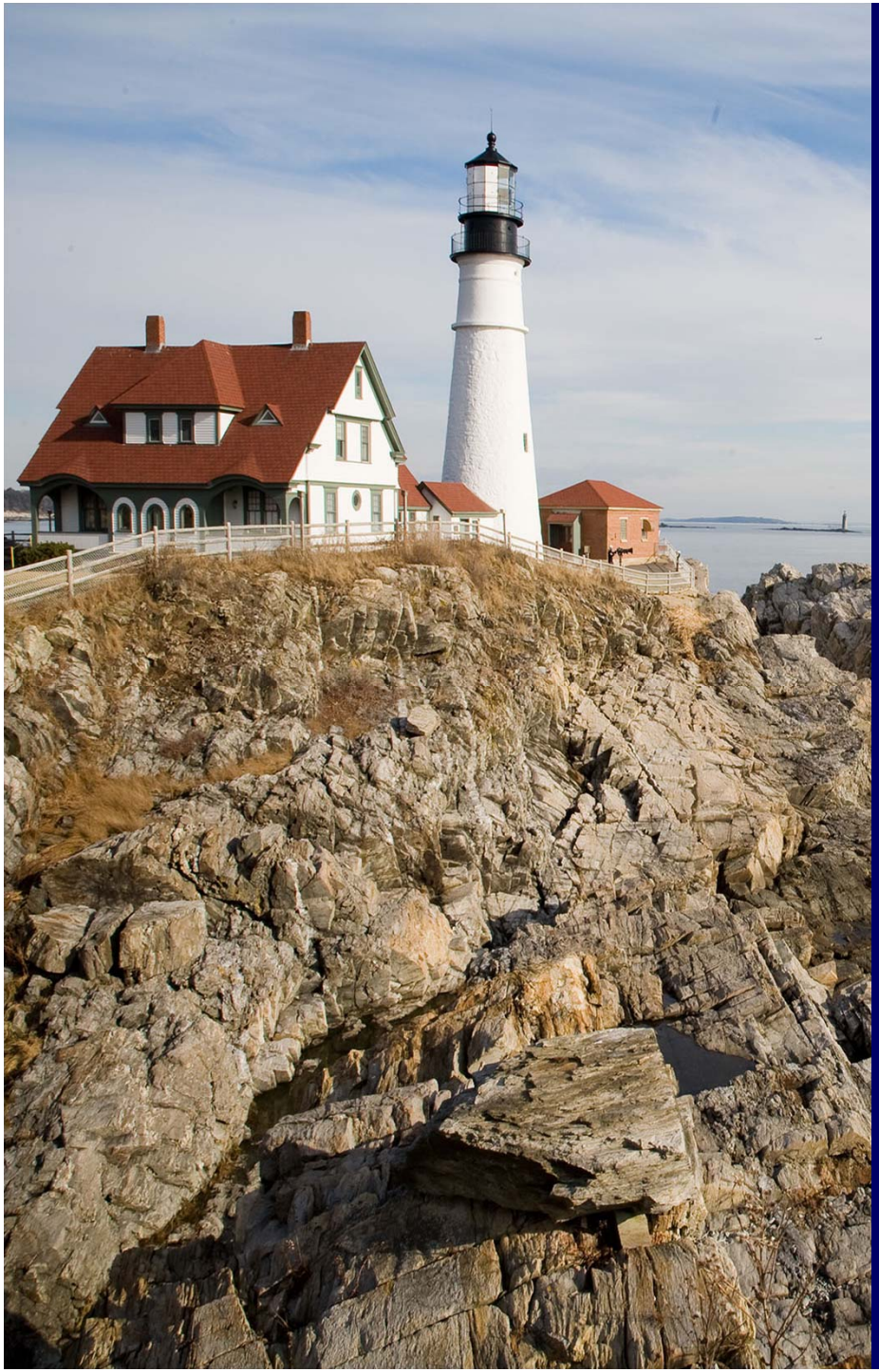

Designing and Implementing Compensation Systems for Employed Physicians:

Compensating today's work while preparing for the future

April 14, 2011

STROUDWATER ASSOCIATES

Meeting Agenda

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- Health reform impact on compensation
- The process
- Linking to strategy
- Design and Implementation
  - Structures
  - Design principles
  - Challenges
- Questions

