Physician Compensation: The Solution Is in the Process

HFMA Gulf Coast Luncheon Meeting

June 17, 2016
Agenda

Why Are We Here?

Key Discussion Points

» What key industry trends are currently affecting physician compensation dynamics across the industry?
» What is the “best” approach or solution to physician compensation in the new healthcare landscape?
» How can organizations change physician compensation to mirror the value-based provider model?
» What related issues should progressive organizations be thinking about?

Meeting Agenda

I. Introduction
II. Audience Poll
III. Key Market Trends
IV. Process Considerations
V. Aspirational Plan Characteristics
VI. Q&A

 Desired Outcomes for Participants

» Gain critical national survey insights on provider performance market trends, including compensation, production, and benefits.
» Understand emerging compensation plans that mirror value-based reimbursement strategies.
» Apply learnings and processes for designing compensation plans in the context of the value-based world.
For more than 40 years, ECG’s mission has been to provide exceptional management consulting services exclusively to healthcare clients.

» ECG is a national consulting firm focused on offering strategic, management, and financial advice to healthcare providers.

» We are particularly known for our expertise in strategy, hospital/physician relationships, business planning, and program development.

» We focus on creating customized, implementable solutions to meet our clients’ specific challenges in both community-based and academic settings.

» We have approximately 200 consultants nationwide.
I. Introduction
Our Compensation Planning Qualifications

Since 2000, we have worked with more than 300 clients on 500-plus projects related to provider compensation planning.

» In addition, physician compensation issues are at the forefront of all the hospital/physician transactions we lead, which means we address physician compensation issues in the context of nearly every project.

» For more than 15 years, we have conducted proprietary compensation and production surveys, notably our annual National Provider Compensation Survey.

» ECG maintains a robust valuation practice, which helps ensure compensation planning approaches are aligned with evolving fair market value and commercial reasonable principles.
We believe that provider compensation plans are an expression of an organization’s culture and values.

We do not believe there is a single “best” compensation formula.

Creating a plan that fits the environment and culture in which you operate is the most critical component to achieving buy-in and using the compensation plan to support your other business objectives.

Because of this, we believe that the planning process is as important as the eventual compensation philosophy and plan elements.
At its best, compensation is a strategic enabler of an organization’s mission, vision, and values. At its worst, it can present significant cultural, economic, and legal risks.
II. Audience Poll
Why Are You Here?

Which of the following best describes you?

- I routinely deal with physician compensation issues as part of my job responsibilities.
- I occasionally deal with physician compensation issues.
- I never deal with physician compensated issues but would like to keep abreast of industry trends.

Is anyone currently in the middle of (or considering starting) a compensation redesign process?
ECG’s national compensation, production, and benefits surveys include over 110 premier provider organizations from across the country, encompassing data from more than 32,000 providers.

Select List of 2015 Members

- Baylor College of Medicine
- Beaumont Health
- Physician Partners/Beaumont Medical Group
- Carle Physician Group
- Catholic Health Initiatives
- DuPage Medical Group
- The Everett Clinic
- Group Health Permanente
- HCA Healthcare
- The Iowa Clinic
- Memorial Health System
- Northwest Permanente
- Palo Alto Medical Foundation
- PeaceHealth Medical Group
- Providence Medical Group
- Scott & White Clinic
- SIU HealthCare
- Springfield Clinic
- Straub Clinic & Hospital
- Sutter Pacific Medical Foundation
- UnityPoint Clinic
- University of Rochester Medical Center
- University of Wisconsin Medical Foundation
- Vanderbilt University Medical Center
- Wake Forest Baptist Health
- Warren Clinic
The majority of physicians are compensated under variable-based compensation plans; however, we have seen a reduction in the variable component of compensation across the board.

The data above is likely a reflection of many factors, including the on-boarding of new physicians with a base salary component and the accelerating employment of hospital-based specialists.
III. Key Market Trends
Utilization of Nonproductivity Incentives Increasing

WRVUs remain the most common measure within incentive plans, and quality is also measured by more than half of the survey members. Additionally, incentivizing patient satisfaction is becoming prevalent within physician compensation plans.

**Compensation Plan Key Performance Indicators**

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Percentage of Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td>WRVUs</td>
<td>76%</td>
</tr>
<tr>
<td>Quality</td>
<td>27%</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>20%</td>
</tr>
<tr>
<td>Provider Profitability</td>
<td>14%</td>
</tr>
<tr>
<td>Net Professional Collections</td>
<td>24%</td>
</tr>
<tr>
<td>Organization Profitability</td>
<td>14%</td>
</tr>
<tr>
<td>Panel Size</td>
<td>N/A</td>
</tr>
</tbody>
</table>

PCPs earned 6.3% of total compensation from quality incentives in 2015, while specialists, as a whole, earned 6.5% for quality incentives. Quality compensation is gaining traction within compensation plans, but at a slow pace.

