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Tomorrow's Doctors, Tomorrow's Cures®

Physician Compensation Strategies in Academic Medical Centers

In a Changing Environment

Learn
Serve
Lead

Lisa Keane, Consultant to AAMC
Kim Mobley, SullivanCotter

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Association of
American Medical Colleges

Introduction

1 Academic Medical Center (AMC) Participants

2 Objectives of the Study

3 Key Findings

- Organizational Structure and Governance
- Perspectives on Compensation
- Advanced Practice Providers

4 Advancing the Compensation Framework

Compensation and Governance Continuum

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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

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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

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Organizational Structure

Comparing Structures

Faculty * Physicians

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

Independent

Subsidiary of medical school, health system, or fully consolidated entity

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***

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Organizational Structure

Category	Characteristics
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

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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

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

1

Hospital/Health System Funding

Provided For

- Medical administration
- Resident teaching
- Network expansion
- Strategic programs
- Salary packages for new recruits/chairs

2

Many AMCs are reviewing continued support and funding levels for unfunded research and scholarly pursuits

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Funding of Physician Compensation

Other Funding

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

3

School of Medicine (SOM)

Provided For

- UME
- Didactic teaching
- Administrative leadership
- Salary packages for new recruits/chairs

4

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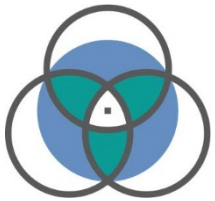
Compensation Governance

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)

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Faculty Compensation

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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**

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Faculty Compensation

Performance incentives include traditional metrics such as:

- Citizenship
- Teaching excellence
- Published research
- Collegiality

↓

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

Quality incentives using performance metrics tied to:

- Clinical process
- Outcomes
- Cost reductions (within regulatory limits)
- Patient experience

↓

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

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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

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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

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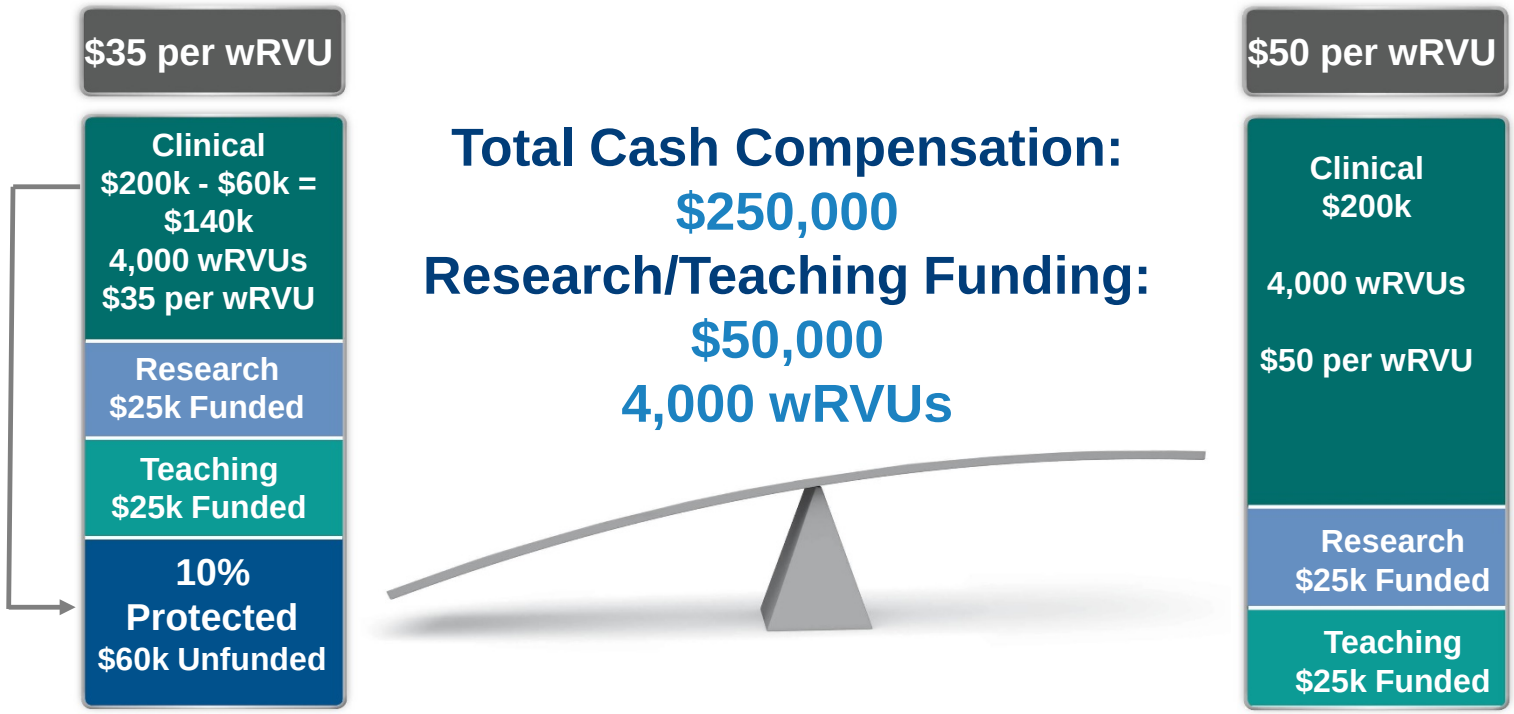
Faculty Compensation



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

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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

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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

