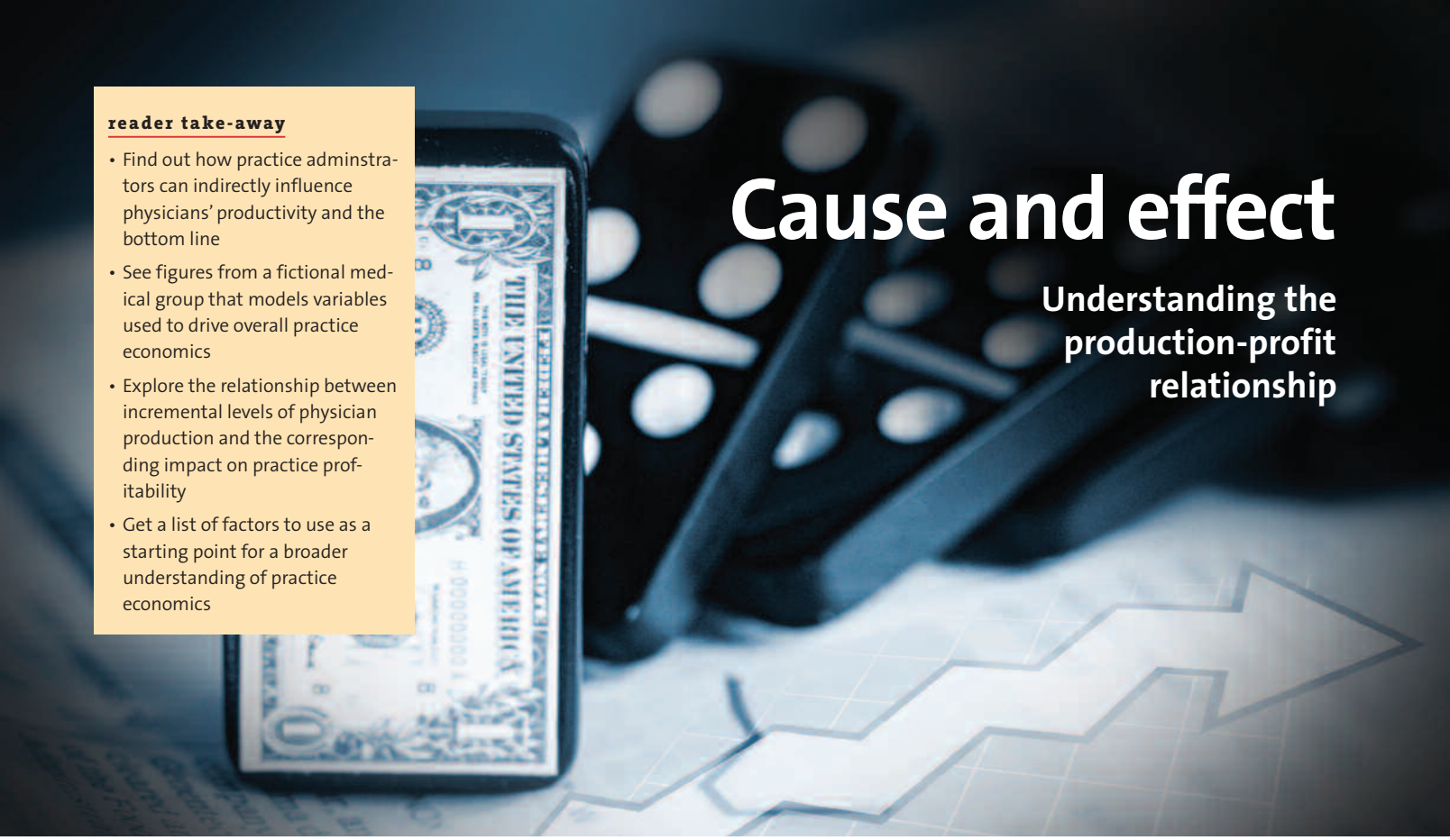

Cause and effect

Understanding the production-profit relationship

reader take-away

- Find out how practice adminstrators can indirectly influence physicians' productivity and the bottom line
- See figures from a fictional medical group that models variables used to drive overall practice economics
- Explore the relationship between incremental levels of physician production and the corresponding impact on practice profitability
- Get a list of factors to use as a starting point for a broader understanding of practice economics

