Physician Compensation
Trends and Models

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Road Map

OUR WORLD IS CHANGING

EMPLOYMENT TRENDS

EXPLORE COMPENSATION MODELS

KEY TAKEAWAYS
OUR WORLD IS CHANGING
Market Forces Continue to Threaten Status Quo

All Purchasers Looking to Curb Spending

1. **GOVERNMENT**
   - Site neutrality provision receiving attention
   - Value-based payment heightening performance pressure
   - Medicare doubling down on risk

2. **EMPLOYERS**
   - Continued expansion of high deductibles, narrow networks
   - Self-insured employers focusing on utilization control
   - Sustained adoption of private exchanges

3. **CONSUMERS**
   - Continued premium sensitivity on exchanges
   - Price sensitivity increasing at point of care
Price Cuts Continue Unabated

Hospitals Bearing the Brunt of Payment Cuts

Reductions to Medicare Fee-for-Service Payments

New proposals Continue to Emerge

President’s FY2016 Budget Proposal Includes Significant Cuts to Providers

$30.8B
Reduction in Medicare bad debt payments

$29.5B
Savings from moving to site-neutral payments

14.6B
Cuts to teaching hospitals and GME payments

$720M
Cuts to critical access hospitals


1) Inpatient Payment System
2) Disproportionate Share Hospital
3) Medicare Access and CHIP Reauthorization Act 2015
Site Payment Differential Seizing National Attention

Administration Budgets for Site Neutrality, CMS Gathers Site-of-Care Data

Obama Targets Site Payment Gaps in 2016 Budget Request

- Budget provision would lower payments to services provided in off-campus hospitals outpatient departments
- Phased-in changes begin 2017

Finalized Timeline for Physicians, Hospitals to Report Place-of-Service Information

Voluntary hospital reporting of place-of-service (POS) using HCPCS' modifier

- January 2015
- Mid-2015
- January 2016

New physician POS codes introduced

POS reporting becomes mandatory for hospitals and physicians

Site-of Service Data Tracking Initiative

- CMS to identify sites that receive provider-based rates for ambulatory care but do not incur hospital facility costs due to being off campus
- Hospitals billing under HOPPS¹ required to report HCPCS² modifier when services are performed at off-campus sites
- Physicians, other billing providers required to report site of care using new place-of-service code on professional claims

¹) Hospital Outpatient Prospective Payment System
²) Healthcare Common Procedure Coding System

Steady Shift Towards Risk-Based Payment

Medicare Value-Based Purchasing Program Performance Criteria

Other Mandatory Risk Programs

Hospital-Acquired Conditions Penalty

Readmission Penalties

No Trivial Thing

6% Medicare revenue at risk from mandatory pay-for-performance programs¹, FY2017

Weight in Total Performance Score

1) Indicates Value-Based Purchasing Program, Hospital Readmissions Reduction Program, and Hospital Acquired Conditions Program
High Deductibles Dominating Exchange Markets

Individual Deductibles Offered on Public Exchanges

2014

$2,500  $6,250

Median  Maximum

Individual Deductibles Chosen on eHealth Individual Marketplace

<table>
<thead>
<tr>
<th>Deductible Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$1,000</td>
<td>30%</td>
</tr>
<tr>
<td>$1,000-$2,999</td>
<td>39%</td>
</tr>
<tr>
<td>$3,000-$5,999</td>
<td>10%</td>
</tr>
<tr>
<td>$6,000+</td>
<td>16%</td>
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</tbody>
</table>

Challenges for Providers

- High out-of-pocket costs discourage appropriate utilization
- Large patient obligations lead to more bad debt, charity care
- Price-sensitive patients more likely to seek lower-cost options

Aggressive Cost Sharing Potential Troublesome for Provider Strategy
Huge Growth Forecast for Private Exchanges

Low-Wage Employers Most Active Today, but Skilled Industries in the Wings

Potential Growth Path for Private Exchange Enrollment

Private exchange operators as of October 2014
Walmart Brining Everyday Low Prices to Health Care

Low-Cost Access Potentially Just the Beginning

Care Clinic Model
Pricing:
For Walmart employees: $4
For Walmart customers: $40

Hours:
Weekdays: 8am-8pm
Saturday: 8am-5pm
Sunday: 10am-6pm

Service:
• Two nurse practitioner providers
• primary care services on site
• Clinic refers to external specialists, hospitals as appropriate

Probably Worth Paying Attention
“Our goal is to be the number one health-care provider in the industry.”

