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Preliminary Findings on Faculty and Community-Based Physician Compensation Plans in Academic Medical Centers

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Lead

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Introduction

- Objectives of the study
- Academic medical center (AMC) participants
- Key findings
  - Organizational structure and governance
  - Perspectives on compensation
  - Advanced practice providers (APPs)
  - Managing change
- Discussion

This presentation is intended to provide an overview of the *preliminary findings* of the physician compensation plan study

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AMC Participants

- Cedars-Sinai Health System
- Cleveland Clinic
- Private Diagnostic Clinic (Duke)
- Emory Healthcare
- Harvard Medical Faculty Physicians
- Henry Ford Medical Group
- Lahey Health
- MCV Physicians (VCU)
- MedStar Health
- North Shore-LIJ Health System
- University of Michigan Medical School
- UNC Health Care
- University of Pennsylvania Health System
- University of Pittsburgh Medical Center
- UT Medicine, San Antonio

AAMC and SullivanCotter interviewed members of AMC leadership between February and March of 2015

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Objectives of the Study

- Identify current and aspirational strategies related to faculty and community-based physician compensation plans in AMCs, including the following:
  - Current organizational structures
    - How are AMC faculty and community-based physicians employed and/or aligned within each organization?
  - Governance processes for overseeing physician compensation
  - Insight on current compensation plan structures
    - In particular, the similarities and/or contrasts between faculty and community-based physician compensation plans
    - Utilization of APPs and APP compensation strategies

AMC leaders are contemplating how they will adjust their compensation strategies in a changing reimbursement environment

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Organizational Structure and Governance

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Organizational Structure

- All but one of the AMCs reported that faculty are employed within **one medical group or faculty practice plan** (FPP)
  - The FPP may be independent or a subsidiary of a health system or medical school
  - All but one are not-for-profit
- AMCs reported **various employment structures for community-based physicians**, including:
  - Multiple community hospitals and/or medical groups owned by the health system
  - A single medical group consisting of all community-based physicians
- A small number of AMCs employ the faculty and community-based physicians within one entity

Significant M&A activity has resulted in more variance in the community-based employment structures compared to the faculty practice groups

Funding of Physician Compensation

- Compensation for faculty physicians is typically funded from several sources
  - **Fee-for-service collections** for professional services represent the **majority of compensation funding** for faculty physicians
  - Hospital/health system funding
    - Provide salary support for **medical administrative roles and resident teaching**
    - May provide strategic and/or programmatic funding that is used in part to fund physician salaries
  - School of medicine (SOM) funding
    - Provides support for **didactic teaching and administrative leadership roles**
    - Often manages grant funds that provide support for funded research

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

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Funding of Physician Compensation

- **Community-based** physician compensation is also predominantly funded through **fee-for-service collections for professional services**
  - Majority of community-based physicians are primary care which currently tends to have a higher prevalence of quality-based reimbursement

Primary care physicians still represent the majority in community-based networks, but there is increasing interest in community-based specialists

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Compensation Governance

- Oversight and management of physician compensation varies widely
- The majority of AMCs have established the following:
  - Physician compensation philosophy and guiding principles
  - Review and approval process(es) for physician compensation
    - At a minimum, review and approval processes ensure that compensation aligns with the financial performance of the department

An organization's leadership and culture tend to dictate where an organization falls on the compensation governance continuum

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Faculty Compensation

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Faculty Compensation

- Among most AMCs, there continues to be a **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
  - Value-based generally refers to some type of metric which **does not** produce wRVUs or professional fees
  - Examples are shown on the following page

The definition of ***value-based compensation*** is evolving

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Faculty Compensation

- **Performance incentives** include traditional metrics such as:
  - Citizenship
  - Teaching excellence
  - Published research
  - Collegiality
  - New grant funding

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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

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

Faculty Compensation

- The prevalence and use of **quality-based incentives** is increasing
  - 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) allocations
  - Reviewing funding and time allocations for research
    - Some have or are **considering eliminating funding/time for unfunded research and/or scholarly pursuits**
  - Reviewing time allocations for teaching

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

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Faculty Compensation

- The need for variance in compensation plans for hospital-based faculty was identified by many of the AMCs
  - This is 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
  - Many indicated that the market position of faculty TCC **falls below** their productivity targets
    - For example, a physician must produce at the 65th percentile to achieve 50th percentile TCC
    - This is to ensure financial sustainability of the enterprise
      - Many AMCs offer mission-driven services resulting in a significant amount of underfunded care
  - Some target market median of the AAMC survey
    - However, they were having difficulty achieving that market position in some instances
- Recruitment and retention issues directly related to faculty compensation were identified by only a few of the AMCs interviewed

AMCs are often able to recruit and retain high quality talent based on their reputation, mission and culture

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Community-Based Physician Compensation

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Community-Based Physician Compensation

