Physician Compensation Strategies in Academic Medical Centers

In a Changing Environment

Lisa Keane, Consultant to AAMC
Kim Mobley, SullivanCotter

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Introduction

Academic Medical Center (AMC) Participants

Key Findings
• Organizational Structure and Governance
• Perspectives on Compensation
• Advanced Practice Providers

Objectives of the Study

Advancing the Compensation Framework
Compensation and Governance Continuum
Academic Medical Center Participants

- Beth Israel Deaconess Medical Center
- Cedars-Sinai Medical Center
- Cleveland Clinic
- Duke Medicine
- Emory Healthcare
- Henry Ford Health System
- Lahey Health
- MedStar Health
- North Shore-LIJ Health System
- Penn Medicine
- UC Health
- UNC Health Care
- University of Michigan Health System
- University of Pittsburgh Medical Center
- UT Health Science Center San Antonio
- VCU Health

AAMC and SullivanCotter interviewed executives representing the physician enterprises associated with these AMCs between Feb. and Aug. of 2015
Objectives of the Study

Identify CURRENT and ASPIRATIONAL physician compensation strategies for:

- Faculty Physicians
- Community-Based Physicians

- Current Organizational Structures
- Insights of Current Compensation Plan Structures
- Governance of Physician Compensation
- Utilization of APPs and APP Compensation Strategies

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Organizational Structure and Governance
Organizational Structure

Comparing Structures

Faculty * Physicians

- Employed physicians – no medical group structure
- Group practice
- Faculty Practice Plan (FPP)

Community-Based Physicians

- Employment through:
  - Primary teaching hospital
  - System community hospital(s)
  - Single integrated medical group
  - Medical groups owned by health system
- Affiliation through CIN, PHOs, etc.

Structures vary significantly and M&A activity has increased this

* Used broadly to describe those physicians engaged in academic activities
### Organizational Structure

<table>
<thead>
<tr>
<th>Category</th>
<th>Characteristics</th>
</tr>
</thead>
</table>
| **10 — Faculty Practice Plans**  | • Physicians employed in a FPP  
• FPP has an executive leader  
• All or most physicians have faculty appointments at an integrated or closely related medical school |
| **1 — Integrated System Employed Physicians** | • No physician organization  
• Many physicians have faculty appointments at an integrated or closely related medical school |
| **3 — Health System Group Practices** | • Physicians employed in a group practice linked to a health system  
• Medical group has an executive leader  
• Some physicians have faculty or teaching appointments at a separate medical school |
| **2 — Health System Employed Physicians** | • Health system employs some but not all physicians  
• Some physicians have faculty or teaching appointments at a separate medical school |
Funding of Physician Compensation

Distribution of funding sources varies among organizations and between faculty and community physicians

Third Party Reimbursement
• FFS for Professional Services
• Quality payments

Hospital/Health System Funding

Provided For
• Medical administration
• Resident teaching
• Network expansion
• Strategic programs
• Salary packages for new recruits/chairs

FFS STILL PROVIDES MAJORITY OF COMP FUNDING FOR BOTH FACULTY AND COMMUNITY PHYSICIANS

Many AMCs are reviewing continued support and funding levels for unfunded research and scholarly pursuits
Funding of Physician Compensation

Other Funding
- Contracted clinical services revenue
- Research grants
- Endowments and special purpose funds
- State funds

School of Medicine (SOM)

Provided For
- UME
- Didactic teaching
- Administrative leadership
- Salary packages for new recruits/chairs
Compensation Governance

Oversight and management varies widely, but the **2 key factors** that tend to dictate where an organization falls along the governance continuum are:

**LEADERSHIP**

**CULTURE**

Many AMCs have established some or all of the following, but to varying degrees:

- **Physician Compensation PHILOSOPHY**
- **Physician Compensation GUIDING PRINCIPLES**
- **Review and Approval of PROCESS(ES)**
Faculty Compensation
Faculty Compensation

Among most AMCs, strong emphasis on clinical productivity to strengthen enterprise financial performance

- Primarily based on work Relative Value Units (wRVUs)

The concept of value-based compensation has not been clearly defined within the industry and is evolving

- Value-based generally refers to some type of metric which DOES NOT produce wRVUs or professional fees
Faculty Compensation

Performance incentives include traditional metrics such as:
• Citizenship
• Teaching excellence
• Published research
• Collegiality

Quality incentives using performance metrics tied to:
• Clinical process
• Outcomes
• Cost reductions (within regulatory limits)
• Patient experience

NO Direct Revenue Impact
Encourages desired behaviors to support the academic mission and culture

Direct Revenue Impact
Consistent with changes in reimbursement. May have more direct impact in future
Faculty Compensation

Quality-based incentives are

- Amount of compensation remains relatively small
  - Typically less than 5% of total cash compensation (TCC)
- Performance typically measured at the individual level; however, some are measuring at the department level
- Development of true and/or meaningful quality metrics remains challenging in highly specialized areas

