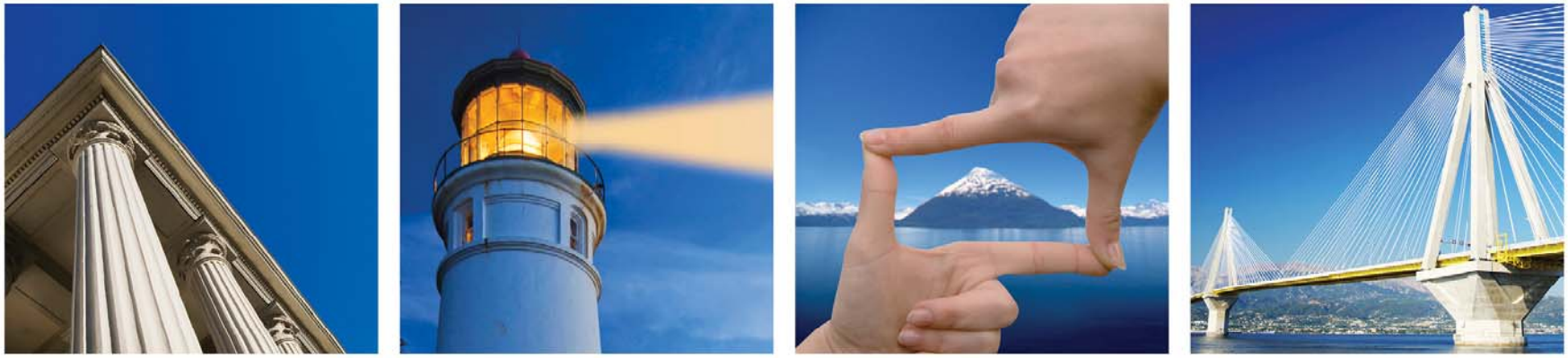


Physician Compensation: Where the Market is Going

HR Council

March 13, 2013

Presented to:

AMGA
American Medical Group Association®

SullivanCotter
AND ASSOCIATES, INC.

INTEGRITY INDEPENDENCE INSIGHT INFORMATION

Today's Presentation

- Key Changes for the AMGA 2013 *Medical Group Compensation and Financial Survey*
- *2012 Advanced Practice Clinician Compensation and Pay Practice Survey*
- The AMGA 2012 *Medical Group Compensation and Financial Survey*
  - Overview
  - Shifts in Physician Compensation Plans
  - Results
- CMS Work Relative Value Unit (wRVU) Changes and Impacted Specialties
- Operational / Financial Performance Benchmarking Initiative
- Questions / Discussion

Key Changes for the AMGA 2013 *Medical Group Compensation and Financial Survey*

Key Changes for the AMGA 2013 *Medical Group Compensation and Financial Survey*

- Data collection
  - Total FTE along with Clinical FTE
  - Compensation breakout
    - Medical directorship
    - On-call pay
    - Administrative
    - Research and teaching
    - Chair Section
  - Primary care panel size
- Online survey submission
- Potential Online Reporting for 2014
- Report Changes (75/25)

Additional 2013 AMGA Survey Specialties

Addition of the following specialties:

Specialty Name	
Anesthesiology – Pediatric	Pathology – Surgical
Cardiovascular Anesthesiology	Perfusionist
Cataract Surgeon	Thoracic Oncological Surgery
Endovascular Surgery	Transplant Nephrology
Internal Medicine – Medical Home	Urological Oncology
Interventional Neurology	Medical Director – ACO
Medical Oncology	Pediatrics and Adolescent – PM and R
Neurology – EMG Lab	Perfusionist
Neurology – Epilepsy/EEG Lab	Thoracic Oncological Surgery
Neuro-Oncology	Transplant Nephrology
Oral-Maxillofacial Surgery	Urological Oncology
Otolaryngology – Pediatrics	Medical Director – ACO
Pathology – Pediatric	

Results From the 2012 *Advanced Practice Clinician Compensation and Pay Practices Survey*

Cover

Advanced Practice Clinician Compensation and Pay Practices Survey

Survey data effective May 1, 2012

Sullivan Cotter 360

AMGA

Introduction

- AMGA annual Human Resources Leadership Council reported (in March 2012) the following:
  - Significant vacancies
  - Base pay demands outside market data
  - Finding the appropriate mix of base, incentive and special pay
- CFO Leadership Council also voiced a desire to have additional benchmarking information specific to APCs
- Conducted in partnership with the AMGA
- Now available on the AMGA website

Background of APC Survey

- Physician shortages
- Changing the medical model by using APCs to account for the expected increase of the insured population
- Movement to outcomes versus productivity-based reimbursement allows for physicians to focus on more complex patients
- APCs can accomplish the following:
  - Monitor patients
  - Educate patients
  - Provide follow-up care
- Assist in developing an APC compensation strategy

Data Collection Process – Current

- Organizations received an email containing a link to participate in the survey
- Online submission of survey, including an electronic submission of incumbent data
  - Minimal organizations unable to submit using the electronic submission
- Timeline
  - Launched on May 4, 2012
  - Collected by June 6, 2012
  - Published on December 12, 2012
- Cost
  - Participants: free
  - AMGA members: $350
  - Non-AMGA members (health care related): $1,500

Data Collection Process – Future

- Future process
  - Completion of prior SullivanCotter survey(s) will allow for pre-population of organizational characteristics
  - Ability to assign a colleague to complete the survey or a sub-section of the survey on your behalf
  - Timeline
    - Launch in June 2013
    - Collect by July 2013
    - Report in November 2013
  - Cost will continue to be free to participants
- Feedback for the 2013 *Advanced Practice Clinician Compensation and Pay Practice Survey*
  - Sarah DeVries, Survey Manager
  - sarahdevries@sullivancotter.com or 612.294.3640

About the APC Survey

- Compensation components
  - Base pay
  - Premium pay
  - Bonus and incentive pay
  - On-call pay
  - Education reimbursement
  - Sign-on or retention bonus
  - Benefits
  - Productivity
- Pay practice strategies
  - Reporting structure
  - Hiring trends
  - Compensation increase and decrease trends
  - Salary grades and ranges
  - Administrative roles
  - Staffing ratios
- Eighty-six percent of the participants represent hospitals or medical centers and integrated delivery systems
- Seventeen percent are academic medical centers

Other responses include ambulatory clinic, ambulatory health care center, health care cooperative – staff model HMO.