Ladeeb Diab
President of Health & Wellness
Walmart

130M
Annual emergency department visits

150M
Weekly visits to Walmart stores
Millennials to Medicare

Primary Care Preferences Vary by Age

18 - 29

Extended Hours
Clinic is open 24/7
ranked highest among convenience attributes by this cohort

Value

Eliminating Out-of-Pocket Charges
Visit will be free was these cohort’s top preference across all 56 clinic attributes

Reputation

What Reputation
These cohorts seemed to care less about reputation than the 65+ cohort – no reputation factors appeared in their top 20 attributes. Their highest-ranked reputation factors were Clinic’s patient satisfaction survey scores are in the top 10% for my area and Clinic has a partnership with best hospital in my area

30 - 49

Time to First Available
I can walk in without an appointment and be seen within 30 minutes ranked highest among convenience attributes by these cohorts

50 - 64

Convenience

Convenience Trumps Free
Time to first available and ancillaries on-site preferred over free visit

65 +

Ancillaries On-Site
I can get lab tests or x-rays done at the clinic ranked highest among convenience attributes

Convenience and Service Trump Free
Provider continuity and Provider credentials preferred over free visit

Brand and Affiliation
4 of the top 20 clinic attributes were on reputation

Source: Primary Care Consumer Choice Survey
EMPLOYMENT TRENDS
Employment and Investment Levels Unsustainable

Ensure Sustainable Investment Levels and Keep Patients in Network

Direct Operating Loss Per Employed Physician

2014 Operating Loss

- 75th Percentile
- Median
- 25th Percentile

2008 2009 2010 2011 2012 2013 2014

($104)  ($215)  ($190)  ($175)  ($176)  ($175)  ($325)  ($194)  ($92)  ($193)  ($309)
## Benchmark Versus Your Reality

Median Compensation per wRVU rates

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2009</th>
<th>09-'10 Change</th>
<th>09-'10 Change</th>
<th>10-'11 Change</th>
<th>11-'12 Change</th>
<th>2013</th>
<th>12-'13 Change</th>
<th>09-'13 Change</th>
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<tbody>
<tr>
<td>Cardiology: Invasive-Interventional</td>
<td>$48.60</td>
<td>7.84%</td>
<td>8.80%</td>
<td>2.52%</td>
<td>$60.79</td>
<td>3.98%</td>
<td>25.08%</td>
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<tr>
<td>Family Medicine (without OB)</td>
<td>$39.12</td>
<td>3.45%</td>
<td>5.56%</td>
<td>2.11%</td>
<td>$45.34</td>
<td>3.93%</td>
<td>15.90%</td>
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<tr>
<td>Gastroenterology</td>
<td>$53.93</td>
<td>2.07%</td>
<td>2.53%</td>
<td>5.86%</td>
<td>$55.29</td>
<td>-7.47%</td>
<td>2.51%</td>
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<tr>
<td>Hematology/Oncology</td>
<td>$79.38</td>
<td>10.52%</td>
<td>4.77%</td>
<td>2.41%</td>
<td>$98.44</td>
<td>4.58%</td>
<td>24.00%</td>
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<tr>
<td>Internal Medicine: General</td>
<td>$42.49</td>
<td>2.78%</td>
<td>6.13%</td>
<td>4.22%</td>
<td>$50.74</td>
<td>5.04%</td>
<td>19.41%</td>
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<tr>
<td>Neurology</td>
<td>$48.80</td>
<td>5.65%</td>
<td>2.11%</td>
<td>4.08%</td>
<td>$60.25</td>
<td>9.96%</td>
<td>23.45%</td>
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<tr>
<td>Orthopedic Surgery: General</td>
<td>$60.10</td>
<td>0.49%</td>
<td>5.21%</td>
<td>8.95%</td>
<td>$68.00</td>
<td>-1.78%</td>
<td>13.14%</td>
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<tr>
<td>Pediatrics: General</td>
<td>$38.91</td>
<td>2.66%</td>
<td>4.89%</td>
<td>0.92%</td>
<td>$43.40</td>
<td>2.64%</td>
<td>11.53%</td>
<td></td>
</tr>
<tr>
<td>Pulmonary Medicine: General &amp; Critical Care</td>
<td>$46.14</td>
<td>8.34%</td>
<td>4.84%</td>
<td>2.32%</td>
<td>$57.85</td>
<td>7.88%</td>
<td>25.39%</td>
<td></td>
</tr>
<tr>
<td>Surgery: General</td>
<td>$50.13</td>
<td>5.12%</td>
<td>2.79%</td>
<td>3.82%</td>
<td>$58.92</td>
<td>4.77%</td>
<td>17.54%</td>
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</tr>
<tr>
<td>Surgery: Vascular (Primary)</td>
<td>$45.46</td>
<td>9.98%</td>
<td>8.48%</td>
<td>3.44%</td>
<td>$56.44</td>
<td>0.61%</td>
<td>24.16%</td>
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<tr>
<td>CMS Conversion Factor</td>
<td>$36.07</td>
<td>2.17%</td>
<td>-7.84%</td>
<td>0.18%</td>
<td>$34.02</td>
<td>-0.06%</td>
<td>-5.68%</td>
<td></td>
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</table>