The use and amount of compensation tied to quality will likely increase as reimbursement shifts from volume to value
Faculty Compensation

A number of AMCs indicated they are in the process of evaluating their approaches to:

- Defining **clinical full-time equivalent** (cFTE)
- Funding and time allocations for **research**
  (some have or are considering eliminating funding/time for unfunded research and/or scholarly pursuits)
- Time allocations for **teaching**
- Redefining “**protected time**”

As economic pressure mounts, more organizations are looking to increase clinical effort across the faculty.
Faculty Compensation

Total Cash Compensation: $250,000
Research/Teaching Funding: $50,000
4,000 wRVUs

Funding of protected time results in lower compensation available on a per wRVU basis

Clinical
$200k - $60k = $140k
4,000 wRVUs
$35 per wRVU

Research
$25k Funded

Teaching
$25k Funded

10% Protected
$60k Unfunded

$50 per wRVU

Clinical
$200k
4,000 wRVUs
$50 per wRVU

Research
$25k Funded

Teaching
$25k Funded
Faculty Compensation

Hospital-based specialties have often had different compensation approaches due to the practice model for these types of physicians

- Models are predominantly shift-based or hourly with additional compensation for extra effort
- Although uncommon today, there is some expectation that these plans will include quality-based components in the future

The approach to faculty compensation among hospital-based specialties in most AMCs is consistent with market practice throughout the country
Faculty Compensation

Faculty compensation and productivity are typically benchmarked to one or more of the following market surveys:

- AAMC: Medical School Faculty Salaries Survey
- UHC-AAMC: Faculty Practice Solutions Center (FPSC) productivity data
- AMGA: Medical Group Compensation and Financial Survey
- MGMA: Physician Compensation and Production Survey
- SullivanCotter: Large Clinic® Physician Compensation Survey
- SullivanCotter: Physician Compensation and Productivity Survey Report

There is considerable variability among AMCs as to which market survey(s) they rely upon for benchmarking faculty compensation.
Faculty Compensation

Most of the AMC’s have a **target market strategy** but indicate market position of faculty TCC falls below their productivity targets.

For example, to ensure financial sustainability, a physician must produce at the **65th percentile** to achieve **50th percentile** TCC.

Many AMCs offer mission-driven services, which tend to result in significant amounts of under-funded care.
Faculty Compensation

- Some target the market median of the AAMC survey – However, some are having difficulty achieving that
- Recruitment and retention issues directly related to faculty compensation were identified by a few of the AMCs interviewed

AMCs are often able to recruit and retain high-quality talent based on their:

- Reputation
- Mission
- Culture
Faculty Compensation

Economic Factors

1. Physician Work Effort Allocations
2. Benchmarking
3. Physician Track

Balanced with Ability to Support the Mission

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Community-Based (CB) Physician Compensation
CB Physician Compensation

- Numerous community-based practices affiliated with AMCs
- Significant variability in compensation plan design
- Strong emphasis on clinical productivity

TREND: Movement towards greater alignment and consistency for compensation plans

Despite the variability in plan design, financial performance continues to be a critical component of most community-based practices
CB Physician Compensation

More likely to include quality-based compensation as the physicians are predominantly primary care

A number of organizations are piloting the use of quality-based metrics in primary care community-based practices

A small number of organizations are considering transitioning to a salaried model with incentive tied to quality metrics

Some interest in use of panel size metrics

Community-based primary care physicians are leading the transition from volume to value
CB Physician Compensation

• Other considerations: competitiveness of compensation

Higher compensation levels than faculty counterparts

Less generous benefits

• A few organizations have indicated they are experiencing challenges with their community-based physician strategy
  – Enhanced competitiveness for CB physicians within their local markets
• May require use of different benchmarks to ensure competitiveness of the compensation levels

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Advanced Practice Providers (APPs)
Advanced Practice Providers

Most groups have a strategy to **increase** the number of APPs

- Generally, APPs are **not considered** faculty
- Compensation is largely or entirely **salary-based** – incentives are **not commonly utilized**
- Variation in billing practices for APPs

Some groups only use **incident-to billing** and/or **shared/split services**

Others allow APPs to bill **independently**, when appropriate

The use of APPs varies widely and is influenced by organizational culture, physician attitudes and state scope of practice regulations
Advanced Practice Providers

Apprehensive Utilizers

• Physicians accept APPs on the care team BUT they do not want wRVU credit assigned to APPs
• Wary of having APP costs assigned to physician P&Ls

Enthusiastic Utilizers (mostly specialists)

• APPs are viewed as a resource that allows the physicians additional time to perform more complicated services and potentially enhance their productivity

Most organizations reported that they have not fully optimized the utilization of APPs
Steps for Advancing Your Compensation Framework
1. Establish a Compensation Philosophy and Driving Lanes

Develop a framework and guiding principles, including:

- Define a target range for total compensation (TCC and benefits) and market positioning
- Define the components of cash compensation to be included, such as base salary, variable compensation and incentive compensation
  - Identify acceptable performance metrics, such as quality/outcomes, scholarly productivity and citizenship
- Establish a minimum percentage of compensation that should be “at risk” based on performance
- Set parameters for exceptions
- Document the process for reviewing and approving compensation, including exceptions
- Ensure all arrangements are legally compliant
2. Define Quality-Based Performance

Agree on what quality-based performance means for your organization

☑ Performance metrics should be a well-balanced portfolio which reflect all aspects of physician performance and should align with the mission and institutional goals

☑ The metrics may be weighted according to the physician’s role; physicians may not be measured on all of the metrics

☑ For leadership roles, performance metrics should generally align with organizational goals

☑ Metrics should be incorporated in all approved compensation model(s)

☑ Metrics should be reviewed annually and modified as appropriate
3. Commit Resources to Analytic Tools

For all performance metrics used in compensation models, ensure the ability to measure results and monitor potential changes

✓ Model the impact of potential reimbursement changes and other significant funds flow changes

✓ Test the impact on compensation models and allow sufficient time for quantifying financial consequences

✓ Assess performance regarding high profile clinical outcomes

✓ Develop infrastructure that can be scaled as needed

✓ Report the metrics to physicians and leaders on a regular basis
4. Educate Physicians

Develop a strategy for educating physicians and key stakeholders regarding the health care environment, including:

☑ The economics of faculty practice
☑ An overview of the evolving health care marketplace, including basic tenets of changing reimbursement models
☑ Market and regulatory considerations affecting physician compensation
☑ The relationship between funding stream changes and the organization’s ability to support operating expenses
5. Develop a Longer-Term Strategy

Develop a long-term strategy to support alignment between organizational success and physician compensation

- Limit the number of plans
  - Primary care physicians
  - Specialist physicians
  - Hospital-based physicians
  - Research physicians
  - Physicians in innovative care arrangements

- Include an approach for addressing outliers

- Ensure all plans are understandable and transparent, with a clear link between organizational, departmental and individual goals

- Imbed sufficient flexibility to respond to financial exigencies
6. Develop a Supportive Infrastructure

At a minimum, this should include:

- A rigorous and thoughtful physician performance evaluation process
- Sufficient reporting to physicians so they can understand their performance throughout the year
- Appropriate and consistent benchmarking and effort reporting
- Sufficient independent review to ensure legal compliance
Compensation Governance Continuum
## Compensation Structure Continuum

### Structural Characteristics

<table>
<thead>
<tr>
<th>Level</th>
<th>Who Develops Principles?</th>
<th>What is the Extent of Compensation Variability and Who Develops the Plans?</th>
<th>What is Driving Individual Physician Compensation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 – Department Driven</td>
<td>Departmental autonomy</td>
<td>Each department develops its own compensation plan</td>
<td>Primarily individual physician performance with some link to department financial performance</td>
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<tr>
<td>Level 2 – Evolving Collaboration</td>
<td>Department and organizational leadership work together</td>
<td>Some standardization (required compensation components, similar types of plans); department and organizational leadership collaborate on design</td>
<td>Individual physician performance and department financial performance; potential for organizational metrics</td>
</tr>
<tr>
<td>Level 3 – Driven by Organization</td>
<td>Organization formulates a single framework that is shared with all</td>
<td>Organizational plan limits the number of models (five or fewer); design may be collaborative and driven by organizational needs</td>
<td>Individual physician performance, department and overall organizational performance</td>
</tr>
</tbody>
</table>

**Who Develops Principles?**
- Departmental autonomy
- Department and organizational leadership work together
- Organization formulates a single framework that is shared with all

**What is the Extent of Compensation Variability and Who Develops the Plans?**
- Each department develops its own compensation plan
- Some standardization (required compensation components, similar types of plans); department and organizational leadership collaborate on design
- Organizational plan limits the number of models (five or fewer); design may be collaborative and driven by organizational needs
## Compensation Governance Continuum

### Compensation Governance Characteristics

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<td></td>
<td>Governance handled at the department level</td>
<td>Department Chair</td>
<td>Chair; exceptions also approved by Chair provided funds are available</td>
<td>Department staff</td>
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<td></td>
<td>Development of a organizational governance structure (typically not an independent body)</td>
<td>Organizational leadership group or executive</td>
<td>Chair, provided comp. is consistent with guidelines; exceptions approved by organizational leadership group or executive</td>
<td>System staff</td>
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<td></td>
<td>Formal Organizational governance body exists (Comp. Committee - disinterested members)</td>
<td>Organizational governance body; guidelines/principles known to all physicians</td>
<td>Organizational governance body</td>
<td>System staff; reported to organizational governance body</td>
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</table>
Contact Information

• Lisa Keane: lkeane@med.wayne.edu
• Kim Mobley: kimmobiley@sullivancotter.com