

Physician Compensation Planning: Beyond the Basics

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Agenda

- Introductions/Learning Objectives
- Compensation Plan Development Process
 - Compensation Planning
 - Step 1: Start Up
 - Step 2: Compensation Plan Options and Selection
 - Base
 - Incentives
 - Other Compensation Concerns
 - Step 3: Plan Approval
 - Step 4: Implementation
- Summary
- Questions
- Tools and Reference Materials



Speaker Introductions

- Frank H. Ford, MBA, MHS, FACMPE
 - Over 30 years executive and consulting experience in practice management for integrated delivery systems and medical practices
- Jeffrey B. Milburn, MBA, CMPE
 - Over 35 years of medical practice management and consulting experience
 - Contributing author to *RVUs: Applications for Medical Practices* 2nd Edition
 - Co-author of *Strategies for Value Based Physician Compensation*
- Consultants with MGMA Healthcare Consulting Group



Objectives

- Describe the process of developing and evaluating a physician compensation plan
- Identify the various value-based incentive options and the selection and implementation processes
- List the steps necessary for approving and implementing a new compensation plan
- Provide tools for use in developing a model for your organization

Compensation Plan Process

Step 1: Start Up



Start Up

- Why are you considering changing compensation models?
- Compensation Plan Committee
- Establish goals and objectives
- Timing expectations
- Potential pitfalls
- Consultant's potential responsibilities in compensation planning

Why are you considering changing your compensation plan?

- External environment (P4P, ACO's, etc.)
- Recruit and retain issues
 - New reimbursement models
- Internal environment
 - Alignment of compensation with production
 - Distributions considered not “fair”
 - Not aligned with culture
 - Changing dynamics (new MD's don't want partnership, part time physicians, etc.)
- Merger/Acquisition/Joining IDS or ACO

Compensation Committee



- Make Up:
 - Size and Representation
 - Schedule
 - Permanent and ad hoc members
- Responsibilities:
 - Establish goals and objectives
 - Individual physician interviews
 - Identify and model options
 - Select preferred option
 - Educate stakeholders
 - Obtain approval



Establish Goals and Objectives

- The Goals and Objectives of the plan will drive which plan is best suited to your practice
 - Alignment with group culture
 - Alignment with Mission and Goals
- There is NO PERFECT PLAN, only the best plan to achieve the results the group wants

Establish Goals and Objectives (continued)

- Data/Document review
- Leadership/physician interviews
- What works, what doesn't work, what needs to change
what are deal breakers
- Prepare plan goals statement
- Compensation Committee review and approve goals
statement
- Distribute to physicians to introduce project and set
objectives

Timing Expectations

- The amount of time it takes to develop a compensation plan can vary significantly based on many factors
 - Organizational structure (Integrated Delivery System (IDS) or group practice).
 - Number of physicians involved
 - Number of specialties involved
 - Types of specialties (outpatient, inpatient, surgical)

Timing Expectations (continued)

- Typical time for each step:
 - Step 1: 1-3 months (project start up)
 - Step 2: 2-6 months (plan options and selection)
 - Step 3: 1-3 months (plan approval)
 - Step 4: 1-? Months (implementation)
- Other Considerations
 - Best time of year to start/implement
 - Implement all at once or phase in

Potential Pitfalls for Administrator

- Situations that put administrator's job at risk:
 - Changing Compensation Model
 - Mergers and Acquisitions
 - Changing Information Systems
- Potential areas of conflict
 - Politics (how full is your bucket?)
 - Blame after the fact
 - Appearance of "playing favorites"
 - Trust/lack thereof
- Consultants can help diffuse the risk



Where Angels Fear
to Tread

Consultant's potential responsibilities in compensation planning


- Identify the current compensation plan's strengths and weaknesses
- Benchmark current and proposed plans against market and peer group performance
- Develop alternative structures and measurement metrics
- Lead formal presentation, and
- Facilitate decision making

Source: Medical Group Management Association, 2014. *Strategies for Value-Based Physician Compensation*.

