Physician Compensation
Models for the Current Environment

February 8, 2012
The Maine Chapter of HFMA
Susan Stowell
Presentation Agenda

• Physician market trends
• Health reform
• Impact on physician compensation
• Structures
• Process
• Challenges
• Ensuring success
• Fundamentals
• Questions
Trends in the physician market
Trends in physician market

- Shortage of physicians
  - According to “The Complexities of Physician Supply and Demand” we are projected to be short between 50,000-312,000 physicians by 2025.
Trends in physician market

- **Changing physician demographics**
  - 30% are female
    - Numerous studies have shown that female physicians work fewer hours than their counterparts
    - In 2012, 450,000 physicians, or 47% of physician population, will be over 50 years old.\(^1\)

- **Lifestyle needs**
  - There will be more part time physicians
  - Little desire to take call or have a heavy call burden

**Impact:**
- No longer seeing a 1:1 replacement on retiring physicians
- Traditional compensation structures must be adapted to accommodate lifestyle needs of new physicians

Source: 2009 AMA Physician Characteristics and Distribution in the US; 1 - Association of American Medical Colleges Center for Workforce Studies; The Physician Workforce Research Agenda: Expanding the Science, Enhancing the Impact; May 5, 2005; AMA; Prepared by NY Center for Health Workforce Studies
Trends in physician market

• Shortage of physicians
  - Shortages drive salary expectations up

Trends in physician market

- In 2005, 2/3 of medical practices were physician-owned.
- Three years later, less than 50% of the medical practices were physician-owned.

Before there was health reform...

- Centers for Medicare and Medicaid Services (CMS) instituted several significant reimbursement initiatives
  - Pay for performance initiatives started over 7 years ago
  - Core measures tracking and benchmarking
  - Medicare Group Practice Demonstration Program
  - Never events
  - Physician Quality Reporting Initiative (PQRI)
## Trends in physician market

<table>
<thead>
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<tbody>
<tr>
<td><strong>Fee schedule changes</strong></td>
<td>-6.1%</td>
<td>-27.4%</td>
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<tr>
<td><strong>Physician Quality Reporting Initiative (PQRI)</strong></td>
<td>Potential 1.0% bonus on total allowable charges</td>
<td>Potential 0.5% bonus on total allowable charges</td>
<td>Potential 0.5% bonus on total allowable charges</td>
<td>Potential 0.5% bonus on total allowable charges</td>
<td>Fee schedule reduced by 1.5% if quality data reporting is not satisfactory</td>
<td>Fee schedule reduced by 2.0% if quality data reporting is not satisfactory</td>
<td>Fee schedule reduced by 2.0% if quality data reporting is not satisfactory</td>
<td>Fee schedule reduced by 2.0% if quality data reporting is not satisfactory</td>
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<td><strong>Board Certification Maintenance program</strong></td>
<td>0.5% bonus on total allowable charges</td>
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<tr>
<td><strong>Electronic Health Records (EHR)</strong></td>
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<tr>
<td><strong>E-prescribing</strong></td>
<td>Earn 10% of physician's or group's total allowable charges</td>
<td>Penalty imposed for not using</td>
<td>Penalty imposed for not using</td>
<td>Penalty imposed for not using</td>
<td>Penalty imposed for not using</td>
<td>Penalty imposed for not using</td>
<td>Penalty imposed for not using</td>
<td>Penalty imposed for not using</td>
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<tr>
<td><strong>&quot;Meaningful use&quot; met</strong></td>
<td>$18,000</td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$2,000</td>
<td>$1,000</td>
<td>$2,000</td>
<td>$3,000</td>
<td>$4,000</td>
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<tr>
<td><strong>Non-participation or inability to meet standards</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1.0% reduction in Medicare allowed charges</td>
<td>2.0% reduction in Medicare allowed charges</td>
<td>3.0% reduction in Medicare allowed charges</td>
<td>4.0% reduction in Medicare allowed charges</td>
<td>5.0% reduction in Medicare allowed charges</td>
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</table>

**Impact:**
- Reimbursement is trending down
- More administrative requirements to achieve full payment

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1. Physicians billing under the Medicare PFS billing Medicare FI are not eligible for PQRI participation. The FI/MAC claims processing systems currently cannot accommodate billing at the individual physician or practitioner level.

