Changing Compensation for Physicians in the New Era

December 6, 2013

Tom Dobosenski
Sullivan, Cotter and Associates, Inc.

612.294.3645
tomdobosenski@sullivancotter.com

Implications of Health Care Reform for Physician Compensation
Today’s Environment

• Rapid changes are occurring in the hospital and health system industry. Health care reform will:
  – Expand access, further increasing demand.
  – Reduce the level of reimbursement.
  – Impact how providers are paid.

• The population is growing and aging, which will also increase demand
• Number of physicians is marginally increasing and aging; thus future scarcity for certain specialties.
• Health care organizations (HCOs) continue to consolidate and move towards increased physician employment.

Bottom Line

• Changes in health care financing and delivery will be incremental and persistent – they will not occur overnight.
• This suggests a gradual evolution of physician compensation approaches with:
  – Increased emphasis on quality and efficiency.
  – Continued strong emphasis on productivity to ensure patient access.
Implications of Health Care Reform

Physician Employment and Affiliation Redefined

- Lower reimbursements and cost cutting pressures will test the relationship between administration and physicians.
  - The transformation of the health care industry requires new performance requirements.
  - Measurement systems of the past may not meet evolving needs going forward.
- Growing demand for physician executives to help lead health care organizations.
  - To help streamline and improve efficiency.
  - To manage complex networks of physicians – both employed and independent physicians.

Physician Pay-for-Performance

- Greater emphasis on incentive plans and performance, with particular focus on:
  - Cost reduction.
  - Quality.
  - Patient satisfaction.
  - Citizenship.
  - Integration.
  - EHR meaningful use.
- Incentive compensation.
  - Compensation Committees and Boards are increasingly active in the goal-setting process.
    - Requiring a greater ROI on incentive dollars.
    - Rethinking performance measurement in incentive plans.

Compensation Committees and Boards are more demanding, and are challenging the status quo.
Emerging Practices Related to Physician Compensation

Overview

- Physician compensation models need to be tailored to the characteristics that make each organization unique.

Physician Compensation Strategies

Overview

- Any physician compensation model has advantages and disadvantages – there is no perfect approach.
- The challenge is to select the model with the advantages of most importance to your organization.
## Compensation Plans by Clinic Size

### Primary Care Specialties

<table>
<thead>
<tr>
<th>Component</th>
<th>Overall (n = 47)</th>
<th>Change From 2012</th>
<th>Avg. % of Comp</th>
<th>Change From 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work RVUs</td>
<td>72%</td>
<td>5%</td>
<td>65%</td>
<td>0%</td>
</tr>
<tr>
<td>Base Salary</td>
<td>60%</td>
<td>3%</td>
<td>55%</td>
<td>7%</td>
</tr>
<tr>
<td>Quality Incentives</td>
<td>47%</td>
<td>47%</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Financial Incentives</td>
<td>23%</td>
<td>17%</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Discretionary</td>
<td>17%</td>
<td>6%</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>APC Supervision</td>
<td>17%</td>
<td>10%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Net Production</td>
<td>6%</td>
<td>6%</td>
<td>52%</td>
<td>6%</td>
</tr>
<tr>
<td>Panel Size</td>
<td>17%</td>
<td>5%</td>
<td>16%</td>
<td>5%</td>
</tr>
<tr>
<td>Cost Accounting</td>
<td>4%</td>
<td>1%</td>
<td>51%</td>
<td>23%</td>
</tr>
<tr>
<td>Equal Split</td>
<td>1%</td>
<td>4%</td>
<td>10%</td>
<td>1%</td>
</tr>
<tr>
<td>Call Pay</td>
<td>6%</td>
<td>4%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Gross Production</td>
<td>0%</td>
<td>2%</td>
<td>0%</td>
<td>37%</td>
</tr>
</tbody>
</table>

