

Compensation Best Practices for Physician Enterprises

White Paper



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Abstract: In an ideal world employed physician enterprises (PE) would have a clear compensation strategy with appropriate governance protocols so that their employed physicians would be on a consistent, well-designed compensation structure. Unfortunately, the realities of what brought together physicians under an employed structure differ significantly from this utopian vision. Compensation design and redesign is a delicate process that encompasses both scientific reasoning to support the economics of the PE as well as artful politicking to engage physicians properly throughout the process.

In this paper, we evaluate the most common components of physician compensation plans and offer best-practice insights on them. Additionally, we provide commentary surrounding the core structures necessary for physician engagement throughout the compensation planning process.

Key Words: Employed Physician Enterprises, physician compensation, compensation strategy, compensation design, compensation redesign

OVERVIEW

In an ideal world employed physician enterprises (PE) would have a clear compensation strategy with appropriate governance protocols so that their employed physicians would be on a consistent, well-designed compensation structure. Unfortunately, the realities of what brought together physicians under an employed structure differ significantly from this utopian vision. Compensation design and redesign is a delicate process that encompasses both scientific reasoning to support the economics of the PE as well as artful politicking to engage physicians properly throughout the process. There is no single finite answer to compensation. Rather, the execution of these two elements will determine the success of the compensation plan for the PE. In this paper, we evaluate the most common components of physician compensation plans and offer best-practice insights on them. Additionally, we provide commentary surrounding the core structures necessary for physician engagement throughout the compensation planning process.

PHYSICIAN ALIGNMENT TRENDS

Over the past ten-plus years, health systems have increased their role within physician alignment arrangements, seeking new ways to affiliate with physicians. The evolution from volume to value will continue this trend as physicians look for alignment vehicles to shield themselves from incremental payer contracting risk. A 2017 American Medical Association (AMA) study shows for the first time that less than half of practicing physicians owned their practice—47.1%, indicating a decline of about six percentage points from the previous study conducted in 2012.ⁱ The departure from private practice is expected to continue to increase as regulatory and associated economic pressures mount. As a result, PEs will grow or find themselves coordinating with physicians from different backgrounds through these affiliations. Either way, new forces are driving compensation decisions.

PEs are often reactive, making defensive acquisitions focused on market share to create critical mass. Consequently, they are apt to make ad hoc arrangements on a physician-by-physician basis resulting in various compensation plans without a common philosophy to move physicians in the same strategic direction. This inconsistency creates the need for physician compensation redesign.

COMPENSATION COMPONENTS

No universal compensation plan fits every PE. Each will have unique nuances to consider. Though there are many different models, the best compensation plans will consider many factors and have a principled approach. A philosophy on compensation that is physician-led, considerate of local economics, and layered on top of an established vision should prevail throughout the organization.

An ideal compensation model for a PE should have common, standardized components with appropriate considerations for differences in primary care, specialty care, surgical care, and hospital-based physicians. Following are the best practice insights for the most conventional compensation components.

BASE COMPENSATION

Base compensation provides a level of stability that is usually not found in private practice, offering an appealing sense of security to physicians interested in employment. Ranges of base compensation are variable, but typically the appropriate level is 75–90% of prior year or projected current year compensation. There are different ways to provide base compensation, most representative as a guarantee or as a draw. Regardless of the base compensation method, the long-term goal should be for the productivity or performance mechanism of the compensation plan to outweigh the base compensation.

If providing base compensation via a guarantee, it is best not to offer long-term guarantees, especially at higher levels of market data. It is reasonable to guarantee more during a ramp-up period for a physician, usually experienced in the first 12–24 months of employment. Guarantees tend to be more prevalent in rural environments where patient panels may not be sizable. When determining a guaranteed amount, use objective reasoning that carries merit. The most customary method is set based on market data and should be closer to the median and no higher than the 75th percentile. The primary guardrail to keep in mind is that guarantees should never outpace the total cash compensation (TCC) paid to the physician, as that would render an ineffective compensation model.

If providing base compensation via a draw, it is critical to understand it is not the same as a guarantee as is sometimes the perception. A draw delivers a regular stream of income that is only a portion of the total cash compensation paid to a physician. The draw is deducted from the TCC amount as incentives are calculated. The pay for the draw can be higher than for a guarantee, but it is better to be conservative than positioned unfavorably by having to recoup compensation from a physician.