### Quality Compensation by Specialty Category

<table>
<thead>
<tr>
<th>Specialty Category</th>
<th>Percentage of Total Compensation Dependent on Quality (Average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCPs</td>
<td>6.3%</td>
</tr>
<tr>
<td>Medical Physicians</td>
<td>6.7%</td>
</tr>
<tr>
<td>Surgical Physicians</td>
<td>6.9%</td>
</tr>
<tr>
<td>Hospital-Based Physicians</td>
<td>6.0%</td>
</tr>
<tr>
<td>APCs</td>
<td>4.9%</td>
</tr>
</tbody>
</table>


^1 Average represents organizations that utilize the indicator within their compensation plan.
II. Key Market Trends

Disconnect Between Compensation and WRVU Production

III. Disconnect Between Compensation and WRVU Production

Healthcare systems employing physicians are discovering a widening disconnect between compensation and fundamental practice economics.

III. Key Market Trends
Reimbursement Trends — At-Risk Revenue

While more organizations are entering into risk-based contracting arrangements, nearly 80% still have less than 10% of their gross revenue at risk.

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**Percentage of Gross Revenue at Risk**

<table>
<thead>
<tr>
<th>Percentage of Organizations</th>
<th>Percentage of Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013</td>
</tr>
<tr>
<td>&lt;10% of Revenue at Risk</td>
<td>79%</td>
</tr>
<tr>
<td>10% to 25% at Risk</td>
<td>15%</td>
</tr>
<tr>
<td>26% to 50% at Risk</td>
<td>6%</td>
</tr>
<tr>
<td>&gt;50% at Risk</td>
<td>0%</td>
</tr>
</tbody>
</table>


The trend toward more revenue being generated from risk-based contracting arrangements is likely to continue with new CMS mandates.
Higher provider compensation and lower production, coupled with downward pressure on reimbursement, have resulted in significant investments for health system-sponsored organizations in the physician enterprise over the last 6 years.

**Integrated Health System Investment/(Loss) Per Physician**

<table>
<thead>
<tr>
<th>Year</th>
<th>Investment Per Physician</th>
<th>Percentage of Net Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>$(138,724)</td>
<td>-29.7%</td>
</tr>
<tr>
<td>2011</td>
<td>$(148,791)</td>
<td>-33.2%</td>
</tr>
<tr>
<td>2012</td>
<td>$(148,025)</td>
<td>-28.3%</td>
</tr>
<tr>
<td>2013</td>
<td>$(181,407)</td>
<td>-28.3%</td>
</tr>
<tr>
<td>2014</td>
<td>$(181,963)</td>
<td>-34.2%</td>
</tr>
<tr>
<td>2015</td>
<td>$(194,266)</td>
<td>-31.5%</td>
</tr>
</tbody>
</table>

We believe successful compensation redesign initiatives are a factor of both process and product.
IV. Process Considerations
Our Typical Planning Approach

**Phase I**
*Assessment and Design Criteria*

- Internal Assessment
- Market Analysis

**Phase II**
*Conceptual Design and Refinement*

- Design Compensation Elements and Mechanisms
  - Overarching Framework
  - Application to Specialty Areas
  - Plan Features and Elements
  - Value-Based Components
- Financial Analysis and Model Refinement

**Phase III**
*Implementation Planning*

- Transition Method and Length
- Infrastructure Requirements
- Governance and Management
- Provider Communication Plan

**Deliverables**

**Phase I**
- Quantitative and Qualitative Assessment Findings
  - Benchmarking Analysis
  - Physician Survey
  - Stakeholder Interviews
- Defined Compensation Philosophy and Principles

**Phase II**
- Physician Compensation Framework
- Financial Modeling Results

**Phase III**
- Management Tools and Processes
- Provider Communication Strategy
- Policy and Procedure Manual
- Transition Plan

**Timeframes**

- **Phase I**: 45 to 90 Days
- **Phase II**: 2 to 4-Plus Months
- **Phase III**: 2 to 3 Months
IV. Process Considerations
Group Development

A successful compensation redesign process should consider a group’s current and aspirational positioning along the following structural continuum:

FEDERATED

INTEGRATED

MULTISPECIALTY

LIMITED CENTRAL GOVERNANCE AND MANAGEMENT

STRONG CENTRAL GOVERNANCE AND MANAGEMENT

COMMON GOVERNANCE, MANAGEMENT, AND FINANCES

How would you characterize the current positioning of your organization?
## IV. Process Considerations

### Typical Work Structures

#### STEERING COMMITTEE

**Typical Composition:** Senior Leadership, Legal, Physician Champions

- Ensures appropriate representation from key stakeholders across the organization
- Approves work group recommendations and associated deliverables
- Provides guidance to work group regarding aspirational plan characteristics
- Drives accountability toward timely completion of project tasks
- Liaises with other governing/approval bodies

**Estimated Meeting Frequency:** Monthly

#### SMALL WORK GROUP

**Typical Composition:** VPs/Directors, Physicians, Project Management

- Creates the project work plan and timeline
- Engages with frontline physicians, managers, and staff as necessary
- Iterates requisite quantitative analyses and associated deliverables
- Formulates initial design recommendations based upon guidance from steering committee
- Identifies potential risks and critical success factors for steering committee review

**Estimated Meeting Frequency:** Biweekly
When selecting project participants, we recommend including a diverse set of physician voices, such as:

» High producers.
» Primary care representative(s).
» Medicine representative(s).
» Surgical representative(s).
» Coverage-based representative(s).
» Part-time physicians.

Active physician participation and leadership is critical to a successful redesign process.
Advanced analytics help ensure data-driven decision making and are an essential ingredient in effective compensation redesign.

Impact: System Wide

<table>
<thead>
<tr>
<th></th>
<th>Current State</th>
<th>Straw Model #2</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total FTEs</td>
<td>58.0</td>
<td>58.0</td>
<td>-</td>
<td>0%</td>
</tr>
<tr>
<td>Total WRVUs</td>
<td>332,437</td>
<td>332,437</td>
<td>-</td>
<td>0%</td>
</tr>
<tr>
<td>WRVUs Per FTE</td>
<td>5,735</td>
<td>5,735</td>
<td>-</td>
<td>0%</td>
</tr>
<tr>
<td>Average WRVU Percentile Rank</td>
<td>52</td>
<td>52</td>
<td>-</td>
<td>0%</td>
</tr>
<tr>
<td>Total Clinical Compensation</td>
<td>$16,311,724</td>
<td>$16,987,411</td>
<td>$675,687</td>
<td>4%</td>
</tr>
<tr>
<td>Compensation Per FTE</td>
<td>$281,397</td>
<td>$293,053</td>
<td>$11,656</td>
<td>4%</td>
</tr>
<tr>
<td>Average Percentile Rank</td>
<td>53</td>
<td>57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians Increased</td>
<td>37</td>
<td>37</td>
<td>23.2%</td>
<td></td>
</tr>
<tr>
<td>Physicians Decreased</td>
<td>24</td>
<td>24</td>
<td>-17.2%</td>
<td></td>
</tr>
</tbody>
</table>
IV. Process Considerations
Pre-Implementation Planning

Pre-Implementation Checklist

- Transition Mechanism and Length
- Infrastructure Requirements
- Governance and Management Processes
- Plan Document
- Market Data
- Provider Communication Plan
V. Aspirational Plan Characteristics

Overview

PERFORMANCE-DRIVEN
Compensation levels should be commensurate with a provider’s work efforts and holistic performance.

TRANSPARENT
Compensation mechanisms should be easily understood, with clear rules for adjudicating exceptions.

COMPREHENSIVE
Plan elements should be inclusive of all relevant mission areas ("CARTS"): Clinical, Administrative, Research, Teaching, and Strategic.

PATIENT-CENTERED
Plan incentives should align with the Triple Aim goals of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of healthcare.

FLEXIBLE
Compensation mechanisms should be sufficiently flexible to accommodate different specialty types (e.g., primary care, medical/surgical specialists, coverage-based specialists, etc.) and diverse work environments.

SUSTAINABLE
Compensation levels should be affordable and aligned with the organization’s fundamental practice economics.
Increasingly, organizations are seeking to remove financial disincentives that may impede their ability to deliver patient-centered care.

1. **Cardiology Example**
   A cardiology practice pooled WRVUs in order to maintain appropriate levels of patient access to noninvasive services.

2. **Gastroenterology Example**
   A gastroenterology practice pooled compensation in order to increase access to chronic disease management services (IBD, Crohn’s, etc.).