Specialties

Specialty Name	
Certified Registered Nurse Anesthetist	Nurse Practitioner – Surgical Specialty – Other
Nurse Midwife	Physician Assistant – Cardiology
Optometrist	Physician Assistant – Emergency Room
Nurse Practitioner – Cardiology	Physician Assistant – Medical (Non-Surgical, Non-Primary Care)
Nurse Practitioner – Emergency Room	Physician Assistant – Medical Oncology
Nurse Practitioner – Medical (Non-Surgical, Non-Primary Care)	Physician Assistant – Medical Specialty – Other
Nurse Practitioner – Medical Oncology	Physician Assistant – Neonatology
Nurse Practitioner – Medical Specialty – Other	Physician Assistant – OB/GYN
Nurse Practitioner – Neonatology	Physician Assistant – Pediatrics
Nurse Practitioner – OB/GYN	Physician Assistant – Primary Care
Nurse Practitioner – Pediatrics	Physician Assistant – Primary Care – Medical Home
Nurse Practitioner – Primary Care	Physician Assistant – Primary Care – Own Patient Panel
Nurse Practitioner – Primary Care – Medical Home *	Physician Assistant – Surgical – General
Nurse Practitioner – Primary Care – Own Patient Panel	Physician Assistant – Surgical Specialty – Cardiovascular
Nurse Practitioner – Surgical – General	Physician Assistant – Surgical Specialty – Other
Nurse Practitioner – Surgical Specialty – Cardiovascular	

**Collected, but not reported.*

APC Hiring Trends

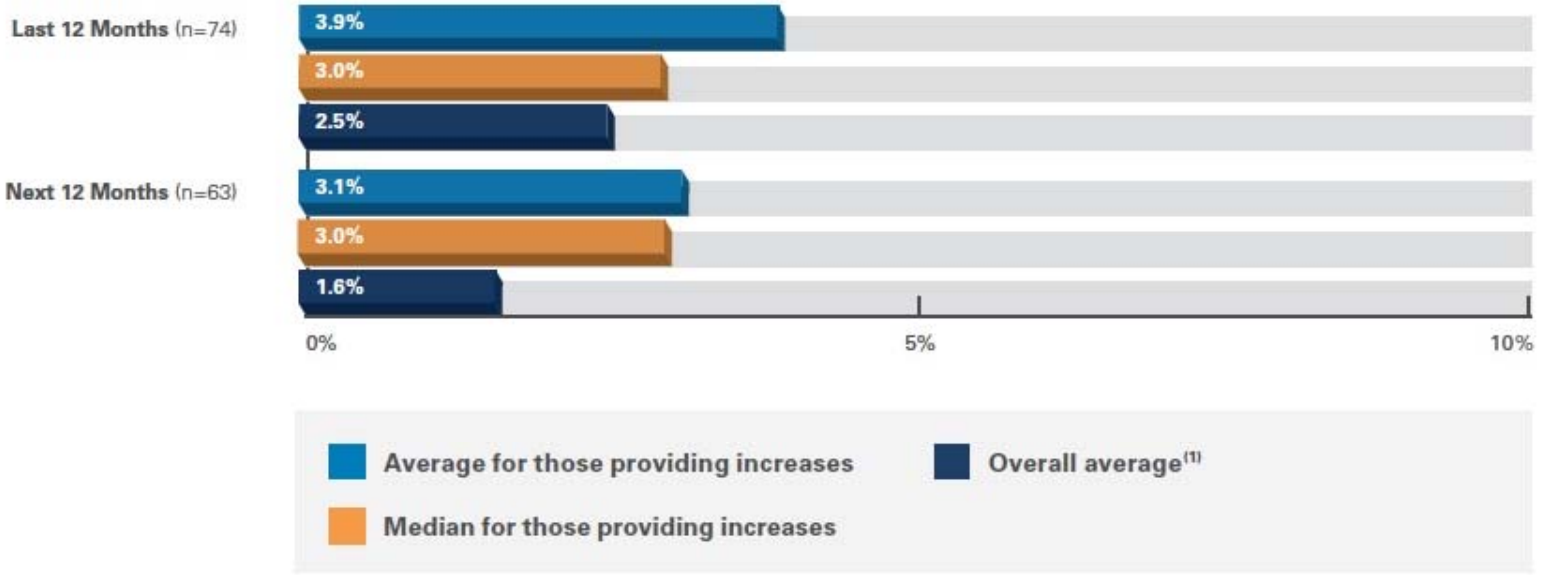
- Sixty-three percent have increased the size of their APC workforce within the last 12 months
- Fifty-three percent indicated they plan to increase the size within the next 12 months

Increase in APC Workforce				
	Increase in Last 12 Months		Projected Increase in Next 12 Months	
	Average	Median	Average	Median
Percentage of APCs	17%	13%	15%	13%
n = 135				

