H&HN DAILY

Weathering Changes to Provider-Based Reimbursement

By Nathan Kaufman *May 30, 2012*

Are the salaries of employed physicians sustainable? That depends on how health systems and physicians respond to looming rate adjustments and to meeting their collective needs.

From the Trenches: Introducing a new monthly series. *Debating and promoting health policy and predicting the future of health care delivery are important. But while the pundits remind us of the gastronomical preferences of culture and Wayne Gretsky's directional skating style, we cannot forget that, down in the trenches, there are health system leaders who have to deal with the intended and unintended consequences of policy decisions in real time, and who have to parse out how lessons learned from Cleveland or Mayo or Kodak will help them deal with multiple and immediate crises facing every health system. This new series, appearing between May and October, is my attempt to contribute useful thoughts to their discussions.*

Deteriorating economics are driving physicians who originally selected entrepreneurial private practice to become employees of a health system. Today physicians in private practice are faced with:

- escalating infrastructure costs;
- exponential growth in regulatory mandates;
- marginal increases, at best, in government payments;
- commoditization by the commercial payers;
- declining profitability of their ancillary services;
- bad debt associated with high-deductible health plans;
- the failure of joint ventures, co-management, call pay and OWA (other weird arrangements) to provide sufficient income protection over time.

These factors are forcing physicians to begrudgingly exchange both their ownership and (at least in theory) their autonomy for the "safety" of employment within a health system.

Along with providing stable or even higher compensation to physicians, health systems are absorbing the cost of significant investments in infrastructure such as an electronic health record and better salaries and benefits for office-based employees. Few health systems pay for goodwill when physicians accept employment; however, many systems are paying for "intangible assets" (stirring a debate in the valuation community over the appropriateness of this practice).

Current Approach to Compensation

In lieu of guaranteed salary, most health systems base a physician's compensation on productivity (compensation per work relative value unit, or wRVU, with relatively insignificant adjustments for quality, patient satisfaction, practice expense control and citizenship. In some cases, the health system is absorbing additional risk by guaranteeing that the compensation per wRVU will not fall below historical levels for a period of time.

This compensation structure aligns the health system and employed physicians with respect to productivity. And because the physicians get paid the same amount

regardless of the patient's payer status, the wRVU method enables physicians to be agnostic with respect to the patient's insurance, thus preserving the health system's mission to serve the entire community. (Absent this approach, physicians will limit access to relatively low-paying Medicare, Medicaid and self-pay patients a looming crisis to be addressed in a future article in this series.)

However, most wRVU compensation formulas do little if anything to encourage physicians to improve practice efficiency, maximize office-based collections, redesign care, participate in teams or adjust their workflow to optimize performance. Health systems risk lower margins if they cannot gain the cooperation of physicians to transform care delivery.

Higher Pay for Employed Physicians

Most hospitals receive higher reimbursement from Medicare and commercial insurance companies for the same services that are provided in independent physician offices. This fact has not gone unnoticed by physicians who are selling their practices to a health system. As one of the lawyers who has represented several cardiology practices noted on his Web page:

"Cardiologists frequently ask how hospitals can afford to purchase their practice and increase their compensation. The answer: provider-based reimbursement. PBR is the method by which hospitals are paid more for diagnostic tests than what physicians receive."

In fact, an industry of lawyers and consultants has emerged that specializes in helping their physician clients receive the highest possible pay from health systems, with little regard for the long-term impact on that health system.

Cardiology provides the most extreme example. In 2010, Medicare implemented major cuts in the cardiology fee schedule. This triggered an unprecedented number of cardiology groups being acquired by health systems. According to the MGMA 2011 report, the median compensation for noninvasive cardiologists who are employed by health systems is approximately $90,000 higher than their peers in independent practice, even though their productivity (median wRVUs) is equivalent. This is not surprising: The cardiologists' business and legal advisers write white papers and speak at seminars convincing the cardiologists that they are entitled to an increase in their compensation when they become employed by a health system.

There is no argument that physician employment is a critical strategy for every health system, and I do not wish to weigh in on the appropriate level of compensation for employed physicians. But I do want to call attention to a looming phenomenon in the payment landscape: The traditional method of absorbing the incremental cost associated with physician employment is beginning to deteriorate.