- Many community-based practices within AMCs are the result of practice acquisition and/or the recent surge in M&A activity
  - As a result, it is not uncommon to see numerous groups of community-based physicians as well as significant variability in compensation plan design within an organization
  - Movement towards greater alignment and consistency relative to compensation plans for community-based physicians
- **Strong emphasis on clinical productivity** in compensation plans
  - The most prevalent plans are usually wRVU-based productivity models
    - Some groups utilize revenue less expense models as that is a common legacy approach for acquired practices

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

Community-Based Physician Compensation

- Community-based compensation plans are **more likely to include quality-based compensation components** (as they are predominantly primary care physicians)
  - A number of organizations are piloting the use of quality-based metrics in primary care community-based practices
    - One participant has incorporated a panel size metric into the compensation plan for primary care physicians
  - A small number of organizations are considering transitioning their community-based physicians to a salaried model with incentive tied to achievement of quality metrics

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

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Community-Based Physician Compensation

- Other considerations for community-based physician compensation
  - Competitiveness of compensation
    - Community-based physicians often have higher compensation levels than their faculty counterparts
    - Benefits for community-based physicians are usually less generous than for the faculty
  - A few organizations have indicated they are experiencing challenges with their community-based physician strategy
    - Enhanced competitiveness within their local markets

Given the predominance of primary care physicians in the community-based practices, there is an expectation that future design will place less emphasis on productivity and more weight on quality

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Advanced Practice Providers

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Advanced Practice Providers

- Most groups have a strategy to increase the number of APPs
- Generally, APPs are not considered faculty and their compensation is largely or entirely salary-based
  - Incentives are not commonly utilized
  - In limited cases, groups have incorporated incentives based upon existing staff compensation plans and/or APP billing practices
- Organizations are varied with regards to APP billing practices
  - Some groups only use incident-to billing and/or shared/split services
  - Others allow APPs to bill independently at times, but no group reported optimum utilization

There is wide variance in how APPs are utilized. The scope of practice can also vary by state

Advanced Practice Providers

- There are two predominant (but different) themes regarding physicians' views of APPs:
  - Apprehensive utilizers
    - While physicians accept APPs on the care team, they do not want wRVU credit assigned to APPs
    - Viewed as "competition" for productivity credits
  - Enthusiastic utilizers (mostly specialists)
    - APPs are viewed as a resource that allows the physicians to perform more complicated services and potentially enhance their productivity

Very few organizations reported having successfully optimized the utilization of APPs

Managing Change

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Managing Change

- Considerations for managing change in a transitional environment
  - Establish and implement a compensation philosophy and framework
    - Define a target level of compensation
    - Set parameters for exceptions
    - Establish “driving lanes” for acceptable models
    - Link to performance metrics
    - Set percentage of TCC at risk
  - Reduce the number of compensation approaches
    - Primary care
    - Specialists
    - Hospital-based
    - Mission support services model
  - Define what quality-based performance means to your organization
    - Ensure the compensation model(s) are aligned with appropriate quality-based metrics

Managing Change

- Develop analytical tools that allow the organization the ability to assess the implications of reimbursement and other market changes
  - Compensation levels
  - Financial performance
  - Operational performance (e.g., outcomes)
- Develop a long-term strategy for physician compensation
  - Early adoption of quality-based performance metrics with low risk to compensation allows physicians to adapt while providing the organization time to refine and improve metrics
  - Watch for changes in reimbursement in local and national markets
- Develop a strategy to ensure physicians and physician leaders understand the following:
  - Changing environment relative to reimbursement
  - Economics of faculty practice
  - Regulatory issues affecting physician compensation

Discussion

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Compensation Structure Continuum

STRUCTURAL CHARACTERISTICS

	Who develops Principles/ Guidelines	What is the Extent of Comp. Plan Variability and Who Develops the Plans?	What is Driving Individual Physician Compensation (i.e., the extent of alignment)?
1  **Level 1 – Department Driven**	Departmental Autonomy	Each Department develops its own compensation plan	Primarily individual physician performance with some link to Department financial performance
2  **Level 2 – Evolving Collaboration**	Department and Organizational leadership work together	Some standardization (e.g., required compensation components, similar types of plans); Department and Organizational leadership begin to collaborate on plan design	Individual physician performance and Department financial performance; potential for Organizational metrics
3  **Level 3 – Driven by Organization**	Organization formulates a single framework that is shared with all	Organizational plan limits the number of models (e.g., 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/Guidelines and Oversees Compliance?	Who Approves Physician Comp. and Exceptions?	Who Performs Comp. Analytics?
1  **Level 1 – Department Oversight**	Comp. governance handled at the Department level	Department Chair	Chair; exceptions also approved by Chair provided funds are available	Department staff
2  **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
3  **Level 3 – Consistent Organizational Oversight**	Formal Organizational - level governance body exists (e.g., Comp. Committee with 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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