APC Compensation Trends

- Sixty-two percent of 135 participants provided salary increases to APCs in the last 12 months
- Median increase is 3.0 percent as noted in the table below

CHART 2.3 – Salary Increase Percentages for APCs

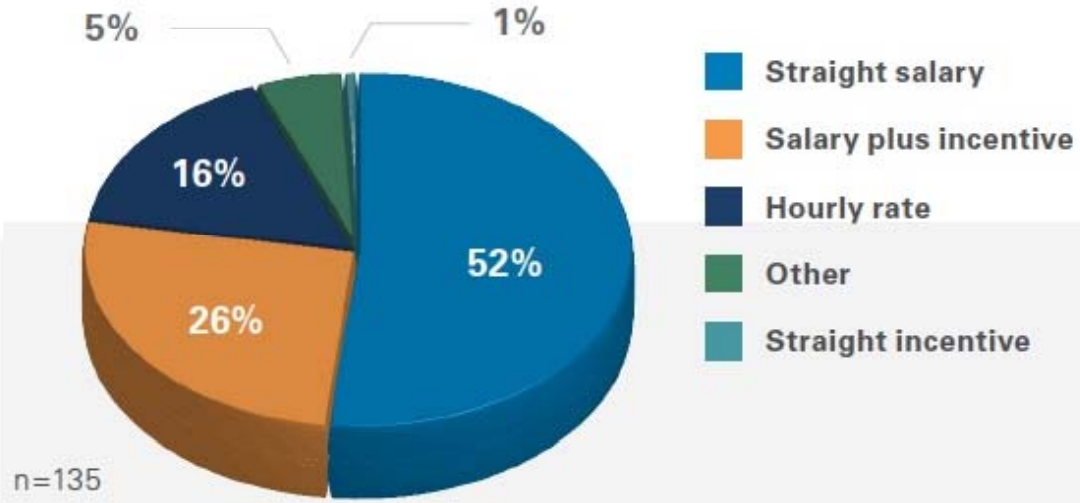


(1)The average actual and projected salary increase percentages, including the organizations that did not or do not plan to make salary increases.

Compensation Approach

- Fifty-two percent use a salary-only compensation approach for their APCs
- Twenty-six percent utilize a salary-plus-incentive approach

CHART 2.4 –Compensation Approaches for APCs



Note: The data reported reflect the approach used for the majority of the APCs.

Premium Pay

- About 40 percent of the organizations provide additional pay to APCs for working weekday nights, weekends and holidays
- Of those providing additional pay, the following was compiled:
  - Weekday nights
    - Eighty-one percent provide a premium to the hourly rate (median: $3.50 or 15 percent)
    - Fourteen percent provide a stipend per shift
  - Weekends
    - Seventy-five percent provide an hourly rate increase (median: $3.50 or 10 percent)
    - Twenty percent provide a stipend per shift
  - Holidays
    - Ninety-two percent provide an hourly rate increase (median: 50 percent equals 1.5x)
    - Four percent provide a stipend per shift

Incentive Compensation – Prevalence

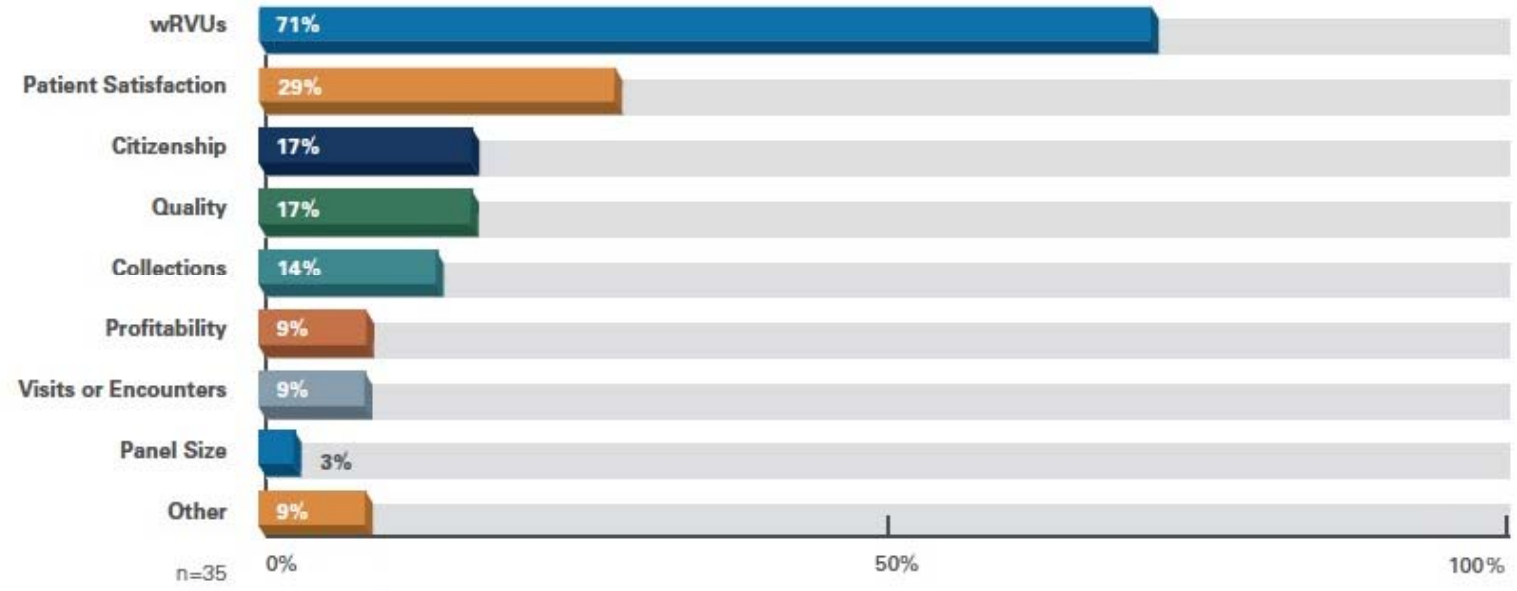
- Forty-one percent of 170 participants provide incentive compensation to their APCs
- Of those that provide incentive compensation, how it is allocated is shown in the table below

