OR/WA MGMA Workshop
Physician Compensation Plans
Tacoma WA

Jeffrey B. Milburn, MBA, CMPE
May 15, 2016
Align to bottom of logo

Program Outline

• Introduction
• Program Objectives
• Compensation Plan Foundations
• Trends in Compensation Plans
• Incentives
• Plan Issues and Options
• Benchmarking
• Practice Assessment
• Compensation Plan Development

Speaker Introduction

• Jeffrey B. Milburn, MBA, CMPE
  – Over 30 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
  – MBA Northeastern University, Boston
  – BSBA Denver University
  – CMPE Certified Medical Practice Executive
  – Past member MGMA Board of Directors, Finance Chair
  – Past member and chair MGMA Survey Advisory Committee and Financial Management Society
Objectives

• Understand basic plan structures
• Be familiar with current trends and options
• Assess your plan through benchmarking
• Describe the process of evaluating and developing a physician compensation plan
• List the steps necessary for approving and implementing a new compensation plan
• Provide tools for use in developing a model for your organization

Question

Is your group an independent private practice (physician owned) or part of an Integrated Delivery System (IDS) combining hospital and physician services?

1. Private Practice
2. IDS
3. Other

Compensation Plan Foundations
Basic Plan Themes

• Salary / Base Guaranty / Shift Based
• Equal Sharing (of profits and/or losses)
• Part Equal and Part Productivity
• Productivity on Various Metrics
• Productivity less Allocated Expenses
• Plus Optional Options

Plan Complexity

Base Salary ..........Expense Allocation

ADMINISTRATIVE COMPLEXITY

OPTIONS

Salaries / Base Guaranty

• Understandable
• Easy to administer
• New physicians
• Part time physicians
• Easy to benchmark
• Employed physicians
  – Integrated Systems
  – Non-Shareholders
• Support shift rate MDs
  – Hospitalists
  – Emergency MDs
• Doesn’t support productivity
• Add quality incentives
### Equal Profit Sharing

**Positives**
- Early private practice model
- Understandable
- Easy to administer
- Low producers
- Single specialty with compatible...
  - Workloads & production
  - Resource utilization
- Quality incentive options

**Negatives**
- Limited IDS applicability
- Minimal productivity incentive
- Doesn’t mature well
- High producers
- Multi-specialty issues
  - Primary care vs. surgimed specialists

---

### Part Equal Part Production

- Hybrid methodology – some combination of equal sharing and productivity based profit sharing
- Transition from sharing to production
- The higher the equal share, the greater the support for lower producers
  - Example: 70% equal 30% productivity
- The higher the productivity based component, the greater the support for high producers
  - Example: 40% equal 60% productivity

---

### Production

- Primarily based on individual productivity
- Productivity metrics
  - Charges
  - Collections
  - Work RVUs (wRVU)
  - Time
  - Patient visits
- Data requirements
### Production - Charges

**Pros**
- Easy to measure
- Understandable
- Internal Benchmarking
- Single specialty groups

**Cons**
- External Benchmarking Limited
  - No consistency in charge setting methodology
- Multi-specialty differences
- Fees vary by market
- Can be manipulated
- Usually not cost-based

### Production - Collections

**Pros**
- Relates to cash available
- Easy to measure
- Understandable
- Better benchmarks

**Cons**
- Payer mix - not payer blind
  - Option: Consolidate collections and allocate
- Depends on business office and contracting effectiveness
- Benchmarking issues

### Production – Time

**Shift Based Compensation**
- Hospitalists, Emergency Departments
  - Hospital based specialties
- Productivity subject to patient demand
- Evening, weekend, holiday rates
- Example: EM MD mean annual comp = $320,000
  - weeks worked per year = 48 x 5 = 240 days
  - $320,000 / 240 = $1,333 day (shift)
- Incentives possible

**Limited benchmarks**
Production - Encounters

- Single specialty practices
- Small to medium size groups
- Profits / pro rata share of encounters = comp $
- Operating profits / pro rata share of encounters less expense allocation = comp $
- Define encounters – office, hospital, procedures
- Benchmarks available
- Incentive payments applicable

Production - Work RVUs

- Pros
  - Measurable and “understandable”
  - Payer mix blind
  - Good benchmarks – National Standards
  - Growing utilization by groups
  - Measure productivity across specialties
  - Assign value by specialty from benchmarks
  - Periodic review and updates
- Cons
  - More complex to administer
  - Subject to CMS changes

Relative Value Units (RVUs)