Source: MGMA 2013 national benchmarks; CMS.gov
SGR Repeal the Latest Push Toward Risk

Both Tracks Impose Greater Risk, Strong Incentives for Alternative Models

PFS Payment Models Beginning in 2019

1 **Merit-Based Incentive Payment System (MIPS)**
   - Consolidates existing P4P programs
   - Score based on quality, resource use, clinical improvement, and EHR use
   - Adjustments reach -9%/+27% by 2022
   - From 2019 through 2024, potential to share in $500M annual bonus pool

2 **Alternative Payment Models (APMs)**
   - Provides financial incentives (5% annual bonus in 2019-2024) and exemption from MIPS
   - Requires that physicians meet increased targets for revenue at risk
   - APMs must involve downside risk and quality measurements

MIPS Performance Category Weights for 2021

1) Physician Fee Schedule
2) Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System
3) Includes risk-based contracts with Medicare Advantage plans

Source: The Medicare Access and CHIP reauthorization Act of 2015
EXPLORE COMPENSATION MODELS
An Uphill Battle

Compensation Change Elicits Strong Feelings on All Sides

It Takes An Expert

“Anyone who can settle the issue of fair and appropriate physician compensation to everyone’s satisfaction within a diverse Group of doctors should then go to the Middle East and settle their affairs.”

Watch Your Back

“When compensation redesign is done wrong, it’s career ending …. While we were going through these changes with our physicians, I was so scared I should have had a dog sniff my car at the end of the day.”
Case Study Mix

A menu of Transition Options from Volume to Value

1. Slow Transition from Volume to Value
2. Paced Transition towards Value (PCMH)
3. Aggressive Transition from Volume to Value
4. Business Model Transformation (Disruptive Innovation)
Case Study #1

University Health System and Faculty Plan

- Physicians compensated via base salary and limited productivity incentives
- Difficult to retain and recruit, losing high producers
- Compensation model design and implementation
Case Study #1
Compensation Undermining Alignment

Findings

Uncompetitive Base Compensation
- Ongoing pressure from physicians to increase base salaries
- Disparate compensation for administrative, non-clinical work
- Lack of transparency fueling concerns about compensation quality

Unaligned Physician Faculty
- Deep rooted distrust between physicians and administration
- High rates of physician turnover

Meaningless Incentive Structure
- Productivity incentive capped at 15% of base
- Productivity physicians maxing out mid-year
- No incentives for revenue cycle charge capture or collections
- All division profits absorbed by the Department
Case Study #1
Compensation Alignment Pre-Implementation

Physician Compensation vs wRVUs

- Review Against Benchmarks
  - Weighted Averages – Private Practice Benchmarks
  - Weighted Averages – Academic Benchmarks
  - Your Physicians
- Create a graph using the data above
  - Creates a story of compensation for your physicians
Case Study #1
Developing a New Model

Promoting Physician Engagement in Compensation Redesign

- Calibrating Mutual Understanding
  - Convened steering committee of key physician leaders, group and hospital administrators
  - Facilitated mutual understanding of income statements, practice and hospital-level finances
  - Grounded expectations regarding reasonable compensation

- Redesigning the Compensation Model
  - Base compensation and related productivity targets based upon national academic benchmarks
  - Incentives pooled and tied to net income
  - Negotiated a fixed investment on a prospective basis tied to service line success

- Transitioning to the New Model
  - Compact born and signed by administration and clinical leadership
  - Ongoing communication between physicians and administrators to ensure overall financial viability
Case Study #1
Definition of a Clinical FTE

Old Method
- Research was based on funded dollars
- Time spent teaching, administrative and clinical was based on whatever the physician documented
- Resulted in VERY low clinical FTEs
- Low threshold to achieve productivity targets
- Unrestricted protection for un-funded time

New Method
- Research was based on funded dollars
- Balance of time was considered clinical
- Examine and standardize protected time for administrative duties
- Result in much higher clinical FTEs
- Higher threshold to achieve productivity targets
- Restricted protection for un-funded time
Case Study #2