CHART 2.6 – Variation of Incentive Compensation

Incentive Pay – Metrics

- wRVUs (71 percent) were the most frequently reported metric
- Patient satisfaction (29 percent) is the second most prevalent

CHART 2.7 – Prevalence of Metrics Used as Part of Incentive Compensation Approach



Note: Percentages add to more than 100% due to multiple responses.

Incentive Compensation – Amounts

- Incentives depend on a number of factors:
  - Measurable goals and reliable metrics in place
  - Incentive payout plans need to make economic sense
  - Shouldn't drive inappropriate competition between APCs and physicians
  - Shouldn't violate regulatory requirements
- The most common change in organizations that plan to change the incentive plan involves the use of quality metrics (35 percent)

Incentive Compensation: Combined Metrics	n	25th Percentile	Average	Median	75th Percentile
Average Annual Amount	16	$4,405	$8,734	$7,148	$9,770
Percentage of Base Salary	11	5.0%	9.4%	9.1%	14.0%

On-Call Pay and Signing Bonus

- On-call pay
  - Sixty percent of 163 participants require APCs to provide unrestricted call coverage
    - Of these, 67 percent provide on-call pay for the coverage
      - Seventy-two percent provide an hourly rate
      - Twenty-eight percent provide a stipend per shift
- Sign-on bonus
  - Approximately 35 percent of 163 participants provide a sign-on bonus to recruited APCs
  - Sixty-seven percent that provide a sign-on bonus to APCs have a payback provision
    - One year: 44 percent
    - Two years: 41 percent
    - Three years: 15 percent

Sign-On Bonus

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    - One year: 44 percent
    - Two years: 41 percent
    - Three years: 15 percent

APC Specialty Specific Data

National Summary Tables						
Data Element by Specialty	n	25th Percentile	Average	Median	75th Percentile	90th Percentile
Compensation						
Nurse Practitioner - Primary Care [1]	5,140	$87,000	$98,828	$96,990	$107,249	$119,686
Physician Assistant - Surgical [2]	1,590	$89,400	$104,087	$101,175	$117,300	$130,925
Collections						
Nurse Practitioner - Primary Care [1]	690	$163,000	$250,573	$241,700	$317,271	$404,501
Physician Assistant - Surgical [2]	225	$102,457	$208,180	$159,639	$265,000	$449,030
wRVUs						
Nurse Practitioner - Primary Care [1]	743	2,432	3,253	3,293	4,155	4,923
Physician Assistant - Surgical [2]	299	1,315	2,335	1,924	3,032	4,497
TCC/Collections						
Nurse Practitioner - Primary Care [1]	690	0.316	0.523	0.398	0.571	NA
Physician Assistant - Surgical [2]	225	0.402	0.817	0.671	0.983	NA
TCC/wRVUs						
Nurse Practitioner - Primary Care [1]	743	$24.86	$35.06	$31.34	$38.96	NA
Physician Assistant - Surgical [2]	299	$37.10	$65.77	$54.52	$83.54	NA

[1] Includes Primary Care, Primary Care - Medical Home, Primary Care - Own Patient Panel

[2] Includes Surgical - General, Surgical Specialty - Cardiovascular and Surgical Specialty - Other

Feedback

- Additional specialties
  - NP/PA: hospitalist
  - NP/PA: pediatric breakout of medical and surgical
  - Emergency medicine: hospital versus physician group
  - Dermatology
  - Chairs
- Separate by at-will versus contracted APCs
- Breakout wRVUs by incident to versus provider billed
- Early evening versus overnight premium pay
- Clarification of allowable versus used (CME, tuition reimbursement, etc.)
- Additional questions regarding supervision
- Information regarding APCs carrying overhead
- Anything else?

Overview of the AMGA 2012 *Medical Group Compensation and Financial Survey*

AMGA 2012 *Medical Group Compensation and Financial Survey* Highlights

- AMGA and SullivanCotter have conducted this survey for 24 years
- One of the top physician compensation salary surveys in the nation
- Compensation and production data based on approximately 55,800 providers and 225 medical groups
- Focused on multispecialty groups across the nation