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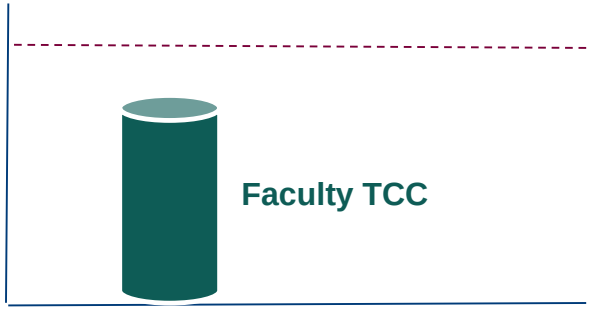
Faculty Compensation

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

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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

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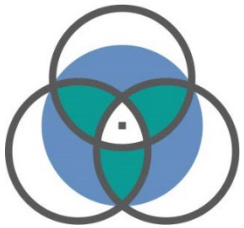
AMCs are often able to recruit and retain **high-quality talent** based on their:

Reputation

Mission



Culture

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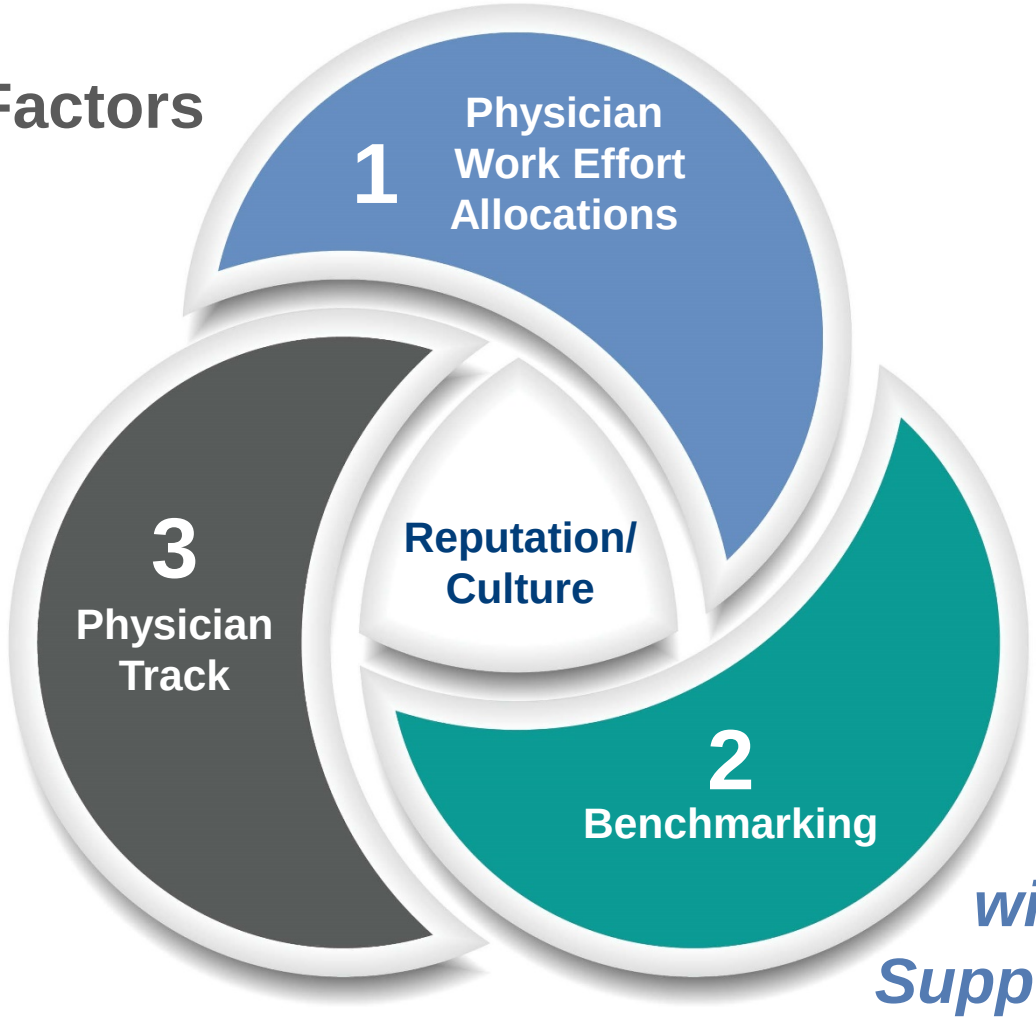
Faculty Compensation

Economic Factors



Balanced with Ability to Support the Mission

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Community-Based (CB) Physician Compensation

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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

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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

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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)

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Advanced Practice Providers

Most groups have a strategy to  **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

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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

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Steps for Advancing Your Compensation Framework

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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

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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

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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

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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

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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

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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

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Compensation Governance Continuum

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Compensation Structure Continuum

Structural Characteristics

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

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Compensation Governance Continuum

Compensation Governance Characteristics

	What is the Extent of the Governance Structure?	Who Approves Principles and Oversees Compliance?	Who Approves Compensation and Exceptions?	Who Performs Analytics?
Level 1 – Department Oversight	Governance handled at the department level	Department Chair	Chair; exceptions also approved by Chair provided funds are available	Department staff
Level 2 – Evolving Oversight	Development of a organizational governance structure (typically not an independent body)	Organizational leadership group or executive	Chair, provided comp. is consistent with guidelines; exceptions approved by organizational leadership group or executive	System staff
Level 3 – Consistent Organizational Oversight	Formal Organizational governance body exists (Comp. Committee - disinterested members)	Organizational governance body; guidelines/principles known to all physicians	Organizational governance body	System staff; reported to organizational governance body

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Contact Information

- Lisa Keane: lkeane@med.wayne.edu
- Kim Mobley: kimmobley@sullivancotter.com

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