- Total RVU (tRVU) has 3 components
  - Work (wRVU)
  - Practice Expense (peRVU)
  - Malpractice (mRVU)
  - $CF \times tRVU = \$ amount billed or paid for a procedure
- Conversion factor ($CF$) is $ amount times the tRVU to determine amount billed or paid for a procedure
Work RVUs

• A $CF times the wRVU determines amount paid to a physician for work performed
• Median Compensation / Median wRVUs = Median $CF to pay physician per wRVU
• Example: $220,000 / 5000 = $CF of $44.00
• Example: Physician annual wRVUs = 6000
  6000 x $44 = $264,000

wRVU Methodology Variations

• Straight wRVU x $CF = productivity comp
• Base salary + productivity incentive of wRVUs exceeding 4000 x $30 = compensation
• Tiered model based on assumption initial wRVUs not as valuable as higher productivity
  A. wRVUs from 0 to 3000 x $CF30 = comp
  B. wRVUs from 3001 to 4500 x $CF40 = comp
  C. wRVUs above 4000 x $CF50 = comp
  A + B + C = Total compensation

Expense Allocation

• Tracks individual physician collections and deducts expenses allocated to the physician.
• Multiple methods and combinations of methods for expense allocation
  – Allocation based on % of collections
  – Equal share of expenses
  – Hybrid equal share and % of collections
  – Direct cost of resource usage
Multiple Plan Components

• “One model doesn’t always fit all”
• Possible plan components:
  1. Primary plan for majority of physicians
     Productivity
  2. New physician plan
     Salary to productivity transition
     One to three years
  3. Part-time physicians
     Permanent or optional duration
     Retirement transition
  4. Wild cards

Wild Cards

• Set up option in the plan for a component addressing physicians who don’t fit in the primary plan.
• Examples:
  – Hospital physician needed to fill scope of services but patient demand won’t support. Salary
  – Extra physicians needed to cover specialty call that patient demand won’t cover.
  – Special deals
  – Legacy deals
  – Non-shareholder track

Stacked Compensation Model

• Individual physician compensation may consist of multiple parts:
  – Base guaranty +
  – Production incentive +
  – Non-production incentives +
  – NPP supervision stipend +
  – Part time medical director +
  – Committee participation = Total Compensation
Stacked Compensation

Question

• Who is using……
  – Straight salary?
  – Equal sharing?
  – Hybrid sharing and productivity?
  – Primarily productivity?
  – Expense allocations?
  – Non-productivity incentives?
  – Wild cards?

Compensation Trends
Compensation Trends

- Salary to production
- Production to wRVUs
- Less cost accounting
- Volume (FFS) to Quality
- Pay for “extras”
  - Call pay
  - Committee
  - Leadership
  - Supervision
- Alternative Payment
- Individual to group culture

Trends continued

- Private practice to system employment
  - Loss of ancillary income
- Specialty to sub-specialty
- Smaller to larger practice size
  - Increased ancillary income
- Telephonic coverage pay
- Risk
  - Capitation
  - Population management

Methodology Change – 2013 to 2015

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% Salary</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>100% Equal Share</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>100% Productivity</td>
<td>42%</td>
<td>20%</td>
</tr>
<tr>
<td>50%+ Salary + Incentive</td>
<td>24%</td>
<td>25%</td>
</tr>
<tr>
<td>50%+ Productivity + Incent</td>
<td>22%</td>
<td>38%</td>
</tr>
<tr>
<td>Other</td>
<td>NR</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: MGMA Comp & Production Surveys
### Production Metric Trends

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work RVUs</td>
<td>67%</td>
<td>71%</td>
</tr>
<tr>
<td>Collections</td>
<td>33%</td>
<td>40%</td>
</tr>
<tr>
<td>Charges</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>Cost Accounting</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Total RVUs</td>
<td>2%</td>
<td>NR</td>
</tr>
</tbody>
</table>

Source: AMGA Medical Group Compensation and Financial Survey

---

### Compensation Plan Incentives

- **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

---

### Incentives

- **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
Question

Do you believe fee-for-service payer reimbursement will represent less than 50% of overall practice income in 3 years?