But the Winds Are Shifting

The PBR pricing loophole that has proliferated in cardiology is under attack. In their last meeting, MedPAC trustees acknowledged that Medicare pays up to 80 percent more for an outpatient visit at a hospital-owned practice than for the same type of visit at a physician's office.

With the growing hiring of physicians by hospitals, MedPAC is focusing its attention on provider-based reimbursement. According to Glenn Hackbarth, the chairman of MedPAC, "Medicare needs to move, over time, to paying the same amount for the same service, regardless of the provider type. & " While MedPAC proposes that this rate adjustment initially apply to evaluation and management services, it clearly signals that the days when hospitals can expect to receive a premium price differential from Medicare for any service are numbered.

The commercial insurance companies are targeting this price differential as well by:

- incorporating "revenue neutralization" language into their new contracts that prevent a health system from increasing the rate for an acquired office-based service;
- promoting the use of lower-cost, freestanding providers by publicizing rate comparisons to referring physicians;
- providing financial incentives for patients to use lower-cost, freestanding ancillary services;
- offering health plans with tiered provider networks at lower premiums (requiring patients to pay a higher co-payment when they use a high-priced provider, e.g., a hospital).

Ways to Weather the Change

The beginning of the end of provider-based reimbursement does not mean that health systems will no longer need to employ physicians, nor can one expect physicians to accept significant reductions in their compensation without a fight. Rather, it should be viewed as a wake-up call for health systems and their employed physicians to focus collectively on identifying new sources of funds to stabilize physician incomes. This includes the following:

- First, do not voluntarily give up provider-based reimbursement. There is no evidence that hospitals that reduce their rates receive a compensatory increase in volume.
- Continue to target commercial reimbursement for employed physician services at a 20 to 30 percent premium over the "street rate." This premium is needed to fund the inevitable "sloppy" process of integrating entrepreneurial practices into the health system. Most health plans can absorb the cost of these rates.
- Start with the assumption that you want to do a very fair deal for the physicians. Do your homework. Understand why the physician is selling and know the *total* value of that practice to the health system. Understand the financial, political and legal ramifications of the deal, especially the potential downside. Recognize that, in some cases, it is better to walk away from a bad deal than to try to fix it after the deal closes. A win-win deal should not mean the physician wins twice!
- Do not refer to your investment in employed physicians as a "loss." Doing so ignores the fact that our industry is moving toward health systems in which employed physicians play an integral role. I was reminded of this when, after complaining about the incremental cost of employing his group, a physician asked me: "How much does the health system lose when they employ a nurse?" The question is not how much are you losing, but whether you are getting an appropriate return on your investment.
- Don't skimp on practice management infrastructure, especially with respect to the revenue cycle and information technology.
- Redesign patient flow to improve throughput. Consider the use of the Lean process redesign method.
- Implement tools to measure the performances of physicians and practice administrators. Establish a hierarchy of physician leaders who can enforce optimal performance.
- Develop a strict job-sharing program that requires part-time physicians to team up so that their combined productivity represents a full practice.
- Eliminate outliers some physicians don't fit in a large group or are unable to tolerate bureaucracy. They can disrupt the performance of the entire organization. It is OK to disagree, but not OK to be disagreeable.
- Identify inefficiencies throughout the health system in most cases, there are a lot of them. By becoming more efficient, the system is tapping a new source of incremental funds that can be used to stabilize physician incomes.

So the answer to the question "Are the salaries of employed physicians sustainable?" is: "It depends." Hospital-based reimbursement is on its last legs, and no one is immune from arithmetic. If a health system and its employed physicians operate in the traditional provincial culture of "us vs. them" and continue to depend on loopholes in the reimbursement system to stabilize physician salaries, then the future is bleak.

Health systems and physicians have a fighting chance to maintain historical levels of compensation for the employed physician workforce, but only if the health system and physicians agree to take the necessary steps: The health system must recognize and treat its employed physicians as a highly valued workforce and develop the competency and infrastructure to acquire and operate this embedded group practice. And the physicians must develop the competency to become highly valued employees, commit to improving value for the patient, and focus on the success of the system by improving productivity, care coordination, and standardization, thus eliminating its costly inefficiencies.

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