There are opportunities to provide a hybrid guarantee that assures the base compensation as long as the physician falls within an established structure of productivity. These options tend to work well in environments where guarantees have been a part of the standard compensation procedure, and, now, physicians are transitioning to an established compensation model, or the organization is moving to phase them out altogether.

PRODUCTIVITY INCENTIVE

While value-based reimbursement is shifting the economics of PEs, fee-for-service is still the most significant revenue stream and likely to remain that way in most markets. Physician incentives should proportionately correlate to their revenue streams to align behavior with funding sources.

Using wRVUs is a standardized way to assign productivity credit and are also payer mix agnostic. These serve as the primary reasons why wRVU-based models are the most commonly used incentives to promote patient volume and typically account for 80–90% of projected TCC. This range can vary based on specialty, where primary care may have more of its revenues tied to quality reimbursement payments.

Some primary care models are beginning to augment wRVU-based incentives with panel size incentives but only as a small portion of compensation. Often, these start around 5% of projected TCC, but they are set up dynamically to enable adjustments for the impact as reimbursement types evolve.

Although there are many considerations within a wRVU-based model, we see one- or two-tier wRVU approaches as the most customary where different wRVU thresholds are set with higher conversion factor rates paid at the higher tiers. The second tier wRVU threshold will not always produce a material financial gain to the physician, so it can be an inexpensive investment to the organization that provides a psychological motivator aimed to incentivize physicians to achieve next-level performance.

The median percentile of a benchmark may serve as a starting point to establish a conversion factor, but it is essential to understand other components of compensation and how local economics factor into the compensation plan.

Market data is the result of bringing together survey data that is self-reported and influenced by the reactive market share state where PEs find themselves. The detail, below, in Figure 1 shows an array of specialties where compensation per wRVU, as measured by the MGMA median rate, has seen a steady increase over the past four years.ⁱⁱ During that same period the CMS conversion factor, which is Medicare's funding source, has remained relatively flat.

Figure 1: Trended MGMA Median Compensation per wRVU Rates

MGMA Specialty	2015 \$\$	2016 \$\$	2017 \$\$	2018 \$\$	Cumulative Change
Cardiology: Invasive-Interventional	62.77	63.59	61.39	62.79	0.0%
Emergency Medicine	54.14	50.34	49.69	54.69	1.0%
Family Medicine (without OB)	46.50	47.92	49.49	50.29	8.2%
Gastroenterology	61.52	62.84	64.95	65.52	6.5%
Hematology/Oncology	97.85	100.46	102.49	100.99	3.2%
Hospitalist: Internal Medicine	64.49	69.15	69.88	70.79	9.8%
Internal Medicine: General	51.06	53.09	53.26	54.57	6.9%
Neurology	60.09	62.21	62.54	63.85	6.3%
Obstetrics/Gynecology: General	50.25	51.94	51.40	53.23	5.9%
Orthopedic Surgery: General	72.55	71.99	74.94	74.71	3.0%
Pediatrics: General	45.26	46.86	46.23	48.90	8.0%
Surgery: General	62.41	62.95	63.33	63.61	1.9%
CMS Conversion Factor	35.75	35.80	35.89	36.00	0.7%

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It is critical to remember that market data is detached from your organization’s economics. Thus, we recommend considering updates to your conversion factors approximately every two to three years as opposed to automatic annual updates as surveys are released. Also, we recommend accounting for local economics when possible by incorporating budget targets and considering your collections per wRVU rate.

QUALITY/NON-PRODUCTIVITY INCENTIVES

These incentives are primarily tied to quality performance or some form of non-productivity metric and have gained greater prominence in the industry due to the shift in focus from “volume to value.” However, for most organizations, due to reimbursement structure, volume is still the most important factor. Therefore, non-productivity incentives range from 10–20% of projected TCC in primary care and 5–10% for specialists. The key is to keep compensation incentives proportionate to revenue streams.

The MGMA survey definition of total compensation is the amount reported as direct compensation plus all voluntary salary reductions and should include salary, bonus and/or incentive payments, research stipends, honoraria, and distribution of profits.ⁱⁱⁱ Therefore, all forms of compensation, including quality incentives, are already reflected in the compensation per wRVU market data and should be carved out of those market-based rates instead of being added on top of those rates.