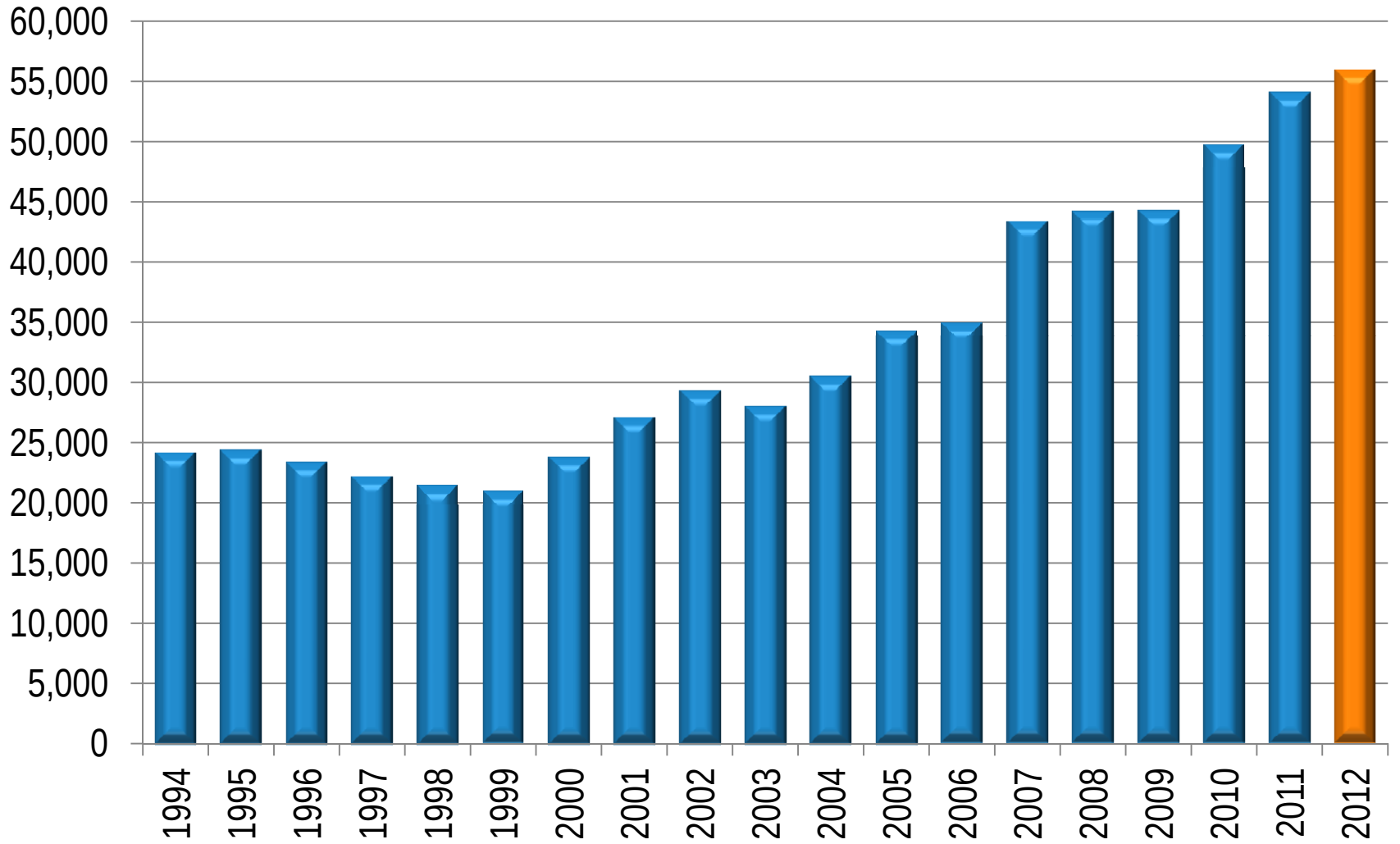
AMGA 2012 *Medical Group Compensation and Financial Survey* Highlights

- Over 150 specialties and non-physician patient care provider positions

- New Specialties in 2012
  - Consult liaison psychiatrist*
  - Hepatology*
  - Neurology – epilepsy/EEG lab
  - Neurology – EMG lab*
  - Pulmonary disease (with and without critical care)
  - Pulmonary intensivist
  - Burn surgery*
  - Oral-maxillofacial surgery*
  - Orthodontics*
  - Anesthesiology – pediatric*
  - Diagnostic radiology – pediatric*
  - Pathology – pediatric*
  - Pathology – surgical