* Results from the 2013 Large Clinic Salary Survey

### Medical and Surgical Specialties

<table>
<thead>
<tr>
<th>Component</th>
<th>Overall (n = 48)</th>
<th>Change From 2012</th>
<th>Avg. % of Comp</th>
<th>Change From 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work RVUs</td>
<td>77%</td>
<td>2%</td>
<td>65%</td>
<td>1%</td>
</tr>
<tr>
<td>Base Salary</td>
<td>60%</td>
<td>3%</td>
<td>56%</td>
<td>4%</td>
</tr>
<tr>
<td>Quality Incentives</td>
<td>38%</td>
<td>45%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>Financial Incentives</td>
<td>27%</td>
<td>20%</td>
<td>9%</td>
<td>0%</td>
</tr>
<tr>
<td>Discretionary</td>
<td>19%</td>
<td>2%</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>APC Supervision</td>
<td>8%</td>
<td>3%</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>Net Production</td>
<td>8%</td>
<td>7%</td>
<td>52%</td>
<td>1%</td>
</tr>
<tr>
<td>Panel Size</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Cost Accounting</td>
<td>6%</td>
<td>2%</td>
<td>33%</td>
<td>4%</td>
</tr>
<tr>
<td>Equal Split</td>
<td>6%</td>
<td>2%</td>
<td>13%</td>
<td>2%</td>
</tr>
<tr>
<td>Call Pay</td>
<td>13%</td>
<td>8%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Gross Production</td>
<td>6%</td>
<td>0%</td>
<td>9%</td>
<td>0%</td>
</tr>
</tbody>
</table>

* Results from the 2013 Large Clinic Salary Survey
Work RVUs in Compensation Design
Still the Dominant Factor

- Seventy-two percent of Large Clinic® members use work RVUs as a direct component for primary care
  - 2012: 77%.
  - 2000: 27%.
- Other groups use RVUs as an indirect measure of productivity.
- Utilization of this component appears to have peaked.

Incentive Compensation

Incentives

- Compensation based on criteria for items other than direct and individual production
  - Average quality incentive as a percentage of total compensation is 9%, average financial incentive is 7%.
Key Trends

Lessons From the 1990s

• Most physician related predictions made in the early 1990s were inaccurate.
• Most compensation arrangements made with physicians at that time proved unsustainable

Hopefully, we can learn from our mistakes.
Critical Differences Today

- Future HCO success requires the ability to effectively and efficiently manage a patient population, which requires strong physician alignment.
- Indications are that private practice will be unsustainable.
- HCOs have enhanced their capacity to manage physician groups.
- Physician compensation may need to be subsidized to a greater extent by the HCO at a time when the ability to do so is declining.

*It is estimated that up to 50 percent of physicians are employed by HCOs and the percentage is expected to grow.*

Key Trends for 2013

Based on our analysis and our current field work, we identified the key trends below which impact physician compensation for 2013.

1. **Physician compensation continue to moderate.**
   - Across the primary care, medical and surgical specialties, compensation increased in some specialties are offset by reduction in others.

2. **The war for talent continues.**
   - More physicians are receiving sign-on bonuses in addition to lucrative base compensation packages.

3. **Other work effort requires payment.**
   - There is more demand for administrative compensation, call pay and mid-level supervision stipends.

4. **The industry transitions to pay-for-value.**
   - Physician organizations are moving towards pay-for-value versus pay-for-volume by integrating more at-risk incentives into their compensation plans.
Key Trends for 2013

5. Organizations align pay practices post-acquisition.
   With the current wave of specialty physician acquisitions, which often include unique and competitive compensation arrangements, health care organizations are challenged by issues of internal equity and prior commitments to physicians.

6. Advance Practice Clinicians (APCs) are on the rise.
   The value of APCs is rising as a result of upward pressure on demand for services, and potential efficiencies inherent in physician APC models. Physician compensation is also impacted.

7. Regulatory compliance concerns evolve.
   Physician compensation is an area of increasing regulatory concern. Traditional considerations of FMV have expanded to commercial reasonableness and effective ongoing governance practices.