1. Yes
2. No
3. Not sure

Incentives - Objectives

• Incentive Factors - Goals and Objectives
  – Improve patient satisfaction
  – Improve **clinical quality**
  – **Reduce costs** – practice and/or payer
  – Change physician behaviors
  – Participate in payer initiatives
  – Address organizational strategic goals
  – Culture change – **individual to group focus**

Incentives - Funding

• Where’s the money?
• Source of Funds
  – Internal
    • Private practice
    • Integrated Delivery System / Hospital
  – External
    • Payer programs
    • Government programs
  – Additive
  – Withhold from MDs
Incentives - Measures

- Incentive Factors – Measures
  - Easily measured (objective)
    - Clinical quality, utilization, panel size
  - Behavior measurements (subjective)
    - Based on opinions and observations – supportable?
    - Patient and peer satisfaction surveys
  - Data issues
    - Source – trustworthy?
    - Accurate
    - Acceptable to physicians
    - Understandable – report methodology
    - Frequency – status feedback

Incentives – Targets & Rewards

- Targets
  - Emphasize objective over subjective
  - Reasonable and attainable
  - Align with goals and objectives
  - Multiple targets – not excessive
  - Flexible – periodic review and recalibration

- Rewards
  - Allocation – individual and group
  - Meaningful
  - Frequent
  - Cash and other options – additional benefits

Incentives - Concerns

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
Incentives – Concerns

- Different payers different metrics = confusion
- Multiple comp plans in organization
- Patient compliance
  - Physicians fire non-compliant patient - immunizations
- Patient acuity
- Patient attribution
- Comp plan complexity – forget KISS
- Risk management – **decapitation**
- Risk allocation

Incentives – Breaking News

- CMS & AHIP “Core Quality Measures Collaborative”  February 2016
- Specialties include….
  - Primary Care & ACOs
  - Cardiology, Gastroenterology, Oncology, OB/Gyn, Orthopedics


Incentives – MD Comp $

- Identify and assess plan component cash flows
  - Start up costs
  - Ongoing costs
  - Timing of expenses and revenue
  - Allocation of costs
    - Individual
    - Practice
    - System
    - Payer
Incentive Implementation

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

Incentive Mix and Phase In

<table>
<thead>
<tr>
<th>Year</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction</td>
<td>75%</td>
<td>50%</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>Citizenship</td>
<td>25%</td>
<td>20%</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>Clinical A</td>
<td>0%</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Clinical B</td>
<td>0%</td>
<td>10%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Clinical C</td>
<td>0%</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Clinical D</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Model Options with Incentives
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

Question

Show of hands…..

How many of you are using non-productivity incentives in your compensation formula now?

Miscellaneous Compensation Plan Issues
Cash Available?

Theory is you can’t (or shouldn’t) pay out more than you have available.

• Hospital / IDS Systems
  – Reconcile to “budget”
  – Reconcile to collections
  – Pay from reserves

• Private Practice
  – Reconcile to collections
  – Other options?

Reconciliation Example

<table>
<thead>
<tr>
<th>Physician</th>
<th>Amount Due</th>
<th>% Total Due Out</th>
<th>Share Available ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$180,000</td>
<td>17.2%</td>
<td>$165,750</td>
</tr>
<tr>
<td>B</td>
<td>$220,000</td>
<td>21.1%</td>
<td>$205,725</td>
</tr>
<tr>
<td>C</td>
<td>$210,000</td>
<td>20.1%</td>
<td>$195,975</td>
</tr>
<tr>
<td>D</td>
<td>$245,000</td>
<td>23.4%</td>
<td>$228,150</td>
</tr>
<tr>
<td>E</td>
<td>$190,000</td>
<td>18.2%</td>
<td>$177,450</td>
</tr>
<tr>
<td></td>
<td>$1,045,000</td>
<td>100.0%</td>
<td>$975,000</td>
</tr>
</tbody>
</table>

Individual MD $ / Amount Due All = % of Funds Available

Additional Considerations

• Research activity and income
• Education activity and income
• Non-Physician Provider supervision
• Call compensation
• Leadership – administrative activities
• Organizational ownership/structure
• Specialty – scope of services
• Multiple specialties
• PCP and med/surg differences
• Outside income – group or individual
Other Considerations

- Ancillary Revenue
- Ancillary Ownership
- Legacy/special deals
- Low volume, strategically important specialties
- One model for all, or a model with multiple components
- New physicians
- Part-time physicians
  - Permanent and temporary
  - Retiring physicians

NPP Supervision

- Physician supervision of NPPs
  - Requests for compensation
    - Loss of production time under production formula
    - Additional medical legal risk
    - Just “because”
  - Methodologies
    - Share of NPP productivity
    - Stipend based on time and effort
  - Competition for patients?
  - NPP increases MD compensation?
  - Who pays NPP expenses?