Consider a top-down approach to pay for non-productivity incentives that encompasses an allocation of value of the compensation per wRVU market rates. Under this approach, the compensation per wRVU market rate is allocated to different incentive categories weighted in proportion to revenue streams. Figure 2, below, provides an example.

Figure 2: Example Allocation of Value

Targeted Compensation per wRVU rate (50 th percentile of market data)		
wRVU Productivity (85%)	Performance Incentive (10%)	Other Incentives (5%)

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If the median rate is \$50.00, the wRVU incentive value is \$42.50, with the performance incentive value, likely associated with quality, creating a \$5.00 per wRVU opportunity. Other incentives in this example are valued up to \$2.50 per wRVU. The terms “opportunity” and “up to” per wRVU value are used because the full amounts depicted may not always be paid. It is common to implement a tiered performance rate structure where varying levels of performance reward full and partial credit. Physicians will likely appreciate having such a structure, especially in scenarios where physicians are transitioning to these incentives.

There are many factors to consider when selecting quality metrics, but best practice aligns measures that drive desired physician performance improvement to those that influence reimbursement. Maintain a coordinated strategy for quality metric selection to ensure payer requirements overlap, and focus on a low number of measures, to begin with, so as not to grow an unmanageable list to track. The list should be short, especially at first, so that physicians can channel energy into specific initiatives. Be cognizant that diminishing returns may result from having too many measures.

Non-productivity incentives are most often tied to quality measures that are chosen by a collaboratively derived physician committee. Other forms of non-productivity incentives may come from patient satisfaction, adherence to group processes, or ad hoc objectives the organization wants to influence. No matter the metric, establish an objective scoring mechanism and implement a tiered system to award partial and full credit.

CALL PAY

Sometimes the compensation plan does not explicitly identify call pay mechanisms, resulting in one-off arrangements leaving organizations without an established call expectation. Determine what constitutes typical coverage and expect to pay hourly or daily rates that exceed that expectation. Meaning, assuming a baseline level of call is expected when providing market-based TCC, and call pay should only be in place for *excess call* defining the *burden* of the call duties and correlating it to proper compensation. These details should be documented in the compensation plan to mitigate the

unintended consequence associated with “stacking” different forms of compensation. (Note: As physician compensation arrangements are under increasing regulatory scrutiny, organizations must make systematic efforts to understand individual components of physician contracts, determine whether overlapping services or duties exist, and review the stacked compensation to avoid overpayment and ensure regulatory compliance.)^{iv} Benchmarks help establish rates and keep pay within Fair Market Value.

ADMINISTRATIVE COMPENSATION

The goal of any PE is to provide care to the community it supports. As such, a defined clinical full-time equivalent (FTE) expectation should be in place, usually based on patient contact hours derived from office hours and surgical time. Naturally, completion of normal administrative functions is an expectation during these hours, but there may be a need for some providers to take on dedicated administrative responsibilities. When that is the case, it is appropriate to compensate for such effort, but designated health system priorities are the only administrative functions that should be compensated (i.e., medical directorships, leadership roles, and the like). These dedicated administrative responsibilities should be paid hourly and subject to an annual compensation cap. Benchmarks help establish rates and keep pay within Fair Market Value. Proper documentation is a requirement to substantiate payment, and at a minimum, the provider should have the dedicated responsibilities identified within their employment agreement and, preferably, memorialized in a separate transaction.

ADVANCED PRACTITIONER OVERSIGHT

Some organizations elect to pay for advanced practitioner (APP) oversight. This decision driver would be the mechanics of the care model based on the manner in which APPs are leveraged, so it may not be a common compensation component found in all compensation structures.

As with most compensation components, there are several ways to compensate, and organizations must be aware of unintended consequences that may occur from “wRVU gaming.” For that reason, we prefer two methods of payment, depending on the scenario:

1. *The Supervisory Stipend Model* consists of a flat rate paid to supervisory physicians. This model is recommended for specialists if the APPs provide an overall positive economic impact.
2. *The Modified wRVU Credit Model* contains a small dollar amount per wRVU that is paid for supervisory services to the supervising physician, subject to an annual cap, based on wRVUs generated by APPs. This recommendation is for primary care if APPs see their own patients.

TREATMENT OF PAID TIME OFF

Benchmark data for wRVUs are predicated on 46–48 weeks of work per year, so double payments occur if paid time off (PTO) is not taken and accrued PTO is paid out in addition to wRVU-based payments. Therefore, a defined number of days off that covers vacation and sick days (but not holidays) is the preferred practice. Unused days are generally not paid out but may be “banked” to be used in the future, if needed.