Health Reform

Compensation under health reform

- Health reform is encouraging tighter alignment between hospitals and physicians
  - The shared savings program requires that participating providers meet 65 different quality and performance metrics
  - These initiatives will force hospitals and physicians to re-examine their approach to compensation
- Even before the Patient Protection and Affordable Care Act (PPACA) was passed into law, payment programs[1] were emphasizing the importance of quality and performance in reimbursement
- In order to drive the relevance to the physician level, new compensation models will likely:
  - Reduce the portion of compensation that is tied directly to production
  - Increase the portion of compensation tied to performance metrics around quality, patient satisfaction, and team based care

1 – Examples include Physician Quality Reporting System and EHR meaningful use

The process

Compensation plan design process

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- An organization's history, experience, and physician complement will drive the compensation design process
- It is important to engage the physicians in the design process at some level
- Organizations that are just starting to employ physicians may chose to engage the physicians at a later point in the structure discussion
- For organizations that are transitioning to a new compensation structure, a committee should be formed to lead the redesign
  - Hospital administration
  - Physicians
    - Cross section of physicians representing different demographics
  - Outside support (legal counsel, consultants)

Compensation plan design process

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- 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)
    - History of approaches used
    - Benchmark historical performance
  - Determine most appropriate approach for the organization
    - Define components
    - Establish measurement system (if not already in place)
    - Create scorecard and feedback mechanism (if not already in place)

Compensation plan design process

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- Process *continued*
  - Develop a transition plan to move physicians from old system to new
  - Establish an ongoing oversight committee or process
    - Addresses questions or issues as they arise
    - Maintains log of issues for future use in compensation plan design
    - Reviews and provides scorecards to physicians

Case studies

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- Client A: 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
- Client B: 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
- Client C: Large, independent primary care group
  - Over 75 physicians and mid-level providers
  - Changing compensation methodology
  - Established a committee including practice administration and physicians

Linking to strategy

Aligning compensation with system goals

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- It is critical to link components of the compensation system to the goals of the organization
  - Helps physicians understand how their actions will move the organization towards stated goals
- For example:
  - Quality metrics are becoming increasingly important as reimbursement methodologies change and organizations drive to become ACOs
  - One dimension 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 to revamp 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.

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.

Design and Implementation

Structures

Structures

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	Approach	Pros	Cons	When to use
1	Straight salary	Team oriented approach	No incentive to produce	Hospitals with service areas that cannot support a FT provider. When physicians are in “start-up” phase
2	Salary plus incentive	Opportunity to add incentive on quality, production	Adds some complexity to administration of compensation	When physicians want a draw and employer wants an incentive piece
3	Set compensation per Work RVU generated	Purely production driven	No opportunity to include additional incentive metrics	Organization’s strategic goal to drive volume through a particular program Ample market for physicians to meet their own compensation goals

Source: Johnson, Bruce and Deborah Walker Keegan, Physician Compensation Plans, MGMA, 2006, pages 401 - 478.

Structures

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	Approach	Pros	Cons	When to use
4	Percentage based. Physicians paid on set percentage of charges or collections	Relatively simple Allows for focus on production	Depending on methodology, payer mix can have significant impact on physicians' pay Does not consider costs	Can be used during transition period of bringing physicians into employment
5	Graduated compensation per Work RVU	More closely mimics financial realities of practice Can accommodate part-time physicians	Adds some complexity to administration of compensation Does not consider costs Requires significant education	Effective approach when a number of part- and reduced-time physicians are involved
6	Hourly pay for professional services	Simple and straightforward	In pure form, no inclusion of additional incentive metrics	Medical directorships Call coverage services Distinct service periods or shifts

Source: Johnson, Bruce and Deborah Walker Keegan, Physician Compensation Plans, MGMA, 2006, pages 401 - 478.