By Craig D. Pederson, MBA, MHA

about the author

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Physician productivity is the single most important factor affecting a medical group practice's net income performance. Therefore, how productivity is managed will, to a large degree, determine a group's economic performance — and the tenure of the group's administrator.

Unfortunately (from an administrative perspective), physicians often fail to view themselves as key drivers of practice income — and ultimately their own compensation. Instead, physicians see their earnings as the output that results from the simple calculation of subtracting a group's operating expenses from its revenues. Within this physician paradigm, the administrator is responsible for managing revenues and overhead to ensure that annual output — practice income — meets the expectations of the physician owners.

Regardless of the administrator's performance in managing reimbursement and overhead, income will fall below expectations if physician productivity fails to reach key thresholds. How do group practice leaders "manage" (albeit indirectly) physician production levels when the owners can frequently undervalue the relationship between compensation levels and their own productivity?

Answer: carefully and indirectly.

Practice administrators do not directly influence any of the factors that contribute to the bottom line. For example, they can't directly increase practice revenues. Instead, administrators must go the indirect route: pursuing increased reimbursement rates through contractual negotiations with payers (assuming that physician productivity remains constant or increases).

The key economic relationship in this effort is the link between physician production and practice profitability. The term "profitability" is purposely used in this instance (vs. practice income) to emphasize how profitability (physician compensation per unit of work produced) is affected by different levels of productivity. While leadership teams understand this relationship at a basic level, groups commonly underestimate the magnitude of the opportunity presented when physicians reach higher levels of productivity.

Understanding the basic relationship between production and profitability

To develop an in-depth understanding of practice profitability, let's profile a fictional,

Generic Primary Care Group PC

Section I	Assumptions			
	Scenario A	Scenario B	Scenario C	Scenario D
Physician FTEs*	6.00	6.00	6.00	6.00
Midlevel FTEs	2.00	2.00	2.00	2.00
wRVUs per physician FTE	3,500	4,000	4,500	5,000
wRVUs per midlevel FTE	2,000	2,000	2,000	2,000
Revenue per wRVU	$109.00	$109.00	$109.00	$109.00

Section II	Estimated profit and loss performance			
	Scenario A	Scenario B	Scenario C	Scenario D
Revenue	$2,725,000	$3,052,000	$3,379,000	$3,706,000
Overhead				
Variable costs	575,000	644,000	713,000	782,000
Fixed costs	1,068,000	1,068,000	1,068,000	1,068,000
Total overhead	$1,643,000	$1,712,000	$1,781,000	$1,850,000
Midlevel providers	184,000	184,000	184,000	184,000
Physician benefits	140,838	140,838	140,838	140,838
Net income (physician compensation)	$757,162	$1,015,162	$1,273,162	$1,531,162

Section III	Estimated physician compensation			
	Scenario A	Scenario B	Scenario C	Scenario D
Per FTE physician	$126,194	$169,194	$212,194	$255,194
Per physician wRVU	$36.06	$42.30	$47.15	$51.04

*Full-time-equivalents

"baseline" medical group and demonstrate how practice economics are affected by the level of physician production.

The box above presents an overview of a primary care group with six full-time-equivalent (FTE) family practice physicians and two nonphysician providers. Section I, Assumptions, shows the modeling variables used to drive overall practice economics. All variables were held constant with the exception of one, physician production, which increases in increments of 500 work relative value units (wRVUs) starting at 3,500 wRVUs per physician FTE (scenario A) and increasing to 5,000 wRVUs (scenario D). A constant reimbursement rate was assumed at $109 per wRVU based on a reasonable payer mix for family practice. On a per-total-RVU (tRVU) basis, the rate would translate to approximately $60. This includes $10 per tRVU related to income earned from ancillary services (lab, X-ray) and drugs, vaccines and injections. Therefore, the reimbursement rate for physician professional services is $50 per tRVU ($60 less $10).