3. **OB/GYN Example**
   An OB/GYN group pooled WRVUs for its laborist shifts; this helped contribute to a 20% reduction in elective inductions compared to an individualized approach.

4. **Primary Care Example**
   A primary care practice funded incentive pools based on group-wide productivity (geographic areas); this helped balance patient loads between/within practice sites and increase access to care.

5. **Multispecialty Example**
   A multispecialty practice migrated away from a revenue-minus-expense plan to a payor-neutral WRVU approach; this significantly increased access for Medicare/Medicaid patients.
The intrinsic variability between different specialty types and work environments typically precludes a “one size fits all” approach to compensation.

Enterprise Standard: No plan specialization

Specialty Groupings:
Plans based on the categorization of specialties, such as the examples provided above

Specialty-Specific Plans

Primary Care
Medical Specialists
Surgical Specialists
Coverage-Based Specialists

Specialty A
Specialty B
Specialty C
Specialty D
Specialty E
Specialty F
Specialty G
Specialty H

Physician-Specific Plans
In an effort to increase plan consistencies, many organizations are framing core clinical compensation elements in terms of broader specialty groupings.

- PRIMARY CARE
- MEDICAL OR OFFICE-BASED SPECIALTIES
- COVERAGE-BASED SPECIALTIES
- SURGICAL OR PROCEDURAL-BASED SPECIALTIES
V. Aspirational Plan Characteristics

Sustainability

A confluence of factors have significantly increased demand within the physician labor market and contributed to a “whatever it takes” approach to compensation.

Bidding wars have prevailed at both local and national levels. This is especially true in certain high-demand specialties (e.g., primary care).

Salary guarantees for new recruits are often significantly higher than the average earnings for existing physicians.

Many organizations are paying exclusively from market benchmarks, regardless of their underlying group financials.

Highly fixed compensation plans continue to increase in prevalence across the industry.

Progressive organizations are beginning to incorporate “economic adjustment factors” in order to maintain long-range affordability.
V. Aspirational Plan Characteristics
Sustainability (continued)

A “hybrid” market definition may help physician organizations keep in touch with the realities of their group’s underlying economic performance.

- In this approach, the amount allocated to physician compensation is based entirely on the financial performance of the system.
- This approach may be applied at the group, specialty/site, or individual level.
- The hybrid approach involves the use of external market benchmarks and an economic adjustment factor.
- Raw market benchmarks are adjusted using a transparent formula that ties to group economics.
- With the market survey approach, the amount allocated to physician compensation is tied directly to external surveys.
- Potential survey sources include MGMA; AMGA; ECG; Sullivan, Cotter and Associates; and specialty-specific sources (e.g., AAARAD, AAAP).
In response to changing market dynamics, some organizations have begun to employ a more progressive payment structure that segments compensation elements by mission area.

**Total Compensation**
A lack of transparency and predictability is the most common complaint among physicians who are surveyed as part of our compensation engagements.

1. **Base/Fixed Salary**
   - Specialty-Specific Benchmark × Clinical FTE Status

2. **Panel Size Incentive**
   - Number of Attributed Risk-Adjusted Patients × Panel Size Payment Rate × Value-Based Modifier

3. **WRVU Incentive**
   - Number of Personally Performed WRVUs Above Performance Threshold × WRVU Payment Rate × Value-Based Modifier

4. **Value Incentive**
   - Value-Based Performance × Value-Based Funding

5. **APC Supervisory Stipend**
   - APC Supervisory Stipend × Attributed APC FTEs
The use of explicit employment obligations and physician compacts supports a performance-driven culture, even as base/fixed salary levels continue to increase.

**Example Employment Obligations (Primary Care)**

<table>
<thead>
<tr>
<th><strong>ACCESS REQUIREMENTS</strong></th>
<th><strong>WEEKS WORKED PER YEAR</strong></th>
<th><strong>CLINIC HOURS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians will maintain a defined number of open slots daily for new patients.</td>
<td>Physicians will work a minimum of 47 weeks per year.</td>
<td>PCPs will work either 9 sessions (if they follow patients in the hospital) or 10 sessions (if they use hospitalists) each week.</td>
</tr>
</tbody>
</table>

**NOTE:** One session = 4 clinic hours.

- Physicians will complete their charts within 48 hours of the patient encounter.
- Physicians will attend a minimum of 75% of group and system professional staff and department meetings.
- Physicians will meet a specialty-specific level of WRVU production. This includes a minimum threshold (e.g., median).
VI. Questions and Discussion

Questions & Discussion

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