Group Practice

Legacy Compensation

- Since inception, physicians were paid on the revenue minus expense model
- Physicians in high commercial market could make the same as physicians in high government market while seeing half as many patients
- The compensation committee was developed (physicians and administration) to review compensation plan due to changing market forces and physician dissatisfaction
- The recommended plan was adopted

Adopted Compensation Plan

- 85% wRVU
- 5% Quality
- 5% Service Excellence
- 5% Strategic Goals
Case Study #2
Group Practice

Productivity
- 85% of the conversion factor times the number of RVUs
- Reconciled quarterly based on year-to-date productivity level

Service Excellence
- The metric used in this case is patient experience
- **Scoring:** If 95% or above (5% comp), 90-94.9% (3% comp), 85-89.9% (1% comp), <85% (0% comp)

Quality
- Specialty specific. Each specialty is measured on the least 2 metrics which will be approved by the Clinical Quality Committee
- **Scoring:** 2 metrics met (5% comp), 1 metric met (2.5% comp), 0 metrics met (0% comp)

Strategic Goals
- Metrics used in this include:
  - Expense Management (2%)
  - Patient Access (2%)
  - Culture of Collegiality (1%)
## Case Study #2
Group Practice

### Productivity Conversion Factor

<table>
<thead>
<tr>
<th></th>
<th>Productivity below the midpoint between the 25th and median MGMA specialty specific percentile</th>
<th>Productivity between 37.5th – 50th MGMA specialty specific percentile</th>
<th>Productivity between 50th – 75th MGMA specialty specific percentile</th>
<th>Productivity above 75th MGMA specialty specific percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Productivity</strong></td>
<td>$38.25</td>
<td>$47.80</td>
<td>$50.20</td>
<td>$52.71</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>$2.25</td>
<td>$2.812</td>
<td>$2.953</td>
<td>$3.1005</td>
</tr>
<tr>
<td><strong>Service Excellence</strong></td>
<td>$2.25</td>
<td>$2.812</td>
<td>$2.953</td>
<td>$3.1005</td>
</tr>
<tr>
<td><strong>Strategic Plan</strong></td>
<td>$2.25</td>
<td>$2.81</td>
<td>$2.953</td>
<td>$3.1005</td>
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<tr>
<td><strong>Total</strong></td>
<td>$45</td>
<td>$56.24</td>
<td>$59.06</td>
<td>$62.01</td>
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</table>
Case Study #3
Medical Group Practice

Pacing the Transition to Value-Based Incentives
Aligning Primary Care Physician Compensation to Care Transformation

1. PCPs act as care team, care managers, referral directors

2. Cost-conscious, value-oriented PCP decisions essential to organization’s success as ACO

3. Looking to reward PCPs whose choices result in high-quality, low-cost care

Case in Brief:
- System has made aggressive moves to population management
- As part of shift, redesigned primary care physician compensation ahead of reimbursement change
Case Study #3
Medical Group Practice

Incentivizing Care Transformation

Components of New Primary Care Compensation

Cost of Care
- Assess utilization of high tech diagnostic imaging
- Assess 72-hour follow-up rate following hospital, ED discharge

Panel Growth
- Teams assessed on:
  - Panel size
  - Encounter volumes
- RVUs not used as the productivity metric

Only 30% of total compensation based on individual productivity performance; remaining 70% (including all cost, quality, and patient experience measures) based on site or department performance.

Patient Experience
- Patient survey used to assess likeliness to recommend
- Compared against external CG-CAHPS benchmark

Clinical Quality
- Specialty-specific metrics, e.g.:
  - Family practice: diabetes, cancer screening, asthma control
  - Pediatrics: immunizations, asthma, ADHD
Road Map
Key Components of an Efficient Model of Care

Are we building a cohesive group culture through organization structure, leadership, and accountability for performance?