1 - Physicians seeking to maximize incentive payment must bill at least $24,000 in allowed charges for services to Medicare beneficiaries during the year (75% of physician’s annual allowed charges). Medicaid incentives increases total to $63,750.
Health Reform
• Top priority for CMS is the “Triple Aim”.

The Triple Aim

1. Better care for individuals, described by the six aims for the health care system in the Institute of Medicine’s 2001 report, Crossing the Quality Chasm: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

2. Better health for populations, through attacking upstream causes of ill health, such as poor nutrition, physical inactivity, and substance abuse.

3. Reducing per-capita costs.

• Anything less than systemic reform will not achieve the level of change necessary to achieve the Triple Aim.
PPACA Includes Several “Value Based” Programs

• Value Based Purchasing Program

• Penalty for high rates of hospital-acquired conditions

• Hospital readmission reduction program

• Payment reductions for health care acquired conditions

• Shared Savings Program
Impact on Physician Compensation
Impact on physician compensation

- Competing realities
  - Physician expectations that compensation will increase
  - Declining reimbursement for physician services
- Additional challenges of physician compensation design:
  - Addressing needs of physicians who are “slowing” down
  - Meeting lifestyle demands of incoming physicians
  - Development of new physician leadership
  - Shifting attention from production to quality

All while the administrative burdens are growing, finances are tight, reimbursement for services is shifting to pay for quality rather than volume
Impact on physician compensation

• Requires a measured approach to compensation design
  • Organizations should begin introducing topics and metrics *NOW* that will need to be addressed in the future
  • Goal:
    • For hospitals, it is to avoid growing subsidies to employed physician practices
    • For independent physicians, it is to ensure stability and viability
• In order to address these challenges, organizations are:
  • “Stacking” components of physician compensation
  • Reducing portion of compensation tied to production
  • Increasing portion of compensation tied to quality and patient satisfaction
  • Re-examining care processes and leveraging other types of providers
Structures
Approach and Structures

- Organizations either:
  - Develop a compensation structure and pay what is earned; or
  - Set a target pool and allocate within the allowed budget
- Basic structures are usually one of two approaches:

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<thead>
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<th>Approach</th>
<th>Pros</th>
<th>Cons</th>
<th>When to use</th>
</tr>
</thead>
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<tr>
<td>1 Straight salary</td>
<td>Team oriented approach</td>
<td>No incentive to produce</td>
<td>Hospitals with service areas that cannot support a FT provider. When physicians are in “start-up” phase</td>
</tr>
<tr>
<td>2 Salary plus incentive</td>
<td>Opportunity to add incentive on quality, production</td>
<td>Adds some complexity to administering the compensation</td>
<td>When physicians want a draw and employer wants an incentive piece</td>
</tr>
</tbody>
</table>

Incentives

- Use of incentive compensation (as a percentage of all types of comp) is growing
  - Quality
  - Patient satisfaction
  - Financial measures
  - Team based care

Source: MGMA Physician Compensation and Production Surveys, 2008 - 2011
## Incentive structures

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<tr>
<td>1 Set compensation per Work RVU generated</td>
<td>Can drive production</td>
<td>If an organization has multiple providers, it can be difficult to establish a conversion factor that is appropriate for all</td>
<td>Organization’s strategic goal to drive volume through a particular program Ample market for physicians to meet their own compensation goals</td>
</tr>
<tr>
<td>2 Graduated compensation per Work RVU</td>
<td>More closely mimics financial realities of practice Can accommodate part-time physicians</td>
<td>Adds some complexity to administration of compensation Does not consider costs Requires significant education</td>
<td>Effective approach when a number of part- and reduced- time physicians are involved</td>
</tr>
<tr>
<td>3 Percentage based. Physicians paid on set percentage of charges or collections</td>
<td>Relatively simple Allows for focus on production</td>
<td>Depending on methodology, payer mix can have significant impact on physicians’ pay Does not consider costs</td>
<td>Can be used during transition period of bringing physicians into employment</td>
</tr>
<tr>
<td>4 Flat fee</td>
<td>Provides method to compensate for factors that are difficult to measure</td>
<td>May not provide strong enough incentive to change behavior</td>
<td>When an organization wants to recognize behavior that is difficult to quantify</td>
</tr>
</tbody>
</table>
Addressing the hard to measure tasks

