

Association of Washington Public Hospital Districts

Administrators' Retreat

What Every Hospital Administrator Should Know About Physician Compensation

May 3, 2006

Presented by: Mr. Kevin M. Kennedy, Principal

ECG

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CONSULTANTS

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Agenda

The purpose of today's meeting is to present an analysis of the current compensation plans and to review conceptual compensation models.

- I. Background – Physician Employment in 2006
- II. Physician Compensation Components and Measurement
- III. Physician Compensation Benchmarking
- IV. Physician Compensation Models
- V. Sample Compensation Planning Process
- VI. Conclusions

Appendix A – ECG Management Consultants, Inc., and
Mr. Kevin M. Kennedy



**I. Background –
Physician Employment in 2006**

I. Background – Physician Employment in 2006

Market Realities and Challenges

Market Realities

- Increasing overhead and stagnant/declining third-party reimbursement rates have put downward pressure on physician compensation.
- Many critical physician specialties are in short supply.
- Compensation levels for different specialties are constantly shifting relative to each other.
- Subspecialists can improve incomes by accessing technical revenue streams in single-specialty groups.

Challenges









- Recruiting and retaining physicians.
- Allaying physicians' concerns and achieving their buy-in.
- Appropriately rewarding physicians for their contribution to the organization (financial and nonfinancial).

Bottom Line: For small and rural hospitals, employing physicians may be a compelling strategy for building the medical staff.

I. Background – Physician Employment in 2006

Recent Trends

After substantial losses in the 1990s, many hospital administrators once again find themselves moving toward physician employment. Why?

Driver		Description
Declining Losses From Employment		Improved management has reduced annual losses to more tolerable levels (\$20–\$40,000 per physician, compared with \$80–\$100,000 in the 1990s).
Recruitment Risks		Medical groups and independent physicians are unable and/or unwilling to recruit to the levels that hospitals demand.
Malpractice Coverage		Certain physicians are unable to obtain medical malpractice insurance at reasonable rates; rising costs pressure physician incomes.
Financial Stability		Physicians are facing income and reimbursement pressures from a number of areas.
Physician Shortages		Specialists and hospital-based physicians are needed in many key areas, and employment is often the easiest method of quickly obtaining coverage.
Alignment of Interests		Medical staff intransigence/disinterest exists regarding issues important to the hospital (medical errors, CPOE, physician behavior).
Regulatory Requirements		Employment avoids a complex regulatory environment around recruitment.
Ancillary Revenues		Ancillary services revenue can remain with the hospital.

I. Background – Physician Employment in 2006

Why is Physician Compensation Important?

Failure to align incentives with physicians was the most important factor causing millions of dollars in losses during the physician employment adventures of the 1990s, but there are many other success factors.

If you pay physicians correctly...

- You will have the chance to keep your operating losses at a reasonable level (\$20–\$40,000 per physician annually).
- You will align incentives between your facility and physicians.
- Physicians will feel appropriately rewarded for their efforts.
- Physicians will not feel torn when “doing the right thing” costs them money.
- You will field competitive offers to good candidates.
- You will eliminate physician candidates who are not good fits with your situation.

What a compensation plan won't do for you:

- Overcome the natural limitations of your environment. (If the spouse really likes to shop/hunt/go to the beach and can't do that in your area, it may not matter how good the pay plan is.)
- Guarantee physician happiness.
- Guarantee successful recruiting.
- Guarantee reasonable operating losses, ED coverage, board happiness, medical staff peace, or administrator job security.

I. Background – Physician Employment in 2006

Recruiting and Retention

Compensation is indeed an important factor in recruiting and retaining physicians, but there are several others.

Factors Influencing Recruiting and Retention

- Geography and local amenities.
- Appropriateness of compensation.
- Professional satisfaction.
- Call schedule.
- Quality of work environment.
 - » Efficiency of operations.
 - » Quality of facilities.
 - » Access to technology.
- Family needs.
- Work/life balance.

Paying physicians appropriately is a necessary, but not sufficient, condition for achieving your goals.



II. Physician Compensation Components and Measurement

II. Physician Compensation Components and Measurement

Key Compensation Model Components

Three key variables should be considered when designing a compensation plan. Several general types of compensation models can be created from these variables and are presented on the following pages.