**Collected, but not reported.*

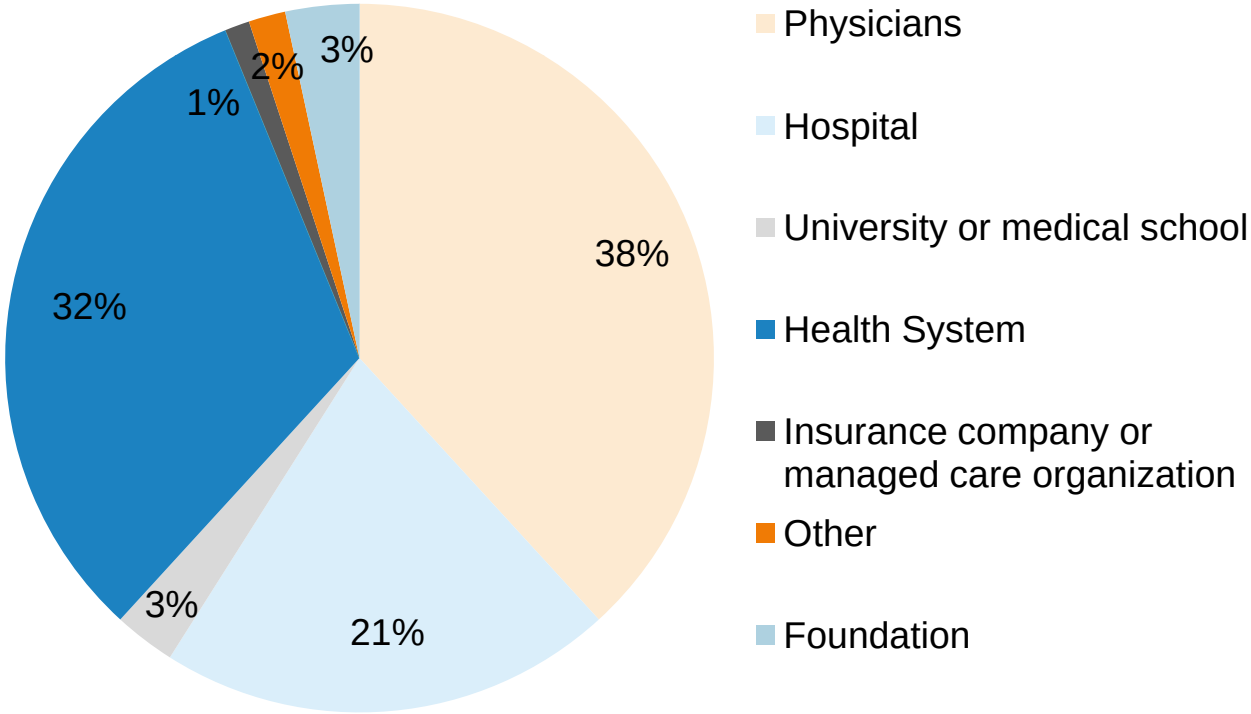
Participants in the Survey



Overall Survey Demographics

- Ninety-five percent are multispecialty groups
- Fifty-eight percent are not-for-profit groups
- Twenty-eight percent have academic affiliations

Figure 2: Majority Ownership (n= 178)



Shifts in Physician Compensation Plans – 2012
Medical Group Compensation and Financial Survey

Compensation Plans by Component

Primary Care Specialties

Component	Overall (n = 174)	Change From 2011	Avg. % of Comp	Change From 2011
Work RVUs	68%	↓ 2%	71%	0%
Base Salary	33%	↑ 4%	55%	0%
Other Incentives	29%	↑ 2%	9%	↑ 1%
Net Production	24%	↓ 3%	73%	↑ 4%
Administration	18%	↓ 2%	4%	0%
APC Supervision	16%	↑ 1%	3%	0%
Discretionary	14%	↑ 1%	5%	↓ 1%
Cost Accounting	11%	↑ 3%	73%	↑ 4%
Panel Size	5%	↑ 1%	10%	↓ 1%
Equal Split	5%	↓ 4%	10%	↓ 4%
Call Pay	4%	↓ 6%	5%	↓ 2%
Gross Production	4%	↓ 3%	51%	1%

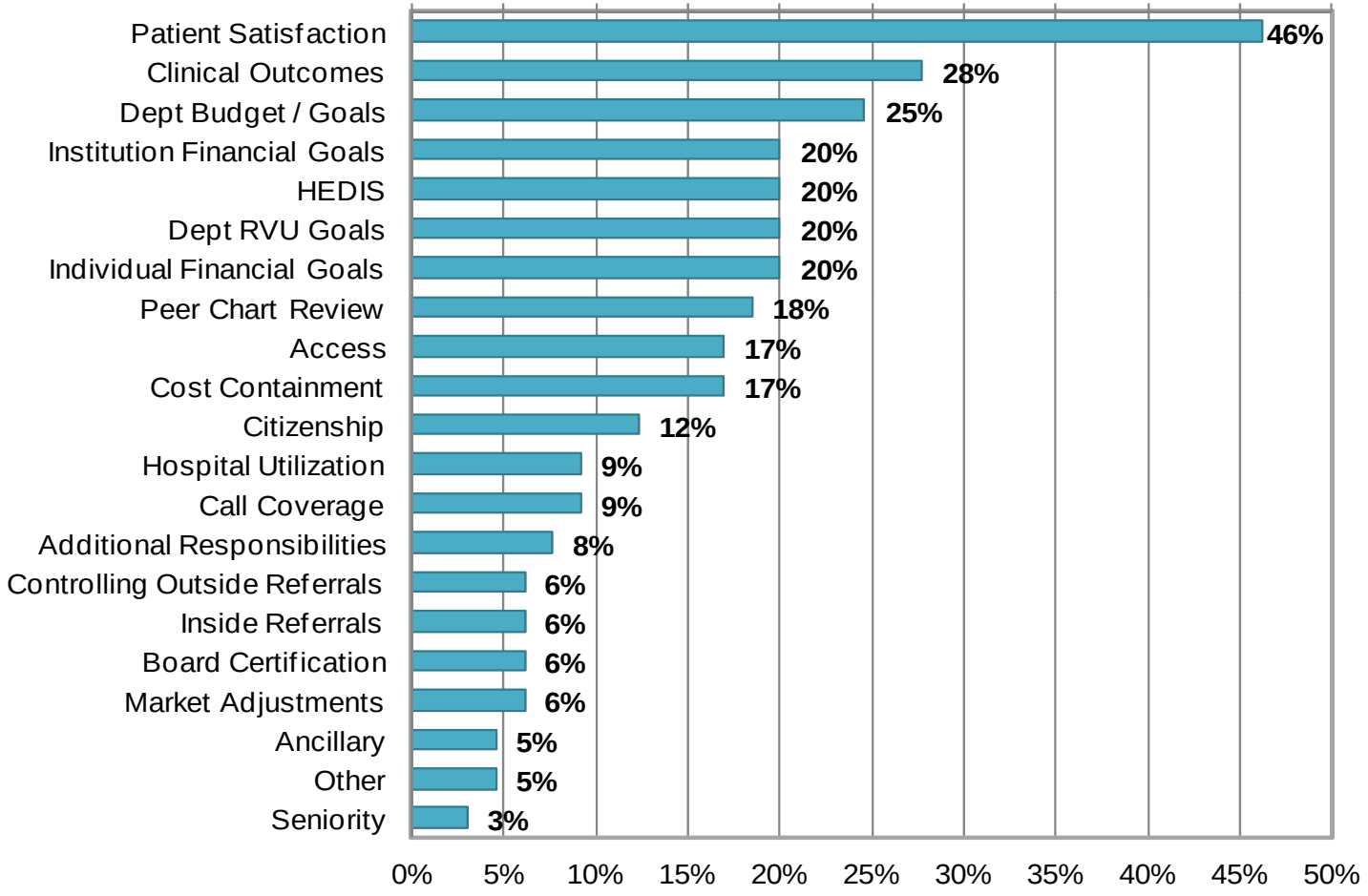
Compensation Plans by Component

Medical and Surgical Specialties

Component	Overall (n = 168)	Avg. % of Comp
Work RVUs	68%	65%
Base Salary	40%	57%
Other Incentives	29%	8%
Net Production	23%	68%
Administration	17%	5%
Discretionary	12%	4%
Call Pay	12%	5%
Cost Accounting	11%	67%
APC Supervision	5%	2%
Equal Split	5%	13%
Gross Production	4%	28%
Panel Size	1%	10%