- **Call**
  - **Approaches:**
    - Include in base
    - “Stack” or add-on call payments based on daily (or hourly) rate
    - Develop a Pay-for-Call program
  - **Items of note:**
    - Expectation that physicians complete a threshold number of call days
    - Call programs increasingly tying quality and performance metrics to payment
Addressing the hard to measure tasks

- Administrative time, Supervising mid-levels
  - Approaches:
    - Stipend
    - Hourly pay rate
  - Items of note:
    - Critical to establish expectations for the administrative time in advance of physician taking on the position
    - Develop a straightforward tracking system to monitor the hours (key for employed physicians)
Addressing the hard to measure tasks

- Team based care, medical coordination
  - Initiatives encouraged by health reform
  - Most physicians, group practices, and hospital employers are not being paid for these tasks

- Easiest approach is to pay a stipend

- Requires:
  - Commitment from organization
  - Acknowledgement that activities are time consuming and should be rewarded
The Process
Compensation plan design process

- An organization’s history, experience, and physician complement will drive the compensation design process
- Engage the physicians!!
- Timing will be organization-dependent
Compensation plan design process

- Process should cover:
  - External marketplace
  - Goals of the organization
  - Goals for the compensation plan
  - Principles of design
  - Different compensation structures (strengths and weaknesses)
  - Review of prior compensation plan (strengths and weaknesses)
  - Determine most appropriate approach for the organization
  - Develop a transition plan to move physicians from old system to new
  - Confirm regulatory compliance
  - Establish an ongoing oversight committee or process
Regulatory Compliance

• Contracts must meet Fair Market Value (FMV):
  – Little regulatory guidance on what this means
  – FMV can be established by “any method that is commercially reasonable”
  – Developing guidelines/standards by valuation experts (AICPA, NACVA)

• Regulatory requirements:
  – Stark
  – Anti-trust
  – IRS / private inurement
  – Anti-kickback
Case studies

• Example 1: Critical access hospital
  - First employment experience
  - Created outline of compensation structure and proposed to physician
  - Engaging the physician around the development of the incentive metrics

• Example 2: Small community hospital
  - Experience employing physicians for over 10 years
  - Started with a handful of physicians but now have over ten in the pool
  - Hospital allocated a set dollar amount to the compensation pool and engaged the physicians in developing a structure to pay individuals

• Example 3: Large, independent primary care group
  - Over 75 physicians and mid-level providers
  - Changing compensation methodology
  - Established a committee including practice administration and physicians
Aligning compensation with system goals

- It is critical to link components of the compensation system to the goals of the organization
  - For example:
    - Quality metrics are becoming increasingly important as reimbursement methodologies change and organizations focus on providing value based care
    - One dimensional measure of productivity doesn’t balance out patient safety, quality, citizenship, and patient satisfaction

Case Study: A large primary care group
- Embraced IHI’s Triple Aim\(^1\)
- Currently in process of revamping compensation model
- Incorporating team based metrics and health outcome metrics in physicians’ bonus pools.
- Discussions are focused on shifting the balance of compensation that is tied to productivity towards quality metrics instead.