HOSPITAL-BASED PHYSICIANS

Hospital-based physicians are dependent on hospital volumes and likely cannot influence their level of patient demand, so their compensation components should differ from primary care and specialist physicians. The core focus of hospital-based physician compensation models should be time-based, which limits the amount of total compensation that can be tied to performance.

Professional reimbursements are moving toward some form of value or quality component universally. Thus, it may still be appropriate to align a proportionate piece of hospital-based physician compensation to performance centered on quality metrics likely to be in the 5–15% range.

wRVUs can again serve as a valuable tool for hospital-based physicians but more to assist in determining when to add another shift or physician.

CORE COMPENSATION STRUCTURES

Identifying the proper compensation components ensures the appropriate economics are in place, but that is only half the battle. The remainder is determined by an effective implementation plan that ingratiates physicians to these newly-identified compensation components and assimilates them into a desired structure. Engaging physicians within the compensation strategy initiative is the best way to promote buy-in, because it provides an opportunity for the physicians to voice their concerns, overcome them, and contribute to a process that will ultimately hold them accountable.

As part of a compensation strategy initiative, it is essential to consider the appropriate structures that must be in place to govern future compensation decisions and think through the details that arise in day-to-day life within the compensation plan. The core compensation structures that should be in place to navigate compensation change effectively are addressed below.

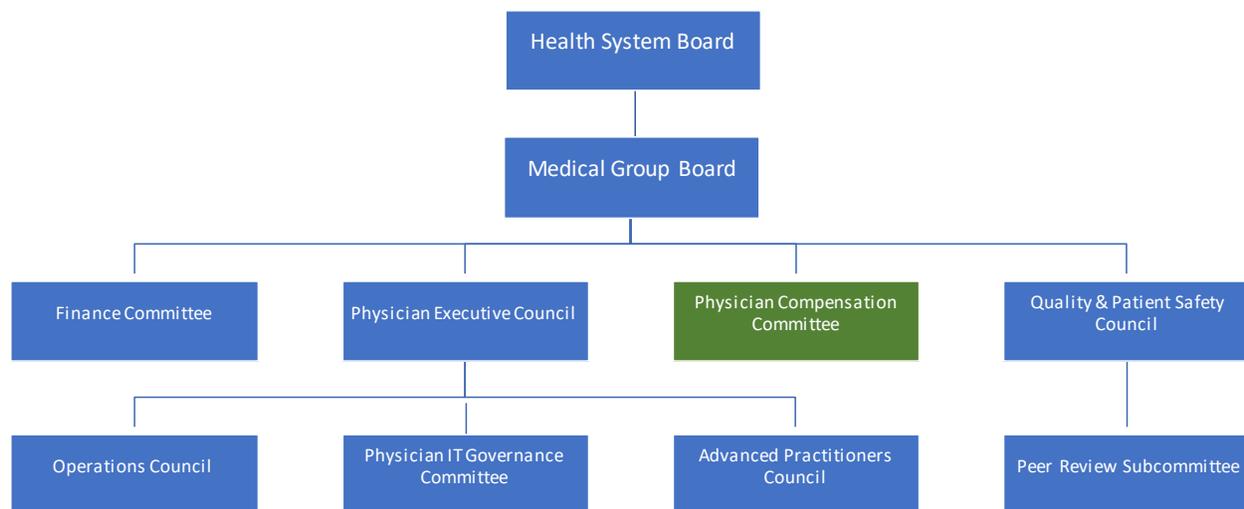
COMPENSATION COMMITTEE

Who governs compensation issues is an important question within the PE compliance arena. The answer can have far-reaching ramifications. Concerns often arise as to whether the hospital board of directors governs or perhaps delegates physician compensation oversight to the PE board. In smaller

organizations, it is commonplace for a member of the c-suite or legal counsel to provide oversight of physician compensation in conjunction with the hospital’s board. Governance structures can take on various shapes and sizes. However, from a best practice standpoint, it is essential for organizations to ensure that a robust governance structure exists and the fiduciary responsibilities surrounding physician compensation are managed proactively.

