

# PHYSICIAN COMPENSATION & RECRUITMENT

## MGMA confirms that costs outpace revenues: What does it mean? And what *will* it mean?

A recent report from MGMA confirms that operating costs are rising faster than revenue in many medical group practices. Although the findings are not surprising, the effect of the costs-revenue disparity is continuing to unfold, and how practices and health systems are responding could have serious implications for the practice of medicine.

*MGMA Cost Survey: 2008 Reports Based on 2007 Data* reports that although multispecialty group practices reported a 5.5% increase in median total revenue in 2007, median operating costs rose by 6.5%. Many single-specialty practices reported a similar trend. For example, cardiology practices' median total medical revenue decreased 0.61%, and operating costs rose 6.3%.

MGMA also reports that during the past decade, operating expenses have risen from 58 cents per dollar of revenue to 61 cents. According to MGMA, the drivers of the trend include the:

- » **Drug supply.** In multispecialty groups, drug supply costs leapt 17% in 2007, compounding a 33% increase from 2006.
- » **Support staff.** Family practices reported a 15.8% increase in support staff costs in 2007. OB/GYN and pediatrics groups reported similar hikes—17.2% and 10.1%, respectively.
- » **Professional liability.** This varied by specialty. Cardiology groups reported an 8% increase in malpractice insurance premiums in 2007; the increase since 2000 is 132.3%.

### No surprise, but ...

None of this should be a surprise to anyone who has been running a practice. A declining economy and escalating pressures from Medicare and other payers mean practices must work harder to maintain the status quo. What is news is that physicians, consultants, hospitals, and others are growing

more concerned, and problems that have been brewing for years are receiving more attention, says **Mary J. Witt**, vice president of The Camden Group in El Segundo, CA.

**Allen Dye**, vice president of marketing at Merritt Hawkins & Associates in Irving, TX, says margins have been diminishing during the past decade, and hospitals have been particularly hard hit.

But now that practices are affected, the problem is gaining more notice, Dye says. "People are more inclined to listen to doctors than to hospital administrators," he says. "As if anything else was needed to suggest that healthcare is far from recession-proof."

**"We've got a pretty good mess on our hands.  
Ultimately, it is broken."**

—Allen Dye

### Too many eggs in one basket?

Physicians and groups offset practice overhead and add revenue streams when they expand into ancillary areas, such as imaging, lab services, and surgery centers. Although this works for diversified groups, it may have the opposite effect in subspecialty practices, says Dye.

Subspecialization may contribute to some of the financial woes practices are facing, especially with surgical subspecialties, as there isn't the same opportunity to spread out the risk as in a more diversified practice. "They are not as insulated from market change," Dye says. Moreover, as the practices add surgery centers and make other attempts to "look and feel more like hospitals, they are going to see what [hospital] margins have been doing for a long time," he says.

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## MGMA

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Practices are—or should be—questioning the role of services and procedures, says **Steven A. Nahm**, vice president of The Camden Group. Such questions include:

- » Are ancillary services covering variable expenses and contributing to fixed overhead?
- » Are the ancillary services offered in the practice the highest and best use of office space?
- » Are there ancillary services that the practice should be offering in-house?
- » Is it financially worthwhile to continue to perform in-office procedures?

### Comp models

Although it makes sense to review how compensation models are structured, “restructuring compensation arrangements or agreements is not the primary response or solution to an economic imbalance,” says Nahm.

“For many years, groups have been forced to adjust compensation models to [ones that are] production-based. Most groups offer a fair base salary for a short term—one to two years maximum—and then change to the production model,” says **Jim Fuller**, marketing vice president of Delta Physician Placement in Dallas.

So what’s left to do? Expect more emphasis on practice style and resource consumption. Practices are becoming more sensitive to the expense side of the equation, say Witt and Nahm.

One critical question for practices is simple and complex, says Nahm. “In a multiple-physician practice, how should overhead be allocated among physicians, especially when there are large variances in their usage of office space and staff?” he says.

The issue isn’t restricted to full-time physicians. Practices are also considering whether compensation models should “take into account part-time or underperforming physicians or midlevel providers who do not fully maximize the overhead allocated to them,” Nahm says.

Witt is working with practices that have a few resource-intensive physicians, which directly affects overhead. Eventually, it will have to be factored into compensation, she says, but addressing the issue may be a challenge: “They are having some interesting conversations.”