Incentives: Factors Considered in Incentives and Discretionary Pay

Figure 8: Other Incentive and Discretionary Compensation (n = 65)



Other Common Issues Affecting Compensation Plans

- Fair market value assessments
- Total cost of care
- Part time
- Team care and medical home
  - APC supervision
  - Quality measures
  - Population management
- Aligning APC compensation arrangements

Other Common Issues Affecting Compensation Plans

- It is common to have multiple plans based on specialty types:
  - Anesthesiology
  - Hospitalists
  - Primary care
  - Emergency medicine
  - Certain sub-specialties
- As revenue opportunities shift (e.g., ACO), so will compensation alignment
  - One- or two-sided shared savings
  - Bundled payments
  - Partial capitation
  - Global payments

Compensation Models Will Evolve

- Compensation models will be gradually adjusted as hospitals and health systems lose the ability to subsidize their medical groups
- Emerging models will maintain a heavy focus on production
- Inclusion of *at-risk* incentives will become commonplace
  - Patient satisfaction is becoming a universal measure
  - Clinical quality and outcomes goals will grow in application
- Organizations will tie at-risk goals to established metrics, including the core measures and the physician quality reporting system

The transition of compensation models will be gradual – not an overnight shift.

Physician Compensation Strategies

The most appropriate compensation model for a physician group is a function of many variables and are unique to each organization, including the following:

- **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.**

Key Trends

- Based on available data and our experience, we note the following environmental trends that will significantly affect physician compensation:
  - Health care reform
  - The growing and aging population
  - The physician shortage and aging physician supply
  - Consolidation to better align physicians and hospitals
  - Changes in health care financing and delivery that will be incremental, but persistent
- This suggests a gradual evolution of physician compensation approaches with more emphasis on quality and efficiency
  - Physician compensation in large groups and health systems will mostly increase in the near term (two to three years)

Results – 2012 *Medical Group Compensation and Financial Survey*

Overall Change Results

Median Component Evaluated*	Weighted Average Change in Physician Specialties	Prior Year Weighted Average Change	Percentage of Specialties Increased	Percentage of Specialties Decreased
Compensation	2.8%	2.4%	80%	20%
wRVU	-0.5%	0.0%	54%	46%
Comp/wRVU	3.3%	3.0%	65%	35%

**Does not include specialties that have not been reported two years or less. Includes specialties reported in 2011 and 2012.*

Specialties – Primary Care

Specialty	Compensation		Work RVUs		Compensation per Work RVU	
	2012 Median	% Change	2012 Median	% Change	2012 Median	% Change
Family Medicine	219,362	5.1%	4,890	-1.7%	$42.94	7.7%
Internal Medicine	224,417	2.2%	4,717	-2.5%	$47.11	6.5%
Pediatrics & Adolescent - General	220,644	3.4%	5,111	0.4%	$42.10	4.6%

- Higher than average compensation increases for primary care
- Decreasing personally performed wRVUs, flat personally performed wRVUs or both
- Aggressive increase in compensation per wRVU rates
- Primary care specialties saw the largest average increase in compensation per wRVU
- Are there one time payments to MDs, such as meaningful use allocations?

Specialties – Medical

Specialty	Compensation		Work RVUs		Compensation per Work RVU	
	2012 Median	% Change	2012 Median	% Change	2012 Median	% Change
Cardiology	430,316	1.7%	6,934	-2.7%	$59.69	5.8%
Dermatology	397,370	2.9%	7,282	-2.1%	$57.16	4.8%
Endocrinology	221,400	-5.0%	4,393	-1.2%	$49.55	-4.6%
Gastroenterology	435,120	4.6%	7,992	-1.0%	$56.18	0.4%
Hypertension & Nephrology	277,934	7.0%	6,159	3.0%	$48.23	7.1%
Infectious Disease	229,511	1.8%	4,299	4.4%	$51.03	2.4%
Neurology	249,250	1.1%	4,717	-3.1%	$52.06	1.0%
Physical Medicine & Rehabilitation	253,750	2.3%	4,621	-2.4%	$52.36	-0.2%
Psychiatry	217,194	0.0%	3,381	-8.1%	$60.27	3.0%
Pulmonary Disease (without Critical Care)	304,901	0.6%	6,057	0.7%	$48.21	-4.3%
Reproductive Endocrinology	336,352	4.3%	4,155	-6.6%	$69.69	-6.6%
Urgent Care	242,145	5.2%	5,217	3.9%	$43.24	2.8%

- Medical specialties compensation per wRVU rate increases were above average (4.2 percent)
- Some of the changes in hypertension and nephrology are due to the creation of a nephrology-only specialty