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1 - Institute for Healthcare Improvement’s three critical objectives which include: Improve the health of the population; enhance the patient experience of care; and reduce or control the per capita cost of care.
Standardization

• To extent possible, standardize!
  – Term and termination
  – Benefits
    ▪ Health, life, disability insurance
    ▪ Retirement plan
    ▪ CME allowance
    ▪ Expenses
  – Malpractice
• Create common approach within specialties
  – Compensation
  – Duties and performance expectations
  – Restrictive covenants
  – Call requirements
Challenges
Challenges: Setting compensation & productivity levels
Challenges: Selecting incentives
Challenges – using the surveys

• Many employers are relying on surveys\(^1\) to establish target compensation levels

• In order to use them effectively, it is critical to:
  ▪ Understand the limitations of the surveys
  ▪ Understand your marketplace and its characteristics
  ▪ Balance local and national market considerations

\(^{1}\) Examples include Medical Group Management Association’s Physician Productivity and Compensation Survey and the American Medical Group Association’s Compensation and Financial Survey
## Challenges – using the MGMA survey

### Example of self selection

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Providers</th>
<th>Practices</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>10th %tile</th>
<th>20th %tile</th>
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<tbody>
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<td>Allergy/Immunology</td>
<td>159</td>
<td>80</td>
<td>$312,268</td>
<td>$141,606</td>
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<td>Anesthesiology: Pain Management</td>
<td>164</td>
<td>54</td>
<td>$488,836</td>
<td>$213,909</td>
<td>$301,486</td>
<td>$369,079</td>
<td>$387,128</td>
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<tr>
<td>Anesthesiology: Pediatric</td>
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<td>$273,476</td>
<td>$333,724</td>
<td>$379,616</td>
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<td>503</td>
<td>133</td>
<td>$491,291</td>
<td>$200,880</td>
<td>$273,476</td>
<td>$333,724</td>
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<td>$220,368</td>
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Source: MGMA Physician Compensation and Production Survey
Challenges – using the MGMA survey

Interpreting MGMA Tables

CAUTION
Watch the sample size when “slicing” the data

• Both tables reflect compensation data but have a significant difference in sample size

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<td>Endocrinology/Metabolism</td>
<td>339</td>
<td>154</td>
</tr>
<tr>
<td>Family Practice (with OB)</td>
<td>926</td>
<td>155</td>
</tr>
<tr>
<td>Family Practice (without OB)</td>
<td>5,524</td>
<td>612</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Providers</th>
<th>Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy/Immunology</td>
<td>84</td>
<td>47</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>1,459</td>
<td>127</td>
</tr>
<tr>
<td>Anesthesiology: Pain Management</td>
<td>73</td>
<td>34</td>
</tr>
<tr>
<td>Anesthesiology: Pediatric</td>
<td>47</td>
<td>3</td>
</tr>
<tr>
<td>Cardiology: Electrophysiology</td>
<td>171</td>
<td>72</td>
</tr>
<tr>
<td>Cardiology: Invasive</td>
<td>339</td>
<td>90</td>
</tr>
<tr>
<td>Cardiology: Invasive-Interventional</td>
<td>456</td>
<td>112</td>
</tr>
<tr>
<td>Cardiology: Noninvasive</td>
<td>455</td>
<td>117</td>
</tr>
<tr>
<td>Critical Care: Intensivist</td>
<td>45</td>
<td>18</td>
</tr>
<tr>
<td>Dentistry</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>Dermatology</td>
<td>159</td>
<td>75</td>
</tr>
<tr>
<td>Dermatology: Dermatopathology</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Dermatology: Mohs Surgery</td>
<td>22</td>
<td>16</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>445</td>
<td>41</td>
</tr>
<tr>
<td>Endocrinology/Metabolism</td>
<td>137</td>
<td>71</td>
</tr>
<tr>
<td>Family Practice (with OB)</td>
<td>407</td>
<td>97</td>
</tr>
<tr>
<td>Family Practice (without OB)</td>
<td>2,297</td>
<td>314</td>
</tr>
</tbody>
</table>

Source: MGMA Physician Compensation and Production Survey, 2010
Challenges – using the MGMA survey

Multiple tables cannot be compared
Examples for Family Practice (without OB)