Call Pay Considerations

- Factors
  - Restricted
  - Unrestricted
  - Hospital trauma status
  - Hospital by-laws
  - Hospital/IDS financial support
  - Payer mix
  - Volume
  - Trade call – buy/sell
  - Stop taking call costs and workload transfer
  - Reasonable call?
<table>
<thead>
<tr>
<th>Factors</th>
<th></th>
</tr>
</thead>
</table>
| **Benefits**  
  - Medical  
  - Retirement  
  - CME  
  - Paid time off  
  - Business expenses  
    - Pre or post tax  
    - IRS Deductible |  |
| **Recruiting Benefits**  
  - Signing bonus  
  - Moving expenses  
  - Education reimbursement  
  - Loans – reimbursement and forgiveness |  |
| **Professional liability**  
  - Claims made (file date) and occurrence (event)  
  - Nose and tail coverage for claims made |  |
| **Retention**  
  - Golden handcuffs  
  - Longevity bonuses |  |
| **Ownership opportunities**  
  - Buy in/out cost and methodology  
  - Primary practice and affiliates |  |
| **Ancillaries**  
  **Expectations**  
  - Productivity  
  - Time |  |
| **Physician “life balance”**  
  **Mergers and acquisitions** |  |
Factors

- Low to high volume physicians
- Practice location
- Reimbursement changes
- Payer mix
- Part-timers
  - Permanent
  - Mid career
  - Retirement
  - Shift based

Benchmarking

Benchmarking – a standard or reference by which others can be measured or judged. A reference point to measure change.

- Survey terminology
- Multiple survey sources
- Differences in surveys
- Detail levels
- Using surveys
Survey Terminology

• **Physician Count** - # physicians responding
• **Groups/Practices** - # groups responding
• **Mean** – arithmetic average of data sum divided by respondent count
• **Standard Deviation** – measure of variability of data. If close to mean, data is dispersed with weak central tendency. SD < 1/3 of mean then data is tightly clustered with strong central tendency.

Terminology - continued

• **25th Percentile** – 25% of responses are lower
• **Median / 50th Percentile** – 50% of responses are lower and higher. Not subject to distortion from extreme high/low responses seen in mean
• **75th Percentile** – 75% of responses are lower

• Standard Deviation examples:
  – Anesthesia Comp Mean/SD = 30% - close tendency
  – Family Practice Comp Mean/SD = 43% - moderate
  – Ophthalmology Comp Mean/SD = 49% - low

Select Survey Sources

<table>
<thead>
<tr>
<th>Survey Firms</th>
<th>Organizations</th>
<th>Providers</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMGA</td>
<td>251</td>
<td>73,006</td>
<td>291</td>
</tr>
<tr>
<td>Comdata Surveys</td>
<td>566</td>
<td>11,546</td>
<td>20</td>
</tr>
<tr>
<td>ECG Management</td>
<td>115</td>
<td>32,000</td>
<td>278</td>
</tr>
<tr>
<td>Hosp &amp; Healthcare Comp</td>
<td>364</td>
<td>42,700</td>
<td>117</td>
</tr>
<tr>
<td>MGMA</td>
<td>3,847</td>
<td>69,411</td>
<td>18</td>
</tr>
<tr>
<td>SullivanCotter</td>
<td>260</td>
<td>89,052</td>
<td>342</td>
</tr>
</tbody>
</table>

Source: Modern Healthcare July 20, 2015
Source Differences

- Number of respondents
  - Groups and providers
- Types of respondents - focus
  - Physician owned
  - IDS / Hospital
  - Academic
- Size Groups
- Detail Level

Surveyed Organizations - Ownership

<table>
<thead>
<tr>
<th>Organization Type</th>
<th>AMGA</th>
<th>MGMA</th>
<th>Sullivan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Owned</td>
<td>25%</td>
<td>19%</td>
<td>24%</td>
</tr>
<tr>
<td>Hospital or Health System (IDS)</td>
<td>67%</td>
<td>76%</td>
<td>60%</td>
</tr>
<tr>
<td>Academic / Medical School</td>
<td>2%</td>
<td>1%</td>
<td>11%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
<td>4%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: Actual Surveys

Surveys – Variable Results ($000)

<table>
<thead>
<tr>
<th>Survey Firm</th>
<th>Family Practice</th>
<th>Cardiology Invasive</th>
<th>General Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMGA</td>
<td>$226</td>
<td>$588</td>
<td>$380</td>
</tr>
<tr>
<td>Compdata Surveys</td>
<td>$222</td>
<td>$544</td>
<td>$358</td>
</tr>
<tr>
<td>ECG Management</td>
<td>$223</td>
<td>$462</td>
<td>$367</td>
</tr>
<tr>
<td>Hosp &amp; Healthcare Comp</td>
<td>$191</td>
<td>$405</td>
<td>$364</td>
</tr>
<tr>
<td>MGMA</td>
<td>$222</td>
<td>$549</td>
<td>$395</td>
</tr>
<tr>
<td>SullivanCotter</td>
<td>$250</td>
<td>$598</td>
<td>$414</td>
</tr>
</tbody>
</table>

Source: Modern Healthcare July 20, 2015
Variable Results – Why?