Structures

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- Many organizations combine the different approaches into one compensation structure
  - Component A: Salary or draw
  - Component B: Productivity payment
  - Component C: Incentive pay using metrics around quality, patient satisfaction, and financial management

Base salary or draw

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- Most organizations include a base salary
  - Decision is around level at which to set the base
  - Some hospitals use a minimal base and add a draw which means more is at risk for the physician

Production

- Measures like collections and gross charges have been used to measure productivity
- Most organizations are selecting work RVUs as the measurement system of choice
  - Work RVUs: relative level of time, skill, training and intensity to provide a given service

GROSS CHARGES

- Timing is better
- Physicians understand
- Less suspicion from physicians
- When revenues decline-formulas are harder to change
- Difficulty in adjusting formulas when charges increased
- System can be "gamed" by billing for services that are not reimbursed.
- Payer neutral

CASH COLLECTIONS

- Less chance for hospital losing money
- Creates more antagonism
- Suspicious of collection effort as out of physician control
- Unfair to physicians who happen to have a poor payer mix
- Timing issues

WORK RVUS

- Physicians don't understand as readily and many still do not trust
- Requires more administrative oversight
- Is payer neutral but pays same rate regardless of productivity
- Doesn't consider practice expense
- Although concept of WRVU often misunderstood, still capable of being used for uncomplicated plans

Incentives

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- Incentive compensation, as a percentage of the total, is growing
  - Quality
    - Health outcome metrics
    - Cost of care metrics
  - Patient satisfaction
  - Financial measures
    - Group profit
    - "Per provider" expense management
  - Team based care
    - Patient's preparation to manage own health
    - Meeting care guidelines

Be prepared: discussions around quality, patient satisfaction, and financial measures will move towards conversations about practice patterns and practice styles. Many initiatives in healthcare today require a significant change in the way many physicians were trained and have practiced medicine. They will need support through these changes…

Challenges

Surveys

Challenges – using the surveys

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- 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

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Example of self selection

Table 1.1 Physician Compensation (More Than 1 Year ... Specialty ... Physicians

Specialty	Providers	Practices	Mean	Std. Dev.	10th % tile	20th % tile	30th % tile
Allergy/Immunology	159	80	$312,268	$141,606	$165,694	$204,669	$228,800
Anesthesiology	3,259	166	$419,596	$128,983	$254,298	$315,200	$355,297
Anesthesiology: Pain Management	164	54	$488,836	$213,909	$301,486	$369,079	$387,128
Anesthesiology: Pediatric	55	6	$498,376	$151,103	$292,768	$394,601	$422,088
Cardiology: Electrophysiology	246	104	$522,984	$189,263	$316,476	$355,890	$407,663
Cardiology: Invasive	503	133	$491,291	$200,880	$273,476	$333,724	$379,616
Cardiology: Invasive-Interventional	669	150	$537,624	$220,555	$307,478	$365,178	$413,681
Cardiology: Noninvasive	733	160	$435,267	$187,285	$223,523	$281,956	$325,533
Critical Care: Intensivist	85	30	$299,043	$108,636	$189,720	$220,368	$243,315
Dentistry	72	16	$190,860	$61,123	$117,726	$131,769	$148,572
Dermatology	312	124	$437,157	$207,895	$210,616	$270,217	$303,791
Dermatology: Mohs Surgery	34	26	$674,454	$246,705	$407,651	$444,200	$499,949
Emergency Medicine	928	73	$280,260	$90,749	$175,797	$211,071	$234,019
Endocrinology/Metabolism	339	154	$224,580	$87,554	$141,400	$164,365	$182,985
Family Practice (with OB)	926	155	$217,089	$74,567	$139,987	$159,707	$174,460
Family Practice (without OB)	5,524	612	$201,512	$80,445	$124,605	$144,344	$158,396
Family Practice: Amb Only (No Inpatient Work)	471	66	$185,455	$61,383	$119,688	$137,952	$152,629
Family Practice: Sports Medicine	71	38	$252,636	$134,502	$146,666	$166,135	$183,136
Gastroenterology	936	209	$496,139	$236,292	$252,013	$322,995	$363,102
Gastroenterology: Hepatology	12	8	$287,529	$78,134	$214,835	$218,000	$229,032
Genetics	11	8	$161,240	$38,441	$103,452	$115,982	$138,350
Geriatrics	95	46	$194,634	$63,186	$128,735	$147,037	$154,041
Hematology/Oncology	608	142	$433,745	$225,896	$210,461	$262,753	$296,253
Hematology/Oncology: Oncology (Only)	63	25	$368,881	$145,767	$182,000	$209,611	$284,366
Hospice/Palliative Care	31	13	$174,531	$40,771	$123,572	$136,474	$156,466
Hospitalist: Family Practice	116	50	$219,930	$44,934	$161,844	$185,075	$201,095
Hospitalist: Internal Medicine	3,140	390	$225,544	$68,320	$163,843	$180,101	$193,086
Hospitalist: IM-Pediatric	38	18	$194,994	$60,378	$119,916	$158,315	$178,500
Hospitalist: Pediatric	156	37	$168,605	$48,029	$120,000	$130,524	$146,394
Infectious Disease	197	86	$221,358	$82,864	$133,648	$162,908	$177,791
Internal Medicine: General	3,868	456	$214,906	$83,982	$134,289	$153,534	$169,005
Internal Medicine: Amb Only (No Inpatient Work	246	36	$212,365	$66,070	$140,262	$155,946	$170,668
Internal Med: Pediatric	135	47	$220,884	$84,630	$140,093	$155,402	$167,830

