the high revenues did not really mean much. Another physician stated that revenues do not necessarily reflect work effort, as some patients appear to generate higher revenues than others even though the amount of physician effort is similar. Yet another physician stated that there is too much emphasis on money. If the physicians do not provide good medical care and keep their patients happy, there will be no revenues in the future. Thus, she argued, "patient satisfaction is just as important as revenue generation."

In addition to the patient satisfaction issue, one partner also noted that some companies that purchase health coverage for their employees have been pressuring insurers to pay physicians an extra amount if they achieve certain clinical goals such as percentage of female patients having mammograms, percentage of diabetics having regular blood tests, and so on. The reaction to this comment was mixed. Two partners thought the whole idea of rewarding physicians for practicing good medicine was ludicrous. One commented that the profession is in a sad state of affairs if physicians have to be paid extra to do what is right. On the other hand, another partner stated that if this was the

trend among payers, it might be wise to consider building such guidelines into Bangor's compensation system.

At the end of the meeting, you could tell that the job would not be an easy one. None of the approaches that you initially identified could be ruled out. Your major hurdle would be to develop a system that would be supported by all four partners. Thus, the ability to "sell" the system to the partners is just as important as the system itself.

To ensure an orderly approach to the assignment, you decided to focus on the following four tasks:

3. Identify the strengths and weaknesses of each model.
4. Recommend the system that you believe is best for Bangor Family Physicians.

Finally, you recognize that the merits of alternative compensation systems are influenced somewhat by the nature of the practice's revenue stream (reimbursement). Almost half of the practice's revenues come from Medicare and Medicaid, while the remainder comes from commercial insurers, including managed care plans. Although some of the managed care plans were using capitated payment systems several years ago, all of the practice's payers now use fee-for-service (FFS) methodologies.

Bibliography

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