- Survey methodology
- Sample size – number of respondents (n)
- Response rates
- Respondent accuracy
- Respondents change year to year
- Sample organizations
  - Different and not so……cross participation
- Surveys aren’t perfect….but best we have

Survey Detail Level

- Compensation
- Provider #
- Group #
- Practice Ownership
  - Private
  - Hospital/IDS
- Location
- Single & Multispecialty
- New / Experienced MDs
- Best practices
- Charges
- Collections
- Encounters
- RVUs & ASAs
- Non-physician data
- Call
- Administrative
- Weeks Worked
- Benefits
- Call comp

MGMA DataDive

MGMA’s Web Based Resource (no books)

- Standard Edition
  - Compensation and production
  - Revenue and costs
  - MD, administrative, staff
  - Regional and state level
  - Filtering options
  - Trend data 3 years
  - Export information
- Pro Edition
  - Percentiles 10-90%ile
  - Enhanced drill down
  - Trend data 5 years
### Using Multiple Surveys

<table>
<thead>
<tr>
<th>Survey</th>
<th># Drs</th>
<th>% Drs</th>
<th>Median Comp</th>
<th>% X Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>MGMA</td>
<td>6,125</td>
<td>.282</td>
<td>$221,419</td>
<td>$62,440</td>
</tr>
<tr>
<td>AMGA</td>
<td>7,042</td>
<td>.324</td>
<td>$244,269</td>
<td>$79,143</td>
</tr>
<tr>
<td>Sullivan</td>
<td>8,547</td>
<td>.394</td>
<td>$239,323</td>
<td>$94,293</td>
</tr>
<tr>
<td></td>
<td>21,714</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Straight Average</td>
<td></td>
<td></td>
<td>$235,004</td>
<td></td>
</tr>
<tr>
<td>Weighted Median</td>
<td></td>
<td></td>
<td></td>
<td>$235,876</td>
</tr>
</tbody>
</table>

### Using Multiple Years

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
</tr>
<tr>
<td>Median Compensationaal</td>
</tr>
</tbody>
</table>

Rolling (Straight) Average: \( \frac{(2013 + 2014 + 2015)}{3} = \frac{555,333}{3} = 555,333 \)

Weighted Rolling Average: \( \frac{(2013 \times 1) + (2014 \times 2) + (2015 \times 3)}{6} = \frac{560,333}{6} = 93,388.83 \)

Source: MGMA Surveys

### Practice Assessment
**Practice Assessment Tool**

- Develop a spreadsheet to……
  - Consolidate physician demographic information
  - Show physician compensation and productivity data
  - Identify compensation and productivity trends
  - Benchmark practice and physician compensation to external and internal benchmarks
  - Facilitate reporting & presentations
  - Utilize spreadsheet to develop and test new plan models and options

**Spreadsheet Example**

<table>
<thead>
<tr>
<th>Column</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Names</td>
</tr>
<tr>
<td>B</td>
<td>Demographic Information</td>
</tr>
<tr>
<td>C</td>
<td>Compensation &amp; Productivity</td>
</tr>
<tr>
<td>D</td>
<td>Benchmarking Metrics</td>
</tr>
<tr>
<td>E</td>
<td>Optional Plan Development</td>
</tr>
</tbody>
</table>

- Smith
- Jones
- Miller
- Riley
- Mitchell

**Physician Demographics**

- Last name
- First name
- Specialty
- FTE level
- Age
- Male / Female
- Ownership status
- Practice location(s)
- Start date
Physician Productivity

- Physician information
  - Compensation (W2 income to physician)
  - Gross Revenue (Charges)
  - Net Revenue (Collections)
  - Encounters (Patient visits office & facility)
  - Total RVUs
  - Work RVUs
- Trend Analysis – 2 years data
- Other information
  - Non-clinical compensation included in total comp

Benchmarking Metrics FTE by Specialty Medians

- FTE Compensation
  - Select appropriate sub-specialty level
- FTE Charges
- FTE Collections
- FTE Encounters
- FTE Total RVUs
- FTE Work RVUs
- FTE Compensation / wRVU = $CF (table)
- Adjust FTE benchmark by MD FTE status as necessary

Physician FTE to Benchmark Medians

- Divide physician compensation and productivity metrics by benchmark median metrics to determine physician metric as % of benchmark.
- Look for material variances from benchmarks for further investigation.
- Look at relationship between compensation & productivity.
  - Compensation at 120% median & productivity at 85% median implies excess compensation (overpayment)
  - Compensation at 85% and productivity at 120% implies underpayment.
Ratio Analysis

∑ MD Compensation / ∑ MD Collections = relative % not available for overhead coverage

MD TRVUs / MD Encounters = total RVU per visit to compare to other MDs. Over/under coding?