# of physicians in U.S.

9,000 →

110,000

Source: MGMA Physician Compensation and Production Survey

Interpreting MGMA Tables

Caution:
Watch the sample size when "slicing" the data

Table 1.1 Physician Compensation (More Than 1 Year in Specialty) All

Specialty	Providers	Practices
Allergy/Immunology	159	80
Anesthesiology	3,259	166
Anesthesiology: Pain Management	164	54
Anesthesiology: Pediatric	55	6
Cardiology: Electrophysiology	246	104
Cardiology: Invasive	503	133
Cardiology: Invasive-Interventional	669	150
Cardiology: Noninvasive	733	160
Critical Care: Intensivist	85	30
Dentistry	72	16
Dermatology	312	124
Dermatology: Mohs Surgery	34	26
Emergency Medicine	928	73
Endocrinology/Metabolism	339	154
Family Practice (with OB)	926	155
Family Practice (without OB)	5,524	612

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

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

Source: MGMA Physician Compensation and Production Survey, 2010

Challenges – using the MGMA survey

Multiple tables cannot be compared

Examples for Family Practice (without OB)

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

Tables do not necessarily include the same respondents

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

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- 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 levels and targets

Setting compensation and productivity levels

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- 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

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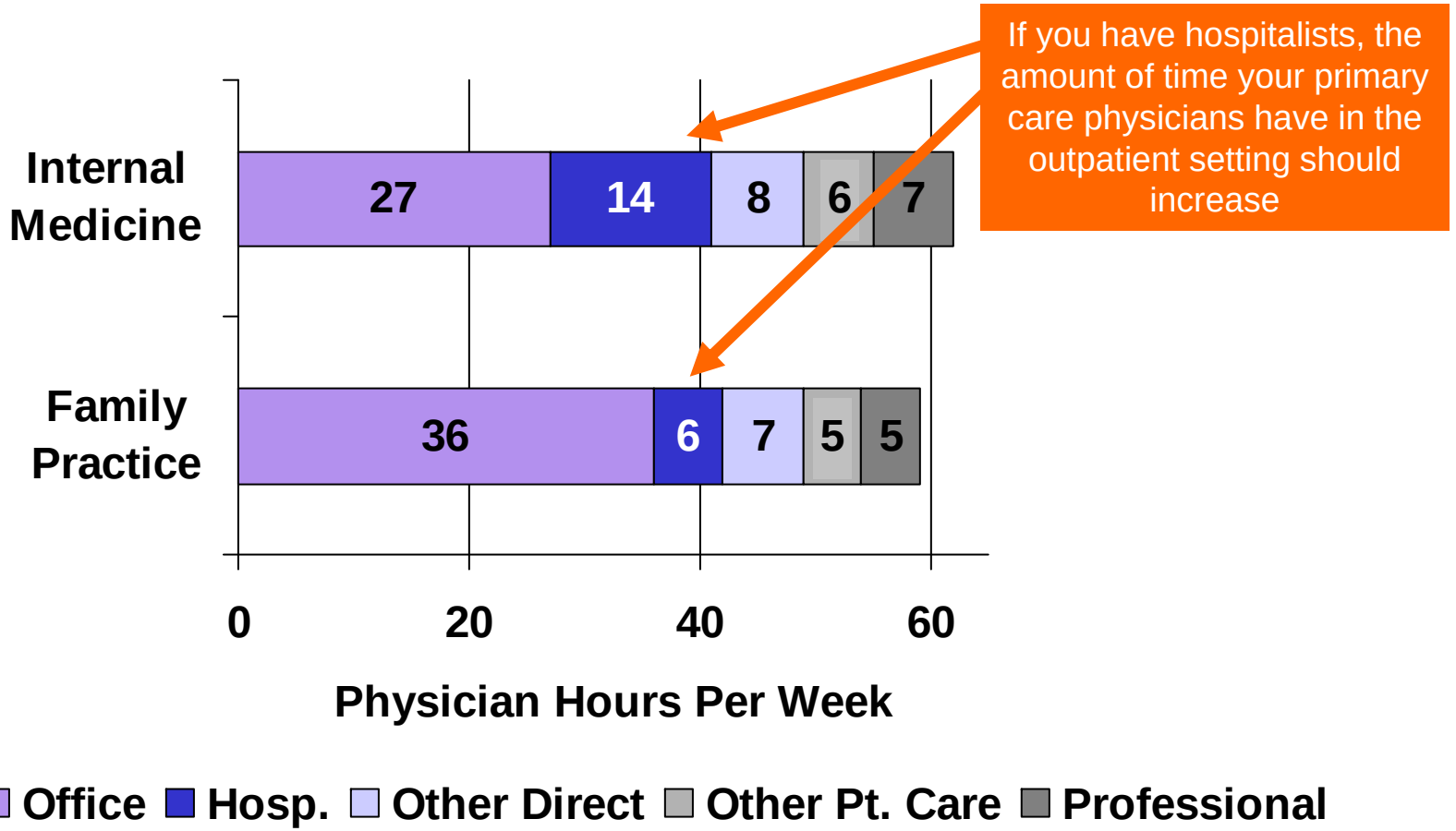
Setting expectations of performance begins with the contract!
Understand how your physicians spend their time.
Be sure to take into consideration the impact of hospital based physicians on outpatient focused physicians!



Source: American Medical Association

Case Studies: setting compensation levels

- Client A – sole community provider, community hospital
  - Base targeted at median of MGMA survey
  - Production and incentive metrics were in addition to
- 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?

Case Studies: setting productivity targets

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- Client A