Compensation Plan Process

Step 2: Identify options and select preferred model





Identify options (Basic plan structures), including current plan

- Base (80-100%)
 - Salary
 - Production
- Incentives (0-20%)
 - Quality
 - Citizenship
- Other additional compensation
 - Administrative Pay
 - NPP Supervision
- Incentives should not exceed 10% in first iteration

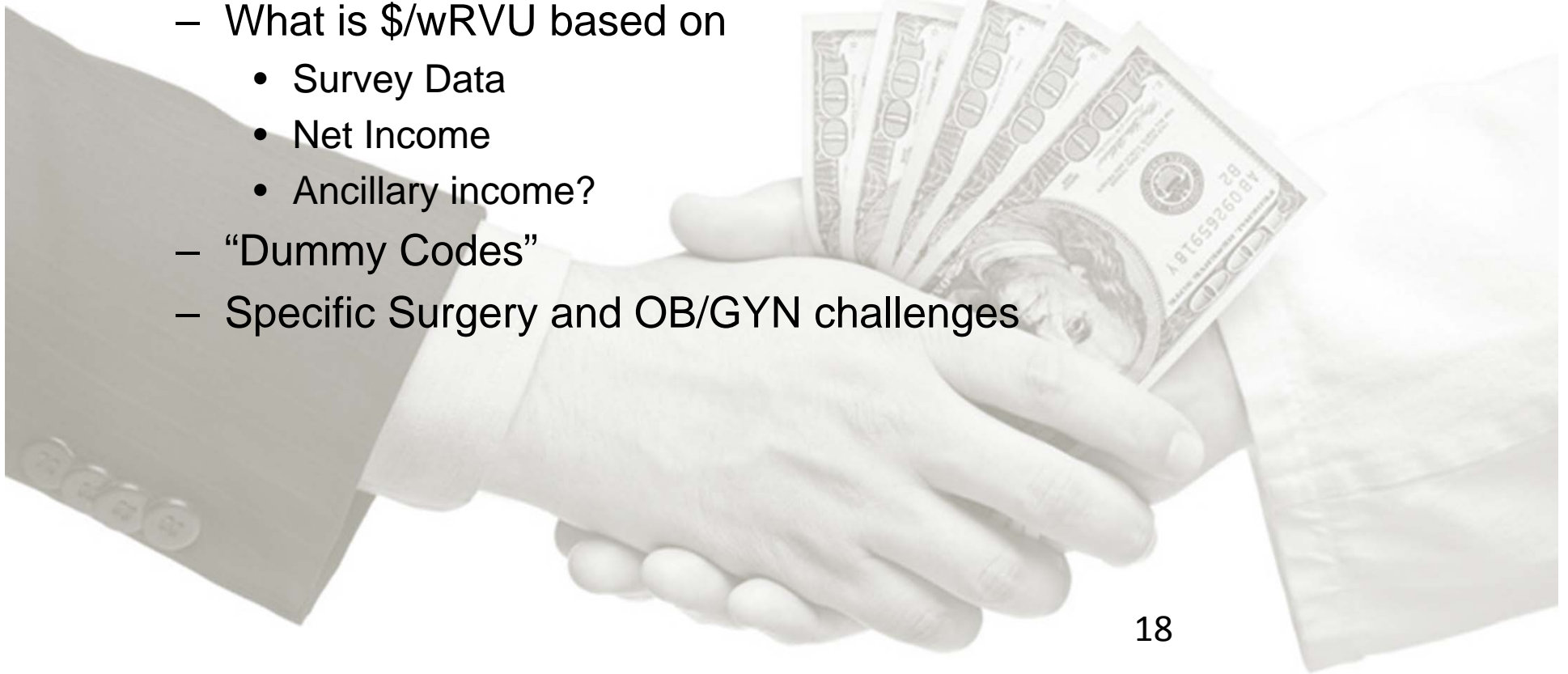


Base Compensation

- Salary
 - Initial guarantee for transition
 - Straight salary
 - Salary with production incentive
 - How are they adjusted
 - Shift Rates
 - Time off (vacation, CME, holidays) adjustment

Base Compensation

- Production
 - Including underlying base salary or not?
 - Establishing Draw
 - What is \$/wRVU based on
 - Survey Data
 - Net Income
 - Ancillary income?
 - “Dummy Codes”
 - Specific Surgery and OB/GYN challenges





Non-Productivity Incentives

Compensation Plans

Incentive Component Trends

- Part of Primary Compensation Plan
 - Private Practice 5% to 10%
 - IDS 10% to 20%
- Pay for Performance (P4P or \$4P)
- Value = Cost + Quality
 - Reduce cost
 - Increase quality
 - Cost of improving quality
- Replace Fee for Service (FFS) ?