∑ MD Collections / ∑ MD wRVUs = $CF by specialty to compare to benchmark tables

Scattergram Example

Compensation & wRVUs to Median Benchmark

Scattergram Example

Compensation to Encounters
Assessment – Practice Level

- Investigate practice financial factors that may impact compensation
  - Operational profitability before compensation
  - Cash flows
  - Accounts receivable
  - Payer mix
  - Patient demand
- Resources
  - MGMA Cost Surveys (print or DataDive)
  - MGMA Performances and Practices of Successful Medical Groups

Compensation Plan Development

- Reasons for Change
- Compensation Committee
- Timelines
- Current Plan Assessment
- Goals and Objectives
- Develop Change Options
- Test & Assess Options
- Approve Plan
- Documentation
- Present to Stakeholders
- Implement Plan
Reasons for Plan Change

- External environment (P4P, ACO’s, Risk, etc.)
  - New reimbursement models
- Recruiting and retention issues - turnover
- Internal environment
  - Distributions considered not “fair”
  - Not aligned with desired culture
  - Changing dynamics (new MD’s don’t want partnership, part time physicians, etc.)
  - Financial issues – productivity, expenses, access
  - Quality
- 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

Committee - continued

- Representative selection of stakeholders
  - Specialties
  - Locations
  - Administration – practice and system
  - Decision makers
  - For and Against changes
- Facilitators
  - Internal
  - External
Committee Facilitator?

- Job Description
  - Manage comp committee schedule & progress
  - Assess current plan pros and cons
  - Develop plan options to review
  - Assist committee assessment of options
  - Facilitate decision making
  - Document final recommendations
  - Present to stakeholders
  - Implement new compensation plan

Facilitator Options

- Internal Administration
  - Inexpensive
  - Knows stakeholders and culture
- Local facilitator
  - Hospital system
  - Accountant
- Outside facilitator
  - More expensive
  - Experienced

Timeline

- 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) – decision making authority
  - Number of committee members
  - Group size – physicians and specialty mix
  - Individual schedules – committee member availability
  - Time of year
  - Level of organizational support
Timeline (continued)

• Typical time for each step:
  – Step 1: 1-3 months (project start up)
    • Committee selection
    • Current plan assessment
    • Establish goals and objectives
  – Step 2: 2-6 months (plan options and selection)
    • Assess test options
    • Decision for best fit
  – Step 3: 1-3 months (plan approval & documentation)
  – Step 4: 1-7 Months (implementation)
    • Presentations

• Other Considerations
  – Best time of year to start/implement
  – Implement all at once or phase in

Current Plan Assessment

• Objective Assessment
  – Benchmarking production & compensation to outside sources
  – Internal peer benchmarking of comp & production

• Subjective Assessment
  – Review reasons for change
  – Interviews with select stakeholders
  – Written or online surveys
  – Address ‘fairness’ concept
    • External equity
    • Internal equity

Assessment - Continued

• Interviews – Face to Face - Confidential
  – Larger groups – 10% to 15% physicians
  – Smaller groups – all stakeholders
  – 45 to 60 minutes in length
  – Summarize findings for committee

• Surveys
  – All physicians so everyone has input opportunity
  – Written or online
  – Allow for comments
Assessment - Continued

- Interview and Survey Questions
  - Like and don’t like about current plan?
  - What would be a better plan?
  - Operational issues impacting current plan?
  - Is the current plan “fair”? Why?
- Test Possible Plan Changes
  - Salary/sharing to productivity?
  - Production and production metrics? Work RVUs?
  - Expense allocation?
  - Non-productivity incentives?
  - What change would be totally unacceptable?

Setting Plan Goals and Objectives

- A mission statement developed by the compensation committee: What do we want the plan to be and do?
- The statement will be used to:
  - Evaluate alignment with current plan, and
  - Evaluate future options alignment with goals

There is NO PERFECT PLAN, only the best plan to achieve the results desired at this point in time under current and near term circumstances.

Sample Goals and Objectives

- Fiscally responsible
- Regulatory compliant
- Support organizational goals
- Recruit and retain physicians
- Promote patient satisfaction
- Easy to administer
- Group culture
- Profits
- Perceived to be "fair" or "equally unfair"
- Promote productivity
- Support and improve clinical quality & value
- Promote expense management
- Understandable
- Explainable
- Utilization management
New Plan Option Development

Based on current plan assessment (benchmarking and interviews) and established goals and objectives, what is required?