<table>
<thead>
<tr>
<th>Table</th>
<th>Providers</th>
<th>Practices</th>
<th>Std. Dev.</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1.1: Physician Compensation</td>
<td>5,524</td>
<td>612</td>
<td>$80,445</td>
<td>$183,999</td>
</tr>
<tr>
<td>Table 13.1: Ambulatory Encounters</td>
<td>3,113</td>
<td>364</td>
<td>1,730</td>
<td>4,008</td>
</tr>
<tr>
<td>Table 9.1: Physician Gross Charges (TC/NPP excluded)</td>
<td>3,248</td>
<td>353</td>
<td>$258,894</td>
<td>$595,153</td>
</tr>
<tr>
<td>Table 20.1: Physician Work RVUs</td>
<td>4,179</td>
<td>417</td>
<td>1,734</td>
<td>4,845</td>
</tr>
<tr>
<td>Table 22.1: Physician Compensation to Physician Work RVUs Ratio</td>
<td>4,159</td>
<td>416</td>
<td>$19.86</td>
<td>$39.13</td>
</tr>
</tbody>
</table>

When comparing across tables, the recommendation is to use a percentage of the median as your starting point and apply that percentage to the median in other tables.

Source: Medical Group Management Association, 2010
Recommendations

- Adjust national survey figures to local market conditions
- Adjust to recruitment environment
- When benchmarking and target setting require you to cut across tables, use a percentage of the median as your starting point
Challenges: Setting compensation & productivity levels

Challenges: Selecting incentives
Setting compensation and productivity levels

• Understand marketplace
  – Competition for services
  – Demographics
  – Location of services
  – Demand for services

• Have a general idea of what the physician(s) should be producing
  – Established physician
    ▪ 3 years of historical production
  – Newly recruited physician
    ▪ Survey targets or projected area demand

• Know how the physician will be spending his/her time
Setting compensation and productivity levels

Setting expectations of performance begins with the contract!
Understand how your physicians spend their time.
Be sure to take into consideration the impact of hospital based physicians on outpatient focused physicians!

If you have hospitalists, the amount of time your primary care physicians have in the outpatient setting should increase

<table>
<thead>
<tr>
<th>Internal Medicine</th>
<th>Family Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>36</td>
</tr>
<tr>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>

Physician Hours Per Week

Office  Hosp.  Other Direct  Other Pt. Care  Professional

Source: American Medical Association
Case Studies: setting comp and productivity levels

- **Client A** – sole community provider, community hospital
  - Base targeted at median of MGMA survey
  - Production and incentive metrics were in addition to base
- **Client B** – rural hospital
  - Base was a smaller percentage of total compensation
  - Dollar amounts allocated to base were not “high enough” for physicians’ personal expenditures, so they received “advances” on their productivity pay
- **Difference** – Client A adjusted pay due to missed production targets in the second year of the contract; Client B was able to adjust in current year

❖ **Considerations:**
  - Are you prepared to have a conversation with a physician about an overpayment to him/her which requires a payback to the hospital?
  - Is the base or draw enough so physicians can manage their own personal expenditures?
  - Is the base/draw enough to support recruitment?
Challenges: Surveys
Challenges: Setting compensation & productivity levels
Challenges: Selecting incentives
Selecting incentive metrics

- Examine your list of potential incentive metrics
- Prioritize the list
  - Focus on those where you anticipate having the greatest impact
  - Select ones that are easily measured
  - If some metrics are captured now but not currently included in the compensation structure, start there
- Have a plan on how to collect data on the metrics the group determines should be in the next phase of the compensation structure
Case Studies: prioritizing incentive metrics

When first incorporating incentive metrics in your physicians’ compensation structure, be sure to keep the number of metrics manageable and meaningful.

<table>
<thead>
<tr>
<th>Metric</th>
<th>At Existing Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation Per Work RVU Based Upon Office Visits and Surgical Cases</td>
<td>Year 1: $64.50</td>
</tr>
<tr>
<td></td>
<td>Year 2: $68.50</td>
</tr>
<tr>
<td>25% Per Work RVU Withheld From the Above for Quality Performance Payment (QPP)</td>
<td>$ 16.13 $ 17.13</td>
</tr>
</tbody>
</table>