Specialties – Surgical

Specialty	Compensation		Work RVUs		Compensation per Work RVU	
	2012 Median	% Change	2012 Median	% Change	2012 Median	% Change
Emergency Medicine	297,500	4.1%	7,073	2.0%	$42.12	0.1%
General Surgery	370,024	0.7%	7,026	-0.8%	$54.00	3.0%
Neurological Surgery	656,250	4.9%	9,261	0.1%	$70.09	4.9%
OB/GYN - General	303,350	0.2%	6,476	-2.5%	$46.33	1.9%
Ophthalmology	371,987	4.4%	8,649	-1.9%	$41.84	1.2%
Orthopedic Surgery	515,759	2.8%	8,026	0.0%	$64.44	0.5%
Otolaryngology	374,387	-0.8%	6,891	-0.5%	$56.20	1.8%
Urology	415,598	0.4%	7,456	-0.6%	$56.59	4.5%

- Surgical specialties had flat to moderate increases in compensation
- Prior year wRVU changes are showing in this year's benchmarks
- This has some impact in higher compensation per wRVU rates

Revenue and Expense

Revenue/Expense	2008 Median % of Net Revenue	2010 Median % of Net Revenue	2011 Median % of Net Revenue	2012 Median % of Net Revenue
Collected Charges	100.0%	100.0%	100.0%	100.0%
Physician Compensation	35.5%	39.1%	41.5%	38.8%
Physician Benefits	3.3%	4.1%	3.9%	4.2%
Retirement	2.1%	1.9%	2.1%	2.3%
Midlevel Compensation	2.2%	2.9%	2.5%	2.9%
Midlevel Benefits	0.5%	0.6%	0.6%	0.6%
Nursing and MA Salaries	6.7%	7.6%	7.9%	7.5%
Radiology and Imaging Salaries	1.5%	1.5%	1.4%	1.4%
Information Systems Salaries	0.7%	0.7%	0.7%	0.9%
Other Operational Support Salaries & Benefits	15.5%	15.6%	15.4%	15.0%
Medical and Surgical Supplies and Drugs Expense	5.1%	6.2%	5.9%	6.9%
Building and Occupancy Expense	6.0%	6.4%	6.4%	6.6%
Information Services Expense	0.8%	1.1%	1.6%	1.5%
Professional Liability	2.3%	1.7%	1.6%	1.4%
Bad Debt Expense	2.2%	3.1%	2.9%	2.6%
Total Expenses	100.7%	102.6%	104.6%	103.7%

CMS wRVU Changes and Impacted Specialties

Operational / Financial Performance Benchmarking

Operational / Financial Performance Benchmarking

- Increasing demand being seen by SullivanCotter, message boards on the AMGA site, CFO council discussion, etc. on more financial benchmarking
  - **Additional detail on total rewards (benefits, etc.)**
  - Normalized benchmarking of practice revenue, volume and cost
  - **Staffing ratios**
  - Statistics on deliveries, visits and surgeries per provider
  - Medical home / ACO breakdowns
- Additional desired data elements
  - Benchmarks of measures and efficiencies
  - Expenses by specialty and skill drilldown (MA, RN, LPN)
- Total cost of care – what is the definition?

Questions and Contacts

Bradley Vaudrey
Principal

Bradley S. J. Vaudrey is a Principal in the Minneapolis office of Sullivan, Cotter and Associates, Inc. Prior to joining the Firm, Brad worked with RSM McGladrey as a director in the human capital consulting group.

Throughout his career, Brad's primary focus lies in providing management and operational consulting services to health care organizations. More specifically, he has managed, designed and implemented a myriad of projects in the following areas:

- Physician compensation planning and implementation.
- Compensation and productivity surveys.
- Productivity and operational best practice results.
- Fair market value and intermediate sanction evaluation.
- Cost accounting development for health care organizations.
- Operational planning.
- Mergers and acquisitions of medical groups.
- Fringe benefits programs.

Brad is a member of the American Institute of CPAs (AICPA), Minnesota Society of CPAs (MNCPA), Healthcare Financial Management Association (HFMA), the National Association of Healthcare Consultants (NAHC) and the Medical Group Management Association (MGMA). He is a frequent speaker and author on the topics of physician compensation and financial benchmarking.

Brad holds a Master of Business Administration with an emphasis in accounting from Missouri State University and a Bachelor of Science in accounting, with finance, IT and management minors.

Brad can be reached at bradvaudrey@sullivancotter.com or 612.294.3644.

Sarah Devries
Consultant

Sarah DeVries is a Consultant in the Minneapolis office of Sullivan, Cotter and Associates, Inc. Sarah has worked in the health care industry since 2001 and has significant expertise with hospital and provider contracting analysis as well as Web-based communications strategies.

During her career, Sarah has participated in and managed numerous projects within health care organizations. A sample of these includes the following:

- Conducting charge analyses and benchmarking studies for all health care service categories.
- Providing financial analysis and acute invoice validation services.
- Performing contract analyses for payers and providers that modeled proposed contracts in order to demonstrate financial position and assist in rate structure development and negotiation strategies.
- Developing a validation tool that analyzed claims data against clinical coding errors and contract compliance issues.
- Analyzing merger and acquisition synergies by determining cost savings as a result of comparing discounts between providers, identifying savings opportunities and prioritizing remediation plans for hospitals and physicians.
- Defining strategies for a health and wellness Web portal in order to optimize the consumer experience.
- Managing communication capabilities by writing business requirements used for website development, developing use cases and assisting in web portal user interface design.

Sarah is also the Survey Manager for the SullivanCotter *Advanced Practice Clinician Compensation and Pay Practice Survey*, which launched in April 2012 and focuses on APC compensation strategies and approaches.

Sarah completed her MBA at St. Cloud State University in May of 2007. She is also a graduate of the Carlson School of Management at the University of Minnesota with a Bachelor of Science degree in actuarial science and a minor in finance.

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