  - Production target (work RVUs) set at median of MGMA survey
  - Any excess work RVUs produced are compensated based on the excess multiplied by a conversion factor
- Client B
  - Targets (work RVUs) were adjusted based on historical performance and market conditions
  - Targets were easier to hit
- Difference – client A had stretch goals that were not "guaranteed" while client B's targets were much easier to reach

❖ Considerations:
  - Are you prepared to measure production?
  - Would you rather pay on real production or an estimate?

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

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

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

Metric	At Existing Volume Year 1	Year 2
Compensation Per Work RVU Based Upon Office Visits and Surgical Cases	$64.50	$68.50
25% Per Work RVU Withheld From the Above for Quality Performance Payment (QPP)	$ 16.13	$ 17.13
Allocation of QPP Withhold:		
Supply Utilization	$ 2.30	$ 2.45
On Time Starts	$ 2.30	$ 2.45
Patient Satisfaction	$ 2.30	$ 2.45
Employee Retention	$ 2.30	$ 2.45
Percentage of Denied Claims	$ 2.30	$ 2.45
Clinical Outcomes	$ 2.30	$ 2.45
Leadership	$ 2.30	$ 2.45
Total Allocation	$ 16.13	$ 17.13
Total QPP Percentage of Payment Rate	25%	25%

- Too many measures:
  - Diffuse incentive effort
  - 'Pools' are too small
  - Create confusion over how structure works

Case Studies: picking incentive metrics

- Client A
  - New employment arrangement (little historical data)
  - Wanted to engage physicians around financial performance of the practice
  - Worked together to establish budgets for the practices
  - Rewarded tight management of provider-influenced expenses
- Client B
  - Had a long history measuring patient satisfaction
  - Focused on one question within the survey that highlighted an area of concern for the practices
  - Set dollar amount per level of performance attained
- Difference – client B had historic information that could be used to set stretch but attainable goals

❖ Considerations:

- What data is available?
- How much of the outcome on a particular metric is within the physician's control?
- Are you prepared to support and improve systems to minimize the "noise"?