Incentives

Incentive Factors – Goals

- Goals and Objectives
 - Improve quality
 - Reduce costs – practice and/or payer
 - Change individual behavior
 - Meet and participate with payer initiatives
 - Organizational strategic initiatives
 - Individual & practice - culture change



Incentives

Incentive Factors – Funding

- Source of Funds
 - Internal
 - Private practice
 - Integrated delivery system
 - External
 - Government programs
 - Payer programs
 - Additive
 - Withhold



Incentives

Incentive Measures

- Generally measurable (objective)
 - Examples – clinical quality, utilization, panel size
- Behavior measurements (subjective)
 - Based on opinions and observations – supportable?
 - Examples – patient and peer satisfaction surveys
- Data
 - Source – trustworthy?
 - Accuracy
 - Acceptable to physicians – solicit input
 - Understandable – report methodology
 - Frequency – status feedback

Incentives

Targets and Rewards

- Targets
 - Emphasize objective over subjective
 - Reasonable and attainable
 - Align with strategic initiatives
 - Multiple
 - Flexible – periodic review and recalibration
- Rewards
 - Allocation – individual and group
 - Meaningful
 - Frequent
 - Cash and other options – additional benefits





Incentives

Physician Concerns

Physicians support concept of...

- Quality care and outcomes
- Coordination of care
- Lower costs

...but worry about their compensation

- “Fair” compensation
- Meet personal expenses
- Quality and value not always easy to define or measure
- FFS is usually a direct line to productivity - understandable



Concerns

- Different payers different metrics = confusion
- Multiple comp plans in organization
- Patient compliance
- Patient acuity
- Patient attribution
- Comp plan complexity – forget KISS
- Risk management – capitation
- Risk allocation

Impact on MD Compensation \$

Identify and assess plan component cash flows

- Start up costs
- Ongoing costs
- Timing of expenses and revenue
- Allocation of costs
 - Individual
 - Practice
 - System
 - Payer