Allocation of QPP Withhold:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply Utilization</td>
<td>$ 2.30</td>
<td>$ 2.45</td>
</tr>
<tr>
<td>On Time Starts</td>
<td>$ 2.30</td>
<td>$ 2.45</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>$ 2.30</td>
<td>$ 2.45</td>
</tr>
<tr>
<td>Employee Retention</td>
<td>$ 2.30</td>
<td>$ 2.45</td>
</tr>
<tr>
<td>Percentage of Denied Claims</td>
<td>$ 2.30 $ 2.45</td>
<td></td>
</tr>
<tr>
<td>Clinical Outcomes</td>
<td>$ 2.30</td>
<td>$ 2.45</td>
</tr>
<tr>
<td>Leadership</td>
<td>$ 2.30</td>
<td>$ 2.45</td>
</tr>
<tr>
<td>Total Allocation</td>
<td>$ 16.13</td>
<td>$ 17.13</td>
</tr>
<tr>
<td>Total QPP Percentage of Payment Rate</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Case study:

- A large community hospital in urban setting
- Structuring contract model with specialty physician
- Wanted to tie quality and performance metrics to pay
- Listed 7-8 metrics to be included

- Too many measures:
  - Diffuse incentive effort
  - ‘Pools’ are too small
  - Create confusion over how structure works
• Understand the capabilities and the limitations of the systems and processes that you currently have in place
  - Production
    • Be certain that your EMR or encounter forms are properly set up
    • Confirm that your physician charge capture and revenue cycle process are efficient and effective

Case study: a small, PPS hospital with 8-10 employed physicians was switching to a productivity based compensation system but its encounter forms did not reflect all of the procedures that were being performed in the office
  ➢ Hospital was losing out on revenue
  ➢ Physician would lose out on compensation

- Incentives
  • Be certain you can easily measure what will be included in the compensation program

Case study: A critical access hospital wanted to include in its compensation structure metrics on adherence to colon screening recommendations. However, with the organization planning to transition to an EMR, current data gathering would be manual. The organization was not ready to implement this metric.
Data Reporting

- If a metric is included in the compensation structure, measure and report!!
- Providers need to know how they are doing:
  - Productivity
  - Financial performance of the practice
  - Other, non-production measures

Give straightforward and timely feedback on performance

<table>
<thead>
<tr>
<th>2007 Budget</th>
<th>2007 Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Net Collections</td>
<td>$8,263,795</td>
<td>$8,938,587</td>
</tr>
<tr>
<td>Other Income</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Interest Income</td>
<td>212,194</td>
<td>216,283</td>
</tr>
<tr>
<td>Total Income</td>
<td>$8,484,739</td>
<td>$9,165,371</td>
</tr>
</tbody>
</table>

Expenses

- Salaries to Physician Primary: $1,604,302
- Salaries- Other Physicians and Medical Providers: $1,860,934
- Salaries and Wages-Administrative staff: $1,617,387
- Payroll Taxes: $311,868
- Payroll Expense: $12,000
- Purchases-Drugs: $36,000
- Purchases-Supplies: $110,000
- Purchases- Supplies- GI Suite: $210,000

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Transition periods

- Organizations contemplating a significant change in its compensation approach should commit to a transition period

Case study: A large physician group, was transitioning from three different models into one consolidated approach. A template was created and shared with participants so they could see the impact of the new system on their compensation