Practice administrators do not directly influence any of the factors that contribute to the bottom line.

Section II summarizes the practice profit and loss (P&L) statements driven by the provider FTE, production and reimbursement assumptions outlined in Section I for each scenario. Overhead costs for each scenario are based on a common set of assumptions and include both fixed and variable costs. Variable costs rise as production increases (i.e., variable costs go up as wRVUs

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- From the home page, search for "productivity" and "physician compensation"
- From the *Practice Management* tab, choose "*Tools*" and select specialty-specific RVU calculation tools
- In the *MGMA Store*, enter 6627 in the *Search Products* box for the MGMA *Physician Compensation and Production Survey: 2006 Report Based on 2005 Data*; 6451 for the book *Physician Compensation Plans — State-of-the-Art Strategies*

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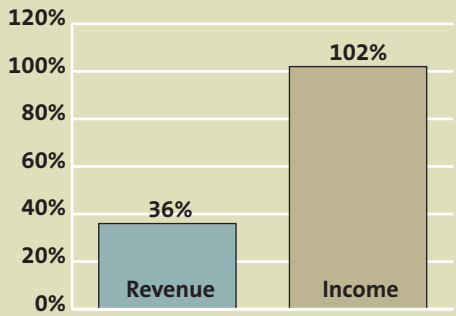
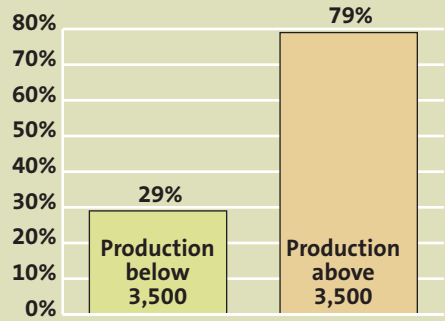
How do you manage physician production levels? Tell us at connexion@mgma.com

Percent change – scenarios A and D



Income as a percent of revenue



increase) while fixed costs, nonphysician provider compensation and physician benefit costs remain unchanged across all scenarios.

Section III of the group practice example calculates physician compensation (net income) for each scenario. Compensation is presented on a per-physician-FTE basis as well as on a per-wRVU basis. Income levels increase as production levels rise, and the *income earned per unit of physician work* (i.e., per wRVU) also grows from approximately $36 in Scenario A to $51 in Scenario D.

Estimating the impact of incremental production

The graphs (left), "Percent change, scenarios A and D" and "Income as a percent of revenue" highlight the benefits of reaching higher production levels. In the first box, percentage differences are calculated for both revenue and income between Scenarios A and D. While revenue increases approxi-

mately 36 percent between the scenarios, income available to physicians increases much more dramatically — approximately 102 percent.

The second graph, which presents practice income as a percentage of revenue, demonstrates why the percentages shown in the first graph differ so dramatically. Approximately 29 percent (or $0.29) of every dollar collected flows to the practice's bottom line and ultimately to physician income for a production level of 3,500 wRVUs. However, for revenue related to incremental production (i.e., revenue related to wRVUs generated *above* 3,500 wRVUs), approximately 79 percent of the total revenue dollar flows to the bottom line. Therefore, after fixed costs are covered, $0.79 of every dollar collected gets paid out as physician compensation.