Case studies: target setting for incentives

- Client C
  - Large, multi-specialty group in urban setting
  - Has robust quality reporting initiative
    - Physicians receive monthly reports on performance across many quality metrics and patient satisfaction
  - Many of the metrics require self-reporting
  - Incentives within compensation plan are NOT based on any metrics requiring self-reporting
- Client D
  - Mid-sized, primary care group in urban setting
  - In transition period to new compensation structure
  - Growing portion of compensation that is tied to quality metrics
    - Turning inward to set performance standards and expectations (rather than relying on payers to set standards)

❖ Considerations

- Do you want to have an internal or external focus when setting the incentive targets?

Ensuring success

Systems

- 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

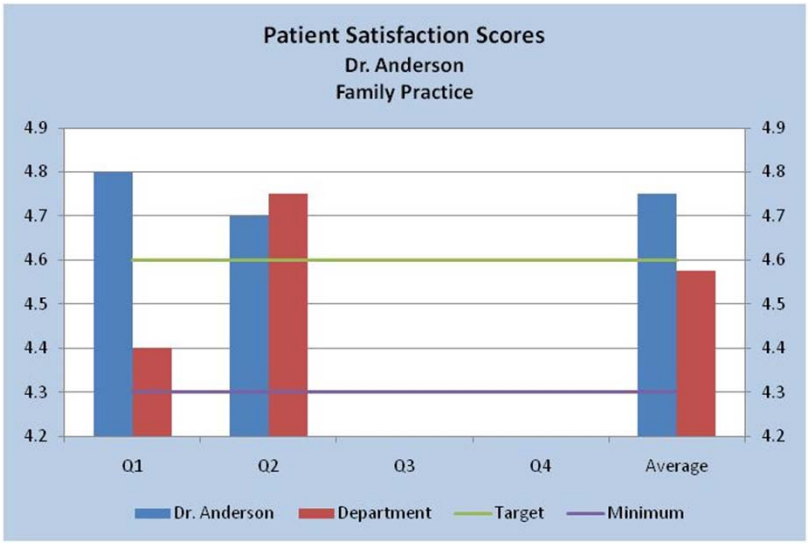
➢Physician would lose out on compensation

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

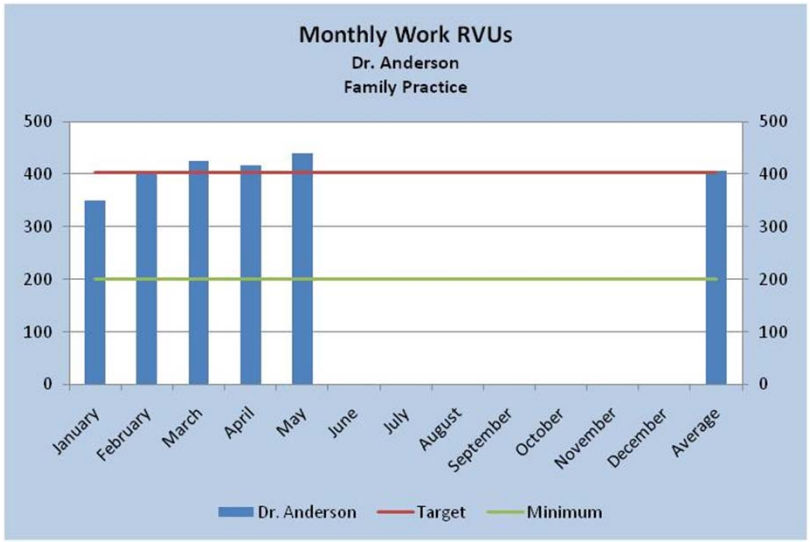
Case study: a critical access hospital wanted to include in its compensation structure metrics on adherence to colon screening recommendations. However, with the organization planning to transition to an EMR, current data gathering would be manual. The organization was not ready to implement this metric.