The size of the PE is a matter to consider before establishing a governance structure. From a functionality standpoint, it probably does not make sense for PEs that have ten employed physicians to have a multilayered governance structure, including a formal compensation committee. In a PE that has 50 or more employed physicians, a compensation committee becomes a necessity. Figure 3 charts a governance structure for a health system and affiliated medical group as the PE, where the health system has delegated physician compensation oversight to the medical group, via the medical group’s physician compensation committee, with ultimate supervision retained by the health system’s board of directors.

Figure 3: Example of Health System and Physician Enterprise Governance Structure



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The compensation committee should be created based on a charter that defines the roles and responsibilities of the committee, including the committee’s duty to provide oversight and reporting and not merely as a body that makes recommendations. A physician compensation committee should oversee compensation model development and the maintenance and ongoing oversight thereof, updates to compensation policies and procedures, advocating for updates to approved compensation models, and compensation related issue resolution.

As Figure 4 illustrates, the compensation committee should have established roles as determined by the compensation committee’s charter.

Figure 4: Example of Health System and Physician Enterprise Compensation Committee Roles

	Medical Group President	Physician Compensation Committee	Medical Group Board of Trustees	Health System Compensation Committee
Committee Charter		Follows	Adopts	
Philosophy	Follows	Adopts	Approves	Approves
Goals and Budgets	Recommends and Follows	Adopts	Approves	Reviews (as needed)
Recruiting		Recommends	Approves	Reviews (as needed)
Agreements	Approves	Reviews		
Policy Exceptions	Recommends	Approves	Reviews	
Evaluations		Reviews		

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COMPENSATION POLICY

A compensation policy documents the organization’s overall compensation philosophy. It focuses the attention of all stakeholders on key tenets of the compensation structure and should provide a lens through which to ensure compensation structures adhere to the mission, vision, and values of the organization.

The policies and procedures concerning Fair Market Value and commercial reasonableness testing should be outlined within the compensation policy. It should document what triggers an internal review and what determines external review.

Although individual physician employment agreements will detail specific terms on a physician-by-physician basis, it is important to have a consistent philosophy that embeds certain agreement terms into each contract. For example, it is standard to see two- to five-year term contracts with automatic one-year renewals and 90–180-day notice periods for termination. Non-compete agreements are subject to negotiation, but be aware that market dynamics will play a factor.

Another consideration is each physician’s contract year. There is separation risk in moving all physicians to the same contract year, but reference should be made to the same calculation period. One-time stub periods may be used to bridge a contract year to a standardized calculation period.

COMPENSATION PLAN

The goal of the compensation plan is to provide consistency for incentives across all physicians and specialties. Many organizations detail compensation mechanics within each physician's employment agreement. This situation is not ideal because it dramatically increases the chances for separate arrangements even among like specialties. Those distinct arrangements incentivize different behaviors resulting in uncoordinated outcomes. A centralized compensation plan document is preferable that aligns physician incentives toward strategic organizational objectives. The compensation plan can be flexible to consider incentives specific to primary care versus that of specialty care, surgical care, or hospital-based physicians. It should be written outside of the employment agreement with each employment agreement referencing the compensation plan. That way updates can be made to a single document versus numerous updates to multiple physician employment agreements.

Contract language is vital within the compensation plan document. It should accurately reflect the spirit of the development of the compensation structure and should include appropriate exhibits that illustrate the critical compensation components. The compensation plan should be detailed in nature so that it can address how different issues will be adjudicated and note operational factors such as the timing of payments. It is essential to attain legal and consulting expertise to ensure a compliant and well-developed compensation plan.

SUMMARY

Best practice in making any compensation change involves engaging physicians to agree collectively on the direction they want to structure compensation with administrative leaders. Addressing compensation is a delicate subject, and if ill-handled, it can be detrimental to a PE. It is critical to go through the appropriate steps of the process to include the proper compensation components, lay the necessary compensation structures, and ensure physician voices are heard.

ⁱ "Policy Research Perspectives." American Medical Association. 2017. <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/health-policy/PRP-2016-physician-benchmark-survey.pdf>. Accessed January 15, 2019.

ⁱⁱ Medical Group Management Association (MGMA) Compensation and Production National Survey 2015-2018. Selection of specialties based on high provider counts within the survey response.

ⁱⁱⁱ MGMA Compensation and Production National Survey, 2016.

^{iv} Harper, Elizabeth. Physician Compensation Stacking: How Much is too Much? December 13, 2018. <https://www.lbmc.com/blog/physician-compensation-stacking>. Accessed January 18, 2019.