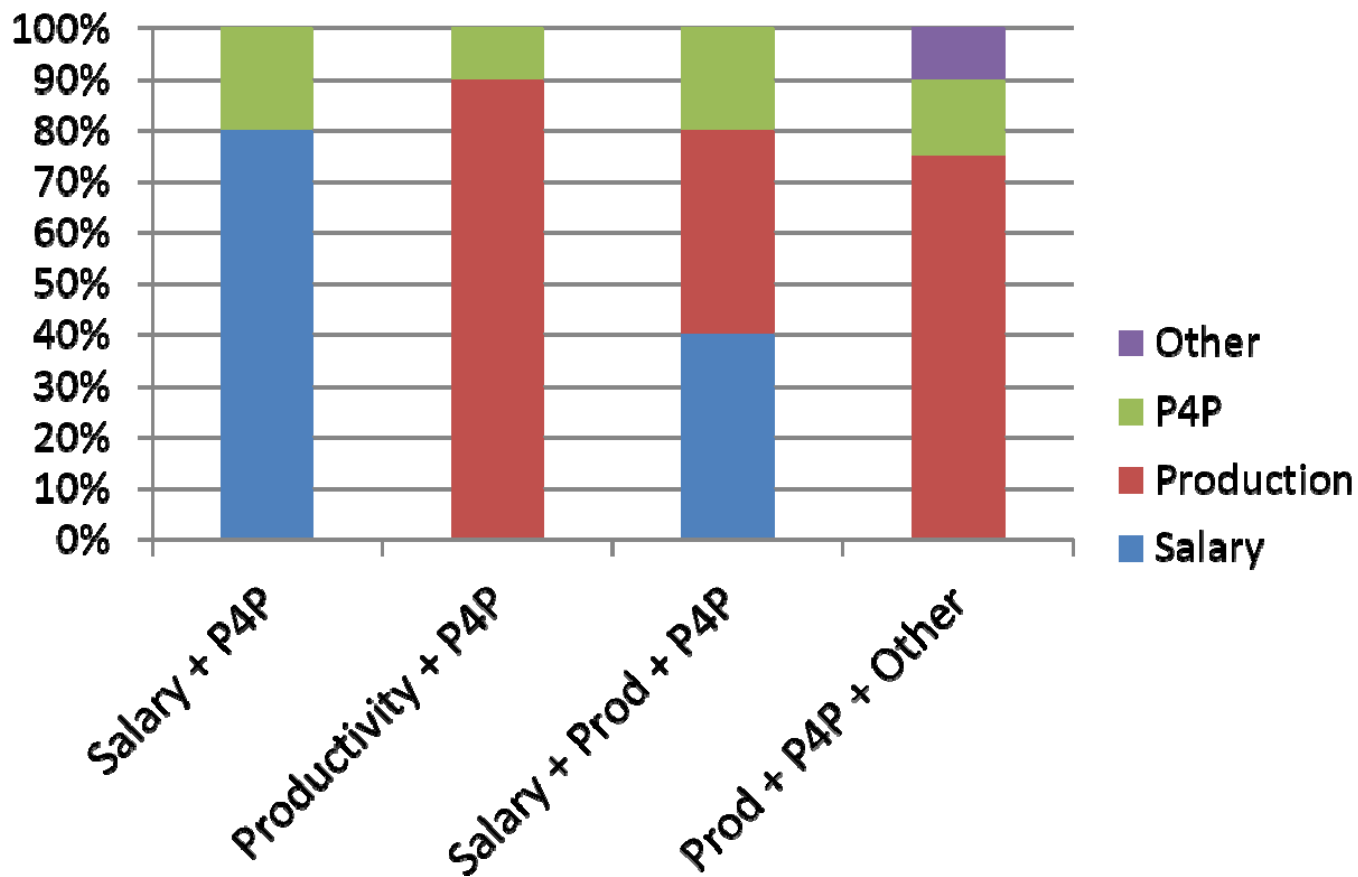
Implementation

- Understand the...
 - Source of funds
 - Scope of services
 - Physician motivation opportunities
 - Risk and reward potential
- Data is critical
 - Internal and external
- Build from P4P
- Evaluation and evolution
 - Start slow and build

Incentive Mix and Phase In

Year	One	Two	Three	Four
Patient Satisfaction	75%	50%	20%	15%
Citizenship	25%	20%	20%	15%
Clinical A	0	10%	20%	10%
Clinical B	0	10%	20%	20%
Clinical C	0	10%	20%	10%
Clinical D	0	0	0	30%
Total	100%	100%	100%	100%

Compensation Model Options



Incentives

Final Points

- Physicians are critical to the process
- P4P methodology will support transition
- Move from an individual to a group culture
- FFS isn't going away quickly
- Payer or source of funds will drive compensation methodology
- Continuous evaluation and evolution
- Value will be defined at various levels from individual to practice



Other Considerations



Other Compensation Considerations

- Ancillary Revenue
- Legacy/special deals
- Low volume, strategically important specialties
- One model for all, or a model with multiple components
- New physicians
- Part-time physicians
- By specialty
- Retiring physicians
- Physician Administrative positions
- Non-physician practitioner supervision

Survey Data Options

- Typical survey sources for benchmarking physician compensation and production:
 - Medical Group Management Association
 - American Medical Group Association
 - Sullivan Cotter and Associates
- Differences
 - Number of respondents
 - Size of groups
 - Detail level
 - Focus
- Using multiple sources





Evaluation of preferred plan options

Now that you've identified potential compensation model(s), they need to be tested with actual data.

- Financial impact on group/fiscal responsibility
- Effect on various specialties
- Individual impact (positive or negative)
- Review against goals and objectives
- Potential adverse impact/unintended consequences

Compensation Plan Process

Step 3: Approval Process



Approval Process

Production of Compensation Plan Document

Fair Market Value Opinion

Presentation of preferred model and modify based on comments

Board or Partner Approval

Production of Compensation Plan Document

The new compensation plan should be documented in complete detail

- How to calculate the initial salaries, rates per wRVU, incentives and goals
- How the above will be modified over time and on what schedule
- How are adjustments made for part-time physicians
- Compensation for additional duties (administrative compensation, NPP's, etc.) and how adjusted in the future.
- Methodology for changes to the plan (requirements to amend contracts?)