• **Tune-up?** “If it’s not broke, don’t fix it”
  – Update or change parts of current plan
• **Major surgery?**
  – Start over with a new concept
• **Focus on 1 to 3 options for development and assessment**

Plan Option Evaluation

Evaluation of proposed option(s)....

• Test new option with most recent compensation and productivity data updated as necessary

• **Fiscal responsibility** impact on.....
  – Group and IDS hospital
  – Specialties or departments
  – Individuals

• **Alignment with goals and objectives**
• **Regulatory compliance**
• **Identify and address adverse impacts**

Regulatory Compliance

• **Federal Health Care Programs:**
  – Stark Self-Referral
  – Anti-Kickback

• **Internal Revenue Code:**
  – Compensation – **Fair Market Value**
  – Tax-Exempt Organization Compensation
  – Excess Compensation
  – Reasonable and necessary practice expense
Regulatory - Stark

- Arrangements between physicians/practices and hospitals:
  - Professional services
  - Administrative duties and services
  - Fair Market Value
- Designated Health Services (DHS) referrals:
  - DHS = labs, radiology, PT, drugs, hospital services, etc.
  - No compensation for referrals
  - Exceptions

Regulatory Compliance

- 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”
- Obtain health care attorney opinion

Phase In Considerations

- Time of year to…..
  - Cut off old plan
  - Start new plan
- Move to new plan all at once option
- Run old and new plan concurrently option
- Identify individuals with material adverse impact
  - Educate why they are being hurt
  - Identify potential productivity and behavior changes
  - Consider 1 to 2 year transition subsidy
Concept Approval and Feedback

- Review and approval by committee
- Review, feedback, and concept approval by:
  - Physician group decision makers – veto power?
    - Board
    - Owner vote
  - Hospital / IDS approval authority
- Vote on concept vs. individual impact?
  - First concept OK….may be non-binding
  - Physicians will want individual impact

Documentation

- Plan Documentation
  - Plan goals and objectives
  - Components
  - Methodology
  - Update frequency and change methodology
- Physician Agreements
  - Standard agreements with comp plan attachment
  - Comp plan amendments allowed without agreement renegotiation

Individual Physician Meetings

- Review physician specific comp projections
- Review contract language and any changes other than compensation
- What original deals will you "grandfather" in the new agreement (e.g. non-compete)?
Individual Physician Issues

• Personal Issues:
  – Work less vs. more (workaholics)
  – Life style expenses and debt
  – Divorce
  – Other family changes
  – Medical issues
  – Behavior
• What issues will impact process?

Post Implementation

• Assessment
  – Initial quarterly impact review
    • Financial
    • Subjective goals
  – Annual review
    • Compensation and/or finance committee
    • Decision makers and stakeholders
    • Individual physician reviews
  – Initiate change as necessary

Other Stuff
Good and Not So Good Plans

**Successful Plans**
- Understandable
- Frequent and trustworthy data
- Perception of “fairness”
- Support individual and entity goals
- Patient quality
- Recruit and retain physicians
- Group culture

**Unsuccessful Plans**
- Not aligned with individual and entity goals
- Inadequate physician participation and buy-in
- Data untrustworthy
- Poor practice operational support
- Inadequate cash
- Too complex
- Individual over group

Problems

- What is a CLE?
- Situations that put administrator’s job at risk:
  - Real Estate Projects
  - Mergers and Acquisitions
  - Changing Information Systems
  - Changing Compensation Plans
- Potential areas of conflict
  - Time available (how full is your bucket?)
  - Politics – internal physician factions
  - Blame after the fact
  - Appearance of “playing favorites”
  - Trust/lack thereof

No Agreement

- Occasionally can’t reach agreement
  - Reasons?
  - Start over?
  - Reset goals and objectives?
  - Change out committee / facilitator?
  - Defer for a year?
  - No change – Live with it
- Break up group?
  - Smaller groups?
  - Totally disband?
Final Recommendations

• Evaluate frequently – annually
• Objective measures
• Subjective measures
• Determine issues and problems
• Develop and test tune-up or fix options
• Involve physicians
• Implement change
• Start over

Contact Information

Jeffrey B. Milburn MBA, CMPE
MGMA Healthcare Consulting Group
1680 Old Stage Rd
Colorado Springs, CO 80906
jamilburn@jmilburn.com
jamilburn@mgma.org
719.4-375.3158

Questions?
Additional Topics and Resources

Physician Executive Leadership

- Survey Benchmarks
- Factors.....
  - Performance
  - Responsibilities
  - Training
  - Time allocation
    - Clinical
    - Management
    - Specialty based?