<table>
<thead>
<tr>
<th></th>
<th>Current Comp.</th>
<th>Base Salary</th>
<th>Call Bonus</th>
<th>Productivity Bonus</th>
<th>Medical Director</th>
<th>Proposed Comp.</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$141,642</td>
<td>$59,880</td>
<td>$9,239</td>
<td>$61,663</td>
<td>$2,101</td>
<td>$132,882</td>
<td>$(8,760)</td>
</tr>
<tr>
<td>B</td>
<td>$148,405</td>
<td>$63,235</td>
<td>$18,478</td>
<td>$64,076</td>
<td></td>
<td>$145,789</td>
<td>$(2,616)</td>
</tr>
<tr>
<td>C</td>
<td>$158,727</td>
<td>$66,749</td>
<td>$21,998</td>
<td>$77,645</td>
<td></td>
<td>$166,392</td>
<td>7,665</td>
</tr>
<tr>
<td>D</td>
<td>$109,030</td>
<td>$45,965</td>
<td>$21,998</td>
<td>$41,556</td>
<td>$2,101</td>
<td>$111,620</td>
<td>2,590</td>
</tr>
<tr>
<td>E</td>
<td>$69,758</td>
<td>$36,560</td>
<td>$21,998</td>
<td>$5,372</td>
<td>$2,101</td>
<td>$66,031</td>
<td>$(3,727)</td>
</tr>
<tr>
<td>F</td>
<td>$82,270</td>
<td>$35,404</td>
<td>$29,389</td>
<td>$26,689</td>
<td>$2,101</td>
<td>$93,582</td>
<td>11,313</td>
</tr>
<tr>
<td>G</td>
<td>$75,000</td>
<td>$59,800</td>
<td>$9,239</td>
<td>$528</td>
<td></td>
<td>$69,567</td>
<td>$(5,433)</td>
</tr>
<tr>
<td>H</td>
<td>$107,182</td>
<td>$57,229</td>
<td>$29,389</td>
<td>$24,247</td>
<td></td>
<td>$110,865</td>
<td>3,683</td>
</tr>
<tr>
<td>I</td>
<td>$59,800</td>
<td>$42,873</td>
<td>$8,444</td>
<td>$2,999</td>
<td>$2,101</td>
<td>$56,417</td>
<td>$(3,383)</td>
</tr>
<tr>
<td>J</td>
<td>$98,500</td>
<td>$57,461</td>
<td>$29,389</td>
<td>$10,318</td>
<td></td>
<td>$97,169</td>
<td>$(1,331)</td>
</tr>
<tr>
<td>Total</td>
<td>$1,050,313</td>
<td>$525,157</td>
<td>$199,560</td>
<td>$315,094</td>
<td>$10,503</td>
<td>$1,050,313</td>
<td>-</td>
</tr>
</tbody>
</table>
• Complexity of structure will be driven by culture of organization but groups should keep the compensation plan simple, straightforward, and transparent
• Standardize contracts when possible
• Engage the physicians in developing the compensation structure
• For every incentive concept, there must be a valid method of measuring performance
  – Measurement systems need to stay one step ahead of compensation incentives
• A well-designed formula implemented poorly is just as sure to fail as a poorly designed formula
• Compensation systems are dynamic. They must change as the group values change, as the market evolves, and as feedback capabilities are refined.
What’s next in compensation structures...

- Increasing use of mid-level providers and team-based care
- Establishing methodologies to distribute funds earned through bundled payments, value based payments, and shared savings programs
5 key parting concepts

- **Align** compensation system with the strategic goals of the organization.
  - Begin to incorporate incentive metrics including quality and satisfaction metrics.

- **Engage** physicians in the process of designing the system.

- **Accept** that there is no perfect compensation system and that regardless of what is designed there will be ‘gaming’ and unintended consequences.
  - Keep the structure as simple and straightforward as possible

- **Measure and report data**

- **Monitor**, continuously, the system and be prepared to revisit it on an annual basis to realign and adjust.
Questions
Contact for more information:

Stroudwater Associates
50 Sewall Street, Suite 102
Portland, Maine 04102

Susan Stowell
Principal
Hospital-Physician Alignment, Practice Leader
207.221.8263
sstowell@stroudwater.com
Ms. Stowell joined Stroudwater Associates in 2002. Her professional focus is hospital-physician relations, facilities planning, and medical staff planning. She has experience working with physician practices as well as hospitals of all sizes ranging from critical access hospitals to academic medical centers.

Susan's recent work has included the development and implementation of the Community Service Plan, a deferred compensation plan for ED Call, at a large community hospital; hospital employment offers and arrangements for physicians; assessment of physician practices for process improvement purposes and sales; Strategic Master Facility Planning for a number of different clients including two academic medical centers in the South Atlantic area and a large community hospital in the south; and affiliations, acquisitions, joint ventures, and divestitures work with acute care hospitals and long-term care facilities in several regions of the United States.