Implications for physician group leadership

While the relationship between increased production and increased compensation is intuitive and obvious, the economics of the production and profitability relationship are less so without the benefit of analysis/economic modeling. For group practices that develop fundamental understanding of the relationship between physician production and profitability (specifically between higher levels of production and incremental profitability), the implications are many:

- **The relationship between physician compensation model and culture** — How does the group's current compensation approach reward physicians at the upper and lower ends of the production spectrum? A model that compensates physicians at a flat rate per wRVU, e.g., $42 per wRVU, may encourage more of them to practice part-

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time and discourage some from reaching higher tiers of production if low producers are paid at the same per wRVU rate as high producers. Therefore, high producers pick up a much higher portion of fixed expenses. A group that wants to foster a culture of hard-working, full-time providers who are compensated well for their high-quality work may need to adopt a model that compensates physicians at significantly higher rates ($0.80 of every $1 collected) for every wRVU generated above key production thresholds (4,200 wRVUs).

- **The "perceived" performance of the group relative to regional or national benchmarks** — Leaders of a single-specialty group practice with compensation rates (on a per-wRVU basis) that have historically been similar to the Medical Group Management Association (MGMA) median may conclude that they are reaching their financial and operational performance targets on an annual basis. However, if the same group generates physician production levels well above the MGMA median, the group's target compensation per wRVU values should also be significantly above that median as a result of the incremental profitability associated with the upper tiers of production. Failure to recognize this performance gap may prevent the group from pursuing the strategies necessary to match production performance with compensation performance.
- **Building a common group economic paradigm** — A common complaint among practicing physicians is how poorly their training prepared them for the business of medicine. As a result, the responsibility for developing future shareholders/partners who understand what it takes to operate a successful practice falls to the group's leaders. They must devote time and effort to fill this knowledge gap. The long-term payoff is an ongoing supply of shareholders with the skills and knowledge to lead the practice.

Understanding the productivity/profitability relationship is only a starting point for developing a broader understanding of group practice economics.

- **Negotiating economic arrangements with external organizations** — Building a solid understanding of incremental profitability helps a practice negotiate arrangements — for compensation and/or integration with external organizations. As with the group's internal compensation model, leaders will want to confirm that salary rates between the practice and external organizations recognize the value of incremental profitability. For example, a physician group may provide physician time/professional services to an external organization, such as a hospital-owned and operated clinic through a professional services arrangement. If the arrangement's payment rate to the physician group is production-based, it can be structured to reimburse the group at a higher rate as higher levels of production are attained. Failure to do so may result in the group underpricing its services.

The fictional group described in the chart on page 41 is oversimplified to highlight the basic economic relationship between practice profitability and productivity. Understanding the productivity/profitability relationship is only a starting point for developing a broader understanding of group practice economics. Physician groups also need to comprehend additional — potentially more important — factors when weighing the economic implications of their decisions. If these factors are ignored, the group risks becoming nothing more than a vehicle through which multiple physicians share/allocate overhead vs. an integrated group practice with a long-term vision.

Get a grasp of broader economic factors

While not all-inclusive, the following list of factors can be used as a starting point by groups seeking a broader understanding of their practice economics:

- **Practice-building behaviors** — Physician compensation models need to take into account the cost and time associated with practice-building behaviors, such as developing and staffing outreach clinics and practice administrative or medical directorship responsibilities.
- **The cost of recruiting new providers** — Bringing new physicians into a group and helping them develop robust practices should be encouraged if leaders hope to expand the organization and/or replace senior physicians as they retire.
- **Overhead management** — The compensation model should emphasize efficient use of resources and overhead. Excessive focus on individual productivity could result in physicians adding too much overhead (e.g., using registered nurses instead of medical assistants or licensed practical nurses).

An understanding of the productivity/profitability relationship is just one of many skills that group practice leaders need to make the best decisions for their organizations. Decreasing or stagnant reimbursement rates and increasing costs require groups to aggressively manage their most expensive resource — physicians — and related provider productivity. Current and projected physician shortages may require groups to rethink their approaches to potential hires. To grow, practices may find it necessary to attract and retain more physicians who want to work less than full-time. Groups will need to understand the economic implications of these decisions to succeed in an increasingly competitive environment.