Fair Market Value Review

- Third party Fair Market Value review/opinion required for all not-for-profit entities
- Provides protection for the organization and executives related to Stark and Fraud and Abuse regulations
- Health systems' and hospitals' tax exempt status and Medicare participation are at risk
- Paying physicians and others above fair market value can be considered "Private Inurement"

Presentation of preferred model and modify based on comments

After Fair Market Review completed, proceed through the process required by the organization's bylaws, policies or physician agreements. Typical steps include:

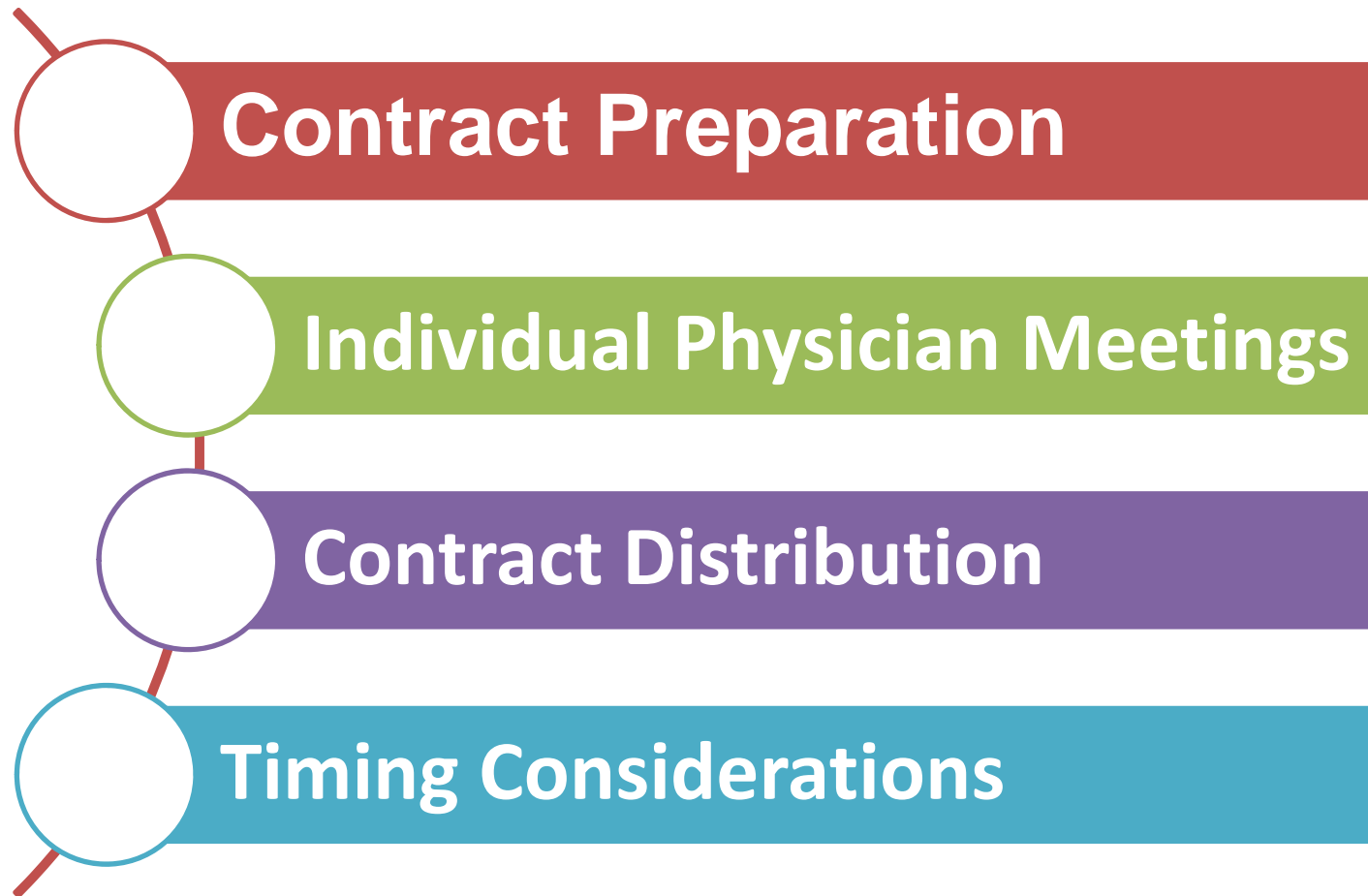
- Compensation Committee
- Physician Group
- Board of Directors (physician group or IDS)
- Final approval by physician owners (if private group and required by by-laws)

Compensation Plan Process

Step 4: Implementation



Implementation





Preparation of Physician Agreements

- Good time to get all physicians on one standard contract
- Compensation Exhibit needs to clearly state the model, but not be overly specific beyond Stark requirements.
- Address changes in wRVU calculation methodology by CMS
- Enable changes to compensation plan incentive goals without amending the agreement

Individual Physician Meetings

- Review physician specific projections
- Review contract languages and any changes other than compensation
- What original deals will you “grandfather” in the new agreement (e.g. non-compete)?