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



	2007 Budget	2007 Actual	Varience
Total Net Collections	$ 8,263,795	$ 8,938,587	$ 674,792
			$ -
Other Income			$ -
Rental Income	212,194	216,283	$ 4,089
Interest Income	8,750	10,500	$ 1,750
Total Income	**$ 8,484,739**	**$ 9,165,371**	$ 680,632
Expenses			
Salaries to Physician Primary	1,604,302	1,669,895	$ 65,593
Salaries- Other Physicians and Medical Providers	1,860,934	2,101,577	$ 240,643
Salaries and Wages-Administrative staff	1,617,387	1,750,128	$ 132,741
Payroll Taxes	311,868	333,329	$ 21,461
Payroll Expense	12,000	12,360	$ 360
Purchases-Drugs	36,000	37,080	$ 1,080
Purchases-Supplies	110,000	113,300	$ 3,300
Purchases- Supplies- GI Suite	210,000	216,300	$ 6,300

Data Reporting

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Case study: an anesthesiology group introduced a performance scorecard to its physicians. Monthly reports to individual physicians started with just five measures but has grown over time to include fifteen measures of performance.

President of the group was one of the worst performers on a specific metric. Once he received the data, he conferred with his colleagues to understand what he was doing differently. The following year, this physician was the top performer on this specific metric.

You can drive behavioral change by providing timely and trusted reports on performance including targets and goals

Financial expectations

- Develop projections to reflect the impact of the physician's performance on the practice's budget and the hospital's budget
  - Completed as part of the compensation development process, the projections will help hospital administrators, physicians, and practice managers understand the impact of performance on the organization
  - Engages the physicians around the finances of the practice
  - Can be used in support of any financial management metrics incorporated into the compensation structure

Case study: a sole community provider wanted to include a group profit sharing approach (not tied to any DHS related services). They had to first develop a budget for the practice. Process included working with the committee to understand the financial results of provider performance at various levels.

Transition periods

- Organizations contemplating a significant change in its compensation approach should commit to a transition period
  - Allows participants time to understand how their current behavior will be reflected in the new system and give them time to make appropriate adjustments
  - Provides time for feedback
  - Any process issues can be identified before "going live"

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

	Current Comp.	Base Salary	Call Bonus	Productivity Bonus	Medical Director	Proposed Comp.	Variance
A	$ 141,642	$ 59,880	$ 9,239	$ 61,663	$2,101	$ 132,882	$ (8,760)
B	$ 148,405	$ 63,235	$ 18,478	$ 64,076		$ 145,789	$ (2,616)
C	$ 158,727	$ 66,749	$ 21,998	$ 77,645		$ 166,392	$ 7,665
D	$ 109,030	$ 45,965	$ 21,998	$ 41,556	$2,101	$ 111,620	$ 2,590
E	$ 69,758	$ 36,560	$ 21,998	$ 5,372	$2,101	$ 66,031	$ (3,727)
F	$ 82,270	$ 35,404	$ 29,389	$ 26,689	$2,101	$ 93,582	$ 11,313
G	$ 75,000	$ 59,800	$ 9,239	$ 528		$ 69,567	$ (5,433)
H	$ 107,182	$ 57,229	$ 29,389	$ 24,247		$ 110,865	$ 3,683
I	$ 59,800	$ 42,873	$ 8,444	$ 2,999	$2,101	$ 56,417	$ (3,383)
J	$ 98,500	$ 57,461	$ 29,389	$ 10,318		$ 97,169	$ (1,331)
Total	$ 1,050,313	$ 525,157	$ 199,560	$ 315,094	$ 10,503	$ 1,050,313	$ -

Recommendations

Design principles

- Simple, straight forward, and transparent
  - If a compensation structure is too complex:
    - Physicians will not understand how their behavior or performance impacts their pay
    - It will breed distrust
    - It will lead to a poor relationship with your physicians
- 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.

5 key parting concepts

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- 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 straight forward as possible
- Measure and report data
- Monitor, continuously, the system and be prepared to revisit it on an annual basis to realign and adjust.

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Hospital-Physician Alignment, Practice Leader

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