Outside Facilitator?

<table>
<thead>
<tr>
<th>Do It Yourself</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less expensive</td>
<td>More expensive</td>
</tr>
<tr>
<td>Resources may not be available, but may be adequate</td>
<td>Benchmarking resources</td>
</tr>
<tr>
<td>Shorter timeline?</td>
<td>Benchmarking experience</td>
</tr>
<tr>
<td>Perception of bias?</td>
<td>ID strengths weaknesses</td>
</tr>
<tr>
<td></td>
<td>Exposure to best practice alternatives</td>
</tr>
<tr>
<td></td>
<td>Facilitate process</td>
</tr>
<tr>
<td></td>
<td>Perceived to be unbiased</td>
</tr>
</tbody>
</table>
Transparency

- Support key organizational goals
  - Recruitment
  - Retention
  - Organizational Culture – individual to group
  - Growth
  - Trust
  - Understand model
- Organizational data & metrics
- Benchmarking data & metrics

Comp Plan Failure

- Physician discontent – perception of “fairness”
  - Internal inequities
  - External inequities
  - High producers
- Data problems – lack of trust
- Inadequate cash
- Understandability
- One size doesn’t fit all
- Subjective vs objective emphasis

Failure-continued

- Alignment of compensation and production
- Expense allocation
- Individual vs. group culture
- Inadequate patient demand
- Competition for patients
- Operational inefficiencies
- Lack of flexibility for environmental change
- Micro manage behavior or address behavior problems


Reimbursement Changes

- Medical homes
- ACO's
- Global payments
- Bundled payments
- Episodes of care
- Risk models

MGMA 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

RVUs: Applications for Medical Practice Success, 3rd Edition, Frank D. Cohen, MBB, MPA, MGMA 2013

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.

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


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

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

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.


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.
• Improve staff productivity.
• Ensure regulatory compliance.
• Reward quality of care.
• Increase participation or citizenship with practice administration and other activities.
• Improve patient satisfaction.
• 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 profit.
• Address changing trends in reimbursement.


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 nonproductivity 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 individuals 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?


Value-Based Team Oriented Compensation Plan Example

<table>
<thead>
<tr>
<th>Value-Based Team Oriented Compensation Plan Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
</tr>
<tr>
<td>Value-Based Team Oriented Compensation Plan Example</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
</tr>
</tbody>
</table>
### Method Used to Accommodate Part-Time Physicians

<table>
<thead>
<tr>
<th>Method</th>
<th>Better Performing Practices</th>
<th>Other Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid less and provided fewer benefits</td>
<td>44.83%</td>
<td>35.83%</td>
</tr>
<tr>
<td>Changed the overhead rate</td>
<td>16.25%</td>
<td>9.84%</td>
</tr>
<tr>
<td>Encouraged job sharing rather than part-time employment</td>
<td>5.42%</td>
<td>6.69%</td>
</tr>
<tr>
<td>Part-time physicians were not employed at the practice</td>
<td>27.59%</td>
<td>29.13%</td>
</tr>
<tr>
<td>Other accommodations for part-time physicians</td>
<td>10.78%</td>
<td>8.66%</td>
</tr>
</tbody>
</table>


### Weighing Options for Incentive Measures

<table>
<thead>
<tr>
<th>Performance or Quality Measure</th>
<th>Incentive Option A</th>
<th>Incentive Option B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Active medication lists maintained for 80% of patients</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Percentage of diabetic patients screened</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Percentage of diabetic patients with reduced A1c</td>
<td>5%</td>
<td>7%</td>
</tr>
</tbody>
</table>


### Differences between Traditional FFS and Value-Based Reimbursement

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

Four Rules to Benchmark Practice Data

1. Use the median instead of the mean. The median is the midpoint of a set of data, while the mean is the average. Typically, it is more beneficial to use the median when benchmarking because the median is not affected by statistical outliers (extremely high or low numbers) that would affect the mean.

2. Use survey tables that apply to your group. Select data to compare practices and physicians that are similar to your group practice. Comparing data based on geographic location, practice type (multi- or single-specialty) and size, ownership, and physician characteristics will result in better analysis and meaning.

3. Normalize your data. When you have to compare practices that are different types and sizes, you should normalize benchmarking data. Divide your data by varying units to assess multiple facets of your business. This will allow you to compare your data in several ways.

4. Know that benchmarking is ongoing. For full benefits, benchmarking your data with external data should be done on a regular basis to support continuous quality performance. For physician compensation and productivity, review comparative data on a monthly or quarterly basis.