Necessary Components for a Good Plan

- Adequate practice data system
- Acceptable benchmarking data
- Plan supports practice and physician objectives
- Physician acceptance and understandability
- Adequate funding
- Adequate patient demand to support productivity requirements
- Document the plan
- Model the plan for different variables
- Annual review and evaluation



Process Summary

- Initial Steps
 - Compensation plan committee
 - Goals and objectives
- Model Development and Selection
 - Primary model and variations
 - Incentives – production and non-production
 - Additional considerations & options
- Approval
- Implementation

Final Thoughts

- Objectively the physician compensation plan impacts the ability to **recruit and retain physicians**.
- Subjectively the physician compensation plan will drive the culture of your group, the behavior of your physicians, and ultimately the **quality of patient care**.
- Plan development and implementation can be a **complex integration process** with multiple stakeholders, goals, options, and consequences.
- There is no perfect plan, but only the **plan that is the best fit for the practice at a specific point in time and foreseeable future**.

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Questions?



Reference Materials and Tools



Reference Materials

[Physician Compensation Plans, an MGMA Research & Analysis Introduction, February 2015](#)

[Strategies For Value-Based Physician Compensation, Jeffrey B. Milburn and Mary Mourar, Medical Group Management Association 2014](#)



Payers looking for results...

[Aetna Aexcel®](#)

[United Healthcare Premium Designation Program](#)

[PQRS Physician Quality Reporting System](#)



Government looking for quality...

Value-Based Payment Modifier

Quality Resource and Use Reports (QRUR)

Quality Tiering Option

Episodes of Care

All of the above can be found at:

<https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram/valuebasedpaymentmodifier.html>



You can start at the basics...

[MOC - Maintenance of Certification](#)

[NCQA - National Committee for Quality Assurance](#)

[BTE - Bridges to Excellence](#)

[ABIM – PIM - American Board of Internal Medicine - Practice Improvement Modules](#)

[CAHPS - Consumer Assessment of Healthcare Providers and Systems](#)

[CG-CAHPS - Clinician and Group Consumer Assessment of Healthcare Providers and Systems](#)

Tools



Compensation Plan Guiding Principles

The following are examples of guiding principles for new compensation plans:

1. To value all missions within the practices and the community
2. The perception of equitable distribution, which is essential to the plan
3. Simplicity with well understood incentives
4. Easy to administer
5. Comprehensive to address the internal and external challenges while keeping the simplicity principle in mind
6. Flexible to incorporate expected and unexpected contingencies and marketplace challenges. Administrative discretion may be needed for exceptional circumstances
7. Linked to the organization's financial performance.

Source: Medical Group Management Association, 2014. Strategies for Value-Based Physician Compensation.



Sample Physician Compensation Committee Charge

1. Determine goals and objectives of the compensation plan
2. Develop a timeline and communication plan for accomplishing the task
3. Investigate options for compensation methodology
4. Identify relevant performance measures to align with organizational goals
5. Consider an alternative methodology
6. Test alternative(s) for market competitiveness, internal equity and financial sustainability
7. Develop a transition or implementation plan
8. Present the recommended plan to the group and obtain consensus and approval
9. Activate the implementation plan
10. Conduct a post implementation review

Source: Medical Group Management Association, 2014. *Strategies for Value-Based Physician Compensation*. 57



Important Benchmarking Metrics

The following are some recommended metrics to be used when benchmarking compensation, as appropriate to the physicians' specialty:

- Total Cash Compensation
- Collections for Professional Charges (TC/NPP excluded)
- Ambulatory Encounters (NPP excluded)
- Hospital Encounters (NPP excluded)
- Work RVU's (CMS RBRVS Method) (TC/NPP excluded)
- Compensation to Physician Work RVU Ratio (CMS RBRVS Method) (TC/NPP excluded)
- Total Encounters (NPP excluded)
- Weeks Worked per Year



Value-Based Compensation Plan

1. The following steps should be taken to develop a value-based incentive compensation plan:
2. Select the value-based metrics
3. Determine individual, team and organizational measures and incentives
4. Establish the size and source of the incentive pool
5. Determine the weighting of measures
6. Decide if the rewards to be based on target achievement, improvement, or maintenance
7. Identify the incentive payment mechanism

Source: Medical Group Management Association, 2014. Strategies for Value-Based Physician Compensation.