Near Term Approaches

• In the near future, primary care provider compensation will focus on:
  – Patient access.
  – Patient satisfaction.
  – Panel size.
  – Efficiency of cost of care.
  – Clinical quality outcomes

• Office-based medical and surgical specialists will remain on wRVU productivity models with incentives based on clinical quality and patient satisfaction.
  – Specialists, however, will be increasingly responsible for taking steps to generate new patients.

• Alignment of compensation with strategic goals will continue, and the proportion of compensation at-risk for quality outcomes will increase.
Emerging Near Term Approaches

- Emerging compensation models will retain a production element over the next two to three years.
- Patient satisfaction is becoming a standard measure.
- Clinical outcomes being introduced; initially clinical process measures.

Next Generation Models

- Will balance production with patient outcome measures.
- Quality measures will move beyond process to outcomes.
- Cost of care across the continuum will emerge as an important factor.
Changing Compensation for Physicians in the New Era
Tom Dobosenski

December 6, 2013

Compensation Program Transition

Culture
How fast to move the pendulum?

People, Process and Technology
How fast to move the pendulum?
Drivers of Successful Physician Comp Plans

- Coordinated Care
- Quality
- Cost Efficiency
- Patient Experience

Compensation Program Transition

Healthcare System

Stakeholders
- Hospitals
- Physician Enterprise
- Community

Business Needs
- Operational
- Growth
- Financial Performance
- Governance and Philosophy

Infrastructure/Delivery
- Leadership
- Financial Data
- Performance Data
- Quality Metrics

Physician Compensation Strategy
- Access
- Recruitment
- Retention
- Culture
- Physician Engagement
Examples of Transitional Compensation Models

The Primary Challenges

- Enhancing measurement systems for use in an environment that pays for value.
- Moving from paying for volume to value at a pace that matches reimbursement approaches.
- Developing the physician leadership needed to change the culture.
Physician Leadership A Must

**TO-DO LIST**

1. Determine and implement new clinical standards.
2. Improve EHR and registries to support population health.
3. Redesign operational processes to support patient care coordination.
4. Engage peers to identify and reduce clinical variation.
5. Engage in strategic and tactical payer contracting.

Transition to Value-Based Plans

- Transition must not outpace payer reimbursement migration to value-based incentives.
- Furthermore, more time is needed to train a new generation of primary care physicians to manage a population (or panel) versus managing an individual patient.
Sample Transition Approach

Example transition from productivity-centric plan to value-based plan

Current Plan  Years 1 to 2  Years 3 to 5  Years 5+

- The plan is assumed at 100% production.
- A major cultural shift is required in the transition.
- Data collecting and reporting is inadequate.
- 100% Production Plan continues.
- Performance measure data collected and tested
- Shadow reports created.
- Work group created to identify non-productivity metrics and tie them to compensation pools.
- Transition completed.
- Potential combination of production, nonproduction and guaranteed salary components.

• Production compensation reduced.
• Funding established for nonproduction pools.
• Nonproduction incentives grow every year and are continuously evaluated and approved.

Summary

- Health care reform has already begun to impact MD compensation.
- HCOs nationally are engaged in MD compensation and benefit plan redesign.
- HCOs are putting compensation at risk based on achievement of patient satisfaction and quality goals, while maintaining a heavy focus on production.
  - Compensation at risk is in the 5%-20% range today.
  - Larger at-risk components in the future.
- Leading organizations are building the infrastructure for improved, timely reporting of quality outcomes and service indicators.
- Compensation will increase modestly in the near-term.
Action Items

• HCOs are well served to prepare a MD compensation and benefits strategy that balances the following:
  – A multi-year transition to outcomes-based payments.
  – MD recruitment needs based on anticipated volume shifts.
  – Anticipated impact of market consolidation with an eye toward key MDs.
• HCOs should be investing in **physician leadership** as it will be critical for success in the future.
• Partner with **payer contracting** to understand and potentially influence the commercial payer direction of at-risk incentives.