Does fulfillment of objectives drive achievement of our vision?
Compensation Plan Should (Help) Reinforce Culture

Current Compensation Practices at Odds with Future Reality

<table>
<thead>
<tr>
<th>Today</th>
<th>Production often favored</th>
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</thead>
<tbody>
<tr>
<td>Other</td>
<td>16%</td>
</tr>
<tr>
<td>Straight Salary</td>
<td>21%</td>
</tr>
<tr>
<td>Percent of Collections</td>
<td>21%</td>
</tr>
<tr>
<td>wRVU Based</td>
<td>42%</td>
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</table>

Tomorrow
Measuring performance in terms other than production

Hospitals and physicians alike will be paid or penalized based on Value:
- Readmit and Value-Based Purchasing
- Shared Savings
- Bundled Payments

Health System Mission Example
Staging a Physician Compensation Plan Redesign

Best Practice Approach

Six-Step Incremental Process to Achieving a Sustainable, Unified Compensation

Agree Upon

Today’s Reality

- Start with vision and mission
- Define and agree upon organization’s current financial and compensation realities

Education and Brainstorming

- Best practice research and insights from other organizations
- Facilitate ownership through brainstorming session

Model and Investigative Impact Scenarios

- Upon principal agreement on construct, model ballpark compensation impact scenarios by provider
- Identify nuances and potential consequences of the proposed work

Today’s Focus

Establish “Ballpark” Framework

- Propose framework construct – “the ballpark”
- Propose responsible transition plan

Finalize the Model

Based on mutual appreciation of the models, devise compensation plan structure and language that can be embedded into a compact or employment agreement

Transition Plan and Initiation

Implementation and roll out of the compensation model across a responsible and agreeable timeline developed and agreed upon prior to initiation
Developing Core Principles of Compensation

Agreeing on the “Menu Set” of Non-Negotiables

SAMPLE

Core Principles of Compensation

- Compensation plan will be simple, easy to understand, and standardized across employees of the same specialty
- Allocations from the health system must be predictable and financially sustainable
- Must be attractive for recruitment and retention
- Must be equitable and within FMV
- Must be grounded within our mission statement
- Must contemplate a short list of meaningful quality metrics by specialty
- Must transition from individual to group compensation pool to incent team-based care and growth of panel
- Transition must be gradual from current model to new model with ability to adjust quality as revenue streams change

- Compensation plan will be flexible year-to-year based upon managed care conditions
- Compensation plan will have a component based upon the quality of medical care
- Compensation plan will have a component based upon the quality of the patient experience
- Compensation plan will reward physicians with higher education
- Compensation plan will contain a mechanism to reward expense management and/or adherence to budget
- Compensation plan will contain a mechanism to define and reward good citizenship and/or support of strategic goals
- Compensation plan will contain a mechanism to recognize and reward physician leadership
Key Components of a Redesigned Plan

Features that Drive Successful Compensation

- Simple, easy-to-understand
- Standardized across employees of the same specialty
- Attractive for recruitment and retention
- Equitable and within fair market value
- Grounded within mission
- Predictable and financially sustainable health system allocations
- Meaningful quality metrics by specialty
- Group compensation pool to incentivize team-based care
- Quality metrics adjusted as revenue streams change

Physician Rewards

- Based on quality of medical care and patient experience
- Reward physicians with higher productivity
- Reward expense management
- Reward good citizenship and physician leadership
- Flexible year-to-year based on managed conditions
A Dashboard: For the Physician

Compensation Dashboard – “Example”
Migrating Away From Pure-Productivity Goals

Key Non-Productivity Priorities for Medical Group Leaders

Ensuring High-Quality Care
- NCQA metrics
- Diabetes management
- Smoking cessation, cholesterol
- Blood Pressure

Expanding Access to Care
- Extended hours
- Engaging in retail, urgent care partnership
- Supervising care team members

Maximizing Patient Experience
- Satisfaction with service
- Limited wait time
- Smooth scheduling processes

Maximizing Avoidable Costs
- Lowering readmissions
- Generic drug prescription
- Preventing excess utilization
What’s Your Threshold for Pain?

Implementation Speed Should Accommodate Physician Resistance

Common Physician Concerns About Compensation Model Change

Inability to predict Future income

Lack of access to data, tools needed to succeed under new compensation imperatives

Sense of confusion, disenfranchisement

<table>
<thead>
<tr>
<th>Pain Scale</th>
<th>Transition Rate</th>
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<tbody>
<tr>
<td>Little to No Pain</td>
<td>Gradual Transition</td>
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<tr>
<td>Moderate Pain</td>
<td>Decelerated Transition</td>
</tr>
<tr>
<td>Extreme Pain</td>
<td>Rapid Transition</td>
</tr>
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</table>

1 2 3 4 5 6 7 8 9 10
Summary Thoughts

1. The world is changing

2. There is a lot of noise

3. Start with the vision and a common understanding of the strategic plan

4. We cannot ignore the current and future financial reality

5. Wonderful excuse to re-engage physician leaders

6. Compensation plan should reinforce desired culture

7. Compensation plan should be documented through a policy

8. Ensure you have the technology in place to report on key metrics

9. Allow time to be your friend (if you can afford it)

10. Be Brave