Goals of a Compensation Plan

- Construct a production-based compensation plan that encourages physicians to maintain reasonable productivity and rewards them according to their productivity
- Provide the opportunity for physicians to earn competitive incomes—locally, regionally and nationally
- Avoid penalizing physicians when serving the group results in lower productivity
- Provide a minimum guaranteed income or the opportunity to earn a minimum income
- Set clear minimum-production standards and impose penalties for failing to meet standards
- Provide financial incentives for behaviors that support the group's vision and strategic plans

Source: Medical Group Management Association, 2014. *Strategies for Value-Based Physician Compensation*.



Objectives of a Compensation Plan

- Create a “fair” or an “equally unfair” compensation method
- Increase physician productivity
- Encourage expense management with allocation of expenses that can be managed by physicians
- Address special internal issues, including part-time physicians, administrative activities, and practice ownership issues
- Integrate fiscal responsibility
- Ensure regulatory compliance

Objectives of a Compensation Plan (continued)

- Reward quality of care
- Increase Participation or citizenship with practice administration and other activities
- Improve patient satisfactions,
- Recruit and retain new physicians
- Improve physician satisfaction and retention
- Promote team participation and service
- Grow the practice in terms of number of patients
- Increase owner profits
- Address changing trends in reimbursement

Source: Medical Group Management Association, 2014. Strategies for Value-Based Physician Compensation.



Confidential Physician Compensation System Questionnaire

- Changes: What changes would you recommend for your system?
- Critical Issues: Are there any approaches or outcomes that would make a new or revised compensation plan unacceptable to you?
- Production incentives: What percentage, if any, of the compensation formula should be based on individual physician productivity? ____%
- Other Incentives: Should the compensation formula address other non-productivity issues like patient satisfaction, clinical quality, expense control, group cooperation, and so forth? What and to what degree? Should incentives be positive, negative or both?

Confidential Physician Compensation System Questionnaire (continued)

- Compensation Sharing: What percentage of available compensation should be shared equally? ____% Why?
- Practice Expense Allocation: Should practice expenses be allocated to individual s through the compensation formula? How much? Why?
- Present Compensation Plan:
 - Do you understand the present plan?
 - Can you explain the present plan to others?

Confidential Physician Compensation System Questionnaire (continued)

- On a scale of 1 (strongly disagree) to 5 (strongly agree) please respond to the following statements:
 - The current plan is fair and equitable to all ____
 - The current plan compensates me fairly for my work ____
 - The current plan is understandable ____
 - The current plan needs to be revised ____
- Other issues: What other issues, if any should be considered as part of this process? Call coverage? Part-time work? Retirement?

Source: Medical Group Management Association, 2014. Strategies for Value-Based Physician Compensation.

Four Rules to Benchmark Practice Data

1. Use the median instead of the mean.
2. Use survey tables that apply to your group.
3. Normalize your data.
4. Know that benchmarking is ongoing.

See session handout for detailed information

Source: Madeline Hyden, "Data Benchmarking: Are You Following These Four Rules?" MGMA InPractice Blog, February 1, 2013.

Differences between Traditional FFS and Value-Based Reimbursement

Feature	Traditional FFS	Value-Based Methods
Payment	Retrospective reimbursement	Prospective payment with rewards and penalties
Risk	None	Low: Shared savings and gain sharing High: Bundled and global payments
Quality of care	Assumed	Measured and reported with rewards and penalties
Provider integration	Not required/optional	Hospital, physician, ancillary providers
Data reporting	None required	Cost and quality metrics, utilization, and patient satisfaction

Source: John P. Schmitt, PhD, and Robert W. Keen, Esq. "Payer Contracting: Strategies to Boost Your Bottom Line while Preparing for Value-Based Contracts." Reliance Consulting Group, MGMA webinar October 11, 2012

Weighing Options for Incentive Measures



Performance or Quality Measure	Incentive Option A	Plan Option B
Patient Satisfaction	5%	2%
Active medication lists maintained for 80% of patients	5%	4%
Percentage of diabetic patients screened	5%	7%
Percentage of diabetic patients with reduced A1c	5%	7%

Source: Medical Group Management Association, 2014. *Strategies for Value-Based Physician Compensation*.