### Recruitment concerns

Recruiting efforts remain dependent on location, says Nahm. For example, in California, reimbursement is low, causing practices to be at a competitive disadvantage, he says, adding that many practices are reluctant to recruit.

Nahm says practices are asking themselves questions such as, “Will adding a new associate be a financial drain or benefit to the practice? Can a new physician add ancillary volume, add a new profitable service line capacity, [and] share in overhead expenses?” This is especially true for solo practices. Many of these physicians are not bringing in associates and, accordingly, they are not thinking about succession planning.

“How do you replace those older physicians who don’t want to recruit anybody? That becomes another challenge for hospitals trying to stabilize their medical staff,” says Witt.

From the physician alignment perspective, hospitals and health systems are trying to create other employment vehicles that will recruit new residents without hurting the existing medical staff. And hospitals (as well as organizations such as Kaiser Permanente) have increasing appeal, especially in areas in which reimbursement is low. They are paying well, providing benefits, and insulating physicians against expenses.

### Hospitals buying practices

One way to ensure a steady supply of physicians is for hospitals to purchase practices. And that’s what they are doing, says Fuller. Hospitals often feel compelled to purchase the groups to maintain community stability. Many hospitals that purchase and manage practices are willing to accept a practice loss for the offsetting benefits, such as ED coverage, he says.

Nahm and Witt report a similar trend. A major issue for practices considering selling to a hospital or health system is figuring out how their compensation models would change, say Nahm and Witt. (Look for more about this topic in a future PCR.)

“Selling a practice is not a panacea for physicians seeking a huge buyout,” says Witt. Practices are not selling for the high multiples that were seen in the last buying cycle.

### Making adjustments

The cost-revenue disparity and the current economic crisis have led to other changes, including:

- » **Expanding hours.** Perhaps driven by competition from retail clinics, more practices are extending hours, say Nahm and Witt. Such a move allows a practice to more fully maximize use of fixed overhead.
- » **Booming locum business.** Dye, Nahm, and Witt all note that more physicians are turning to locum tenens work.
- » **Delayed retirement.** “[Physicians] have lost the ability to retire early,” says Witt. This could be one factor driving the locum surge.
- » **Call coverage.** Economic pressures on practices are one big reason for the increasing demands for on-call compensation. Increasingly, physicians believe that if they are going to be doing work, it needs to generate revenue, says Witt.

### ‘A pretty good mess’

Even with all the issues raised, Dye says the report is just that—a report.

It’s not predictive, and he suggests not responding rashly. Being too reactive and reactionary would only make things worse, he says. “We don’t want people to freak out.”

This report will require physicians and payers to reexamine how medicine is practiced, says Witt.

Still, don’t mistake Dye’s call for calm for undue optimism. “We’ve got a pretty good mess on our hands,” he says. “Ultimately, it is broken.” ☒

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#### PCR sources

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## Questions to consider

The cost-revenue imbalance is prompting physician practices to analyze operations and business practices to maintain compensation levels, says **Steven A. Nahm**, vice president of The Camden Group in El Segundo, CA. Practice managers are asking questions regarding expense control and revenue generation, such as:

- » Can staffing be reduced without harming quality or patient throughput?
- » How can spending on supplies and other operating expenses be decreased?
- » What is the appropriate mix and use of RNs versus medical assistants and other types of personnel?
- » In practices with multiple offices, are there locations that can be closed and volume consolidated to remaining sites? Is it time to relocate to an area with a more favorable payer mix?
- » Can physicians reduce non-revenue-producing time in the practice?
- » Are there new ways to communicate with patients and providers that can reduce administrative costs?
- » When should the practice implement electronic medical records, and how will the costs of implementation and ongoing operations be paid? Should the practice participate in a consortium with other practices or a hospital to implement a common system?
- » Is physician medical record documentation and charge coding truly reflective of the services being provided?
- » Is the practice collecting copayments and outstanding balances as well as updating patient data at the time of service?
- » Does the group have good billing performance?
- » Should the practice terminate low-reimbursement payers who refuse to increase rates to appropriate levels, or at least close the practice to new patients from these plans?
- » Will a local hospital assist with the cost of recruiting and establishing a new physician in the practice?
- » Does it make financial sense for an individual physician to maintain outpatient and inpatient practices?
- » Is it time to leave independent practice and join a health system or merge with other physicians?