Variable	Description
Base Compensation	Income that is paid to physicians irrespective of their productivity. Generally, the larger this component, the less that can be paid on productivity incentives.
Compensation per Productivity Unit	An amount that is paid on a per productivity unit basis. This amount is multiplied by all or part of physicians' productivity to determine the production portion of their compensation.
Productivity Threshold	A level of productivity that must be attained before a given compensation per productivity unit payment takes effect.

Newly recruited physicians are often guaranteed salary for an initial period (12 to 24 months), with an expectation of transitioning to incentive compensation over time.

II. Physician Compensation Components and Measurement *Measuring Productivity*

A variety of productivity metrics can be utilized; the table below summarizes the pros and cons of each.

Variable	Pros	Cons
WRVUs	<ul style="list-style-type: none"> ■ Most accurate measure of physician effort. ■ Not influenced by reimbursement. ■ Allows consistent comparison of physician productivity. 	<ul style="list-style-type: none"> ■ Not aligned completely with finances; for example, provides physicians with equal payment regardless of payor. ■ Many physicians do not understand how WRVUs are compiled and/or do not believe that they are a true indicator of productivity.
Collections	<ul style="list-style-type: none"> ■ Direct measure of cash inflow. ■ Aligned with financial strategy. 	<ul style="list-style-type: none"> ■ Affected by payor mix and effectiveness of billing/collections office.
Gross Charges	<ul style="list-style-type: none"> ■ Aligned with financial strategy. 	<ul style="list-style-type: none"> ■ Influenced by fee schedules, which can vary widely and are not necessarily representative of productivity or reimbursement.
Visits/Patient Encounters	<ul style="list-style-type: none"> ■ Easily measurable and understandable. 	<ul style="list-style-type: none"> ■ Not meaningful for procedural specialties. ■ Does not consider acuity or length of visit.

In general, WRVUs represent the best productivity measure available for physician compensation planning and are the most common metric we utilize in our compensation planning engagements with nonprofit medical groups.

II. Physician Compensation Components and Measurement

WRVUs – Background

RVUs are the most common method for measuring physician activity and determining reimbursement.

- The resource-based relative value system (RBRVS) was developed in the 1980s by a team of academics and is now managed by the Centers for Medicare & Medicaid Services (CMS).
- Medicare began basing physician reimbursement on RVUs in 1992.
- Payment for each service (as defined in a CPT code) is determined by the resources required in terms of:
 - » Physician work (measured in WRVUs).
 - » Practice expense (PE).
 - » Malpractice.
- Annually, CMS determines a conversion factor (CF) for payment. This rate is \$36.177 per RVU in 2006.
- Each RVU component is adjusted by Geographic Practice Cost Index (GPCI) to allow for cost differences across locations.

II. Physician Compensation Components and Measurement *WRVUs – Calculating Payment*

Specifically, the formula for calculating Medicare reimbursement is:

$$\text{Payment} = [(WRVUs \times GPCI\ WRVUs) + (RVU\ PE \times GPCI\ PE) + (RVU\ malpractice \times GPCI\ malpractice)] \times CF.$$

Example: Established office/outpatient visit, Level 3, CPT code 99213; GCPI is based on the rest of Oregon outside Portland.

$$\text{Payment} = [(0.67\ WRVUs \times 1.00\ GCPI\ WRVUs) + (0.69\ RVU\ PE \times 0.925\ GCPI\ PE) + (0.03\ RVU\ malpractice \times 0.441\ GCPI\ malpractice)] \times \$36.177\ CF = \$47.81\ \text{per\ visit.}$$

II. Physician Compensation Components and Measurement *WRVUs – Common CPT Codes*

The following are some common CPT codes:

Procedure	CPT Code	WRVUs	PE	Malpractice
New Office/Outpatient Visit – Level 3	99203	1.34	1.14	0.09
Established Office/Outpatient Visit – Level 3	99213	0.67	0.69	0.03
Initial Hospital Care – Level 1	99221	1.28	0.45	0.07
Subsequent Hospital Care – Level 1	99231	0.64	0.23	0.03
Hospital Discharge Day	99238	1.28	0.54	0.05
Critical Care, First Hour	99291	3.99	2.58	0.21



III. Physician Compensation Benchmarking

III. Physician Compensation Benchmarking Overview

There are many available benchmark sources for physician compensation, each with advantages and disadvantages.