Method Used to Accommodate Part-Time Physicians



Method	Better Performing Practices	Other Practices
Paid less and provided fewer benefits	44.83%	35.83%
Changed the overhead rate	16.26%	9.84%
Encouraged job sharing rather than part-time employment	5.42%	6.69%
Part-time physicians were not employed at the practice	27.59%	29.13%
Other accommodations for part-time physicians	10.78%	8.66%

Source: Medical Group Management Association. 2012. Performance and Practices of Successful Medical Groups, 2012 Report based on 2011 Data.

Value-Based Team Oriented Compensation Plan Example



Family Medicine (w/o OB):	Doc A	Doc B	Doc C	Total	
Step 1 Determine market median compensation per work relative value unit (wRVU) value for each specialty	\$ 40.00	\$ 40.00	\$ 40.00		median compensation/wRVU
Step 2 Assign compensation per wRVU for practice at 90% of market median	\$ 36.00	\$ 36.00	\$ 36.00		assigned compensation/wRVU
Step 3 Determine "draw" and "compensation credit" based on production					
Actual wRVUs during compensation period	4,500	3,700	3,900		physician annual wRVUs
Actual wRVUs during compensation period X assigned compensation per wRVU	\$ 162,000	\$ 133,200	\$ 140,400	\$ 435,600	compensation credit based on production
Step 4 Amount used for monthly (or bi-weekly) draw	\$ 162,000	\$ 133,200	\$ 140,400		
Step 5 Determine each physician percent of total wRVU production	37%	31%	32%	100%	
Step 6 Assign value-based compensation based on performance and production					
Example: Additional \$2 per wRVU for performance on quality, cost and patient satisfaction measures (total of \$6 per wRVU possible)					<i>*This may need to be updated based on compensation plan formula</i>
Quality (\$2 per wRVU of physician production when quality targets met)	\$ 9,000	\$ *0	\$ 7,800		
Cost management (\$2 per wRVU of physician production when cost management targets met)	\$ *0	\$ 7,400	\$ 7,800		
Satisfaction (\$2 per wRVU of physician production when satisfaction targets met)	\$ 9,000	\$ *0	\$ *0		
Subtotal	\$ 18,000	\$ 7,400	\$ 15,600		
Step 7 Production plus value-based compensation (Step 4 + Step 6)	\$ 180,000	\$ 140,600	\$ 156,000	\$ 476,600	
Step 8 Determine compensation pool based on practice financial metrics					
Practice net collections	\$ 2,050,000				
Less practice total operating expenses (including physician draw + value-based compensation paid) and reserves	\$ 1,931,600				
Practice net income (available for additional compensation)	\$ 118,400				
Step 9 Physician-owned practices -- allocate practice net income based on physician % of wRVU production (to ensure budget neutrality)	\$ 44,033	\$ 36,205	\$ 38,162		
Total compensation per physician in physician-owned practice (Step 7 + Step 9)	\$ 224,033	\$ 176,805	\$ 194,162		

Note: Calculations may be inexact due to rounding and other variables

Source: *Physician Compensation Plans, An MGMA Research & Analysis Introduction, February 2015*



CMS Innovation Models

- Accountable care
- Bundled payments for care improvement
- Primary care transformation
- Initiatives focused on Medicaid and CHIP population
- Initiatives to speed adoption of best practices
- Initiatives to accelerate the development and testing of new payment and service delivery models

<http://innovation.cms.gov/initiatives/index.html#views=models>

Summary

Successful plans

- Understandable
- Trustworthy and frequent data
- Considered to be “fair”
- Promote individual and entity strategic goals
- Patient quality
- Recruit and retain physicians

Unsuccessful plans

- Not aligned with entity and/or physician goals
- Inadequate physician participation and buy-in
- Data issues
- Poor cash and/or benefit levels – fair?
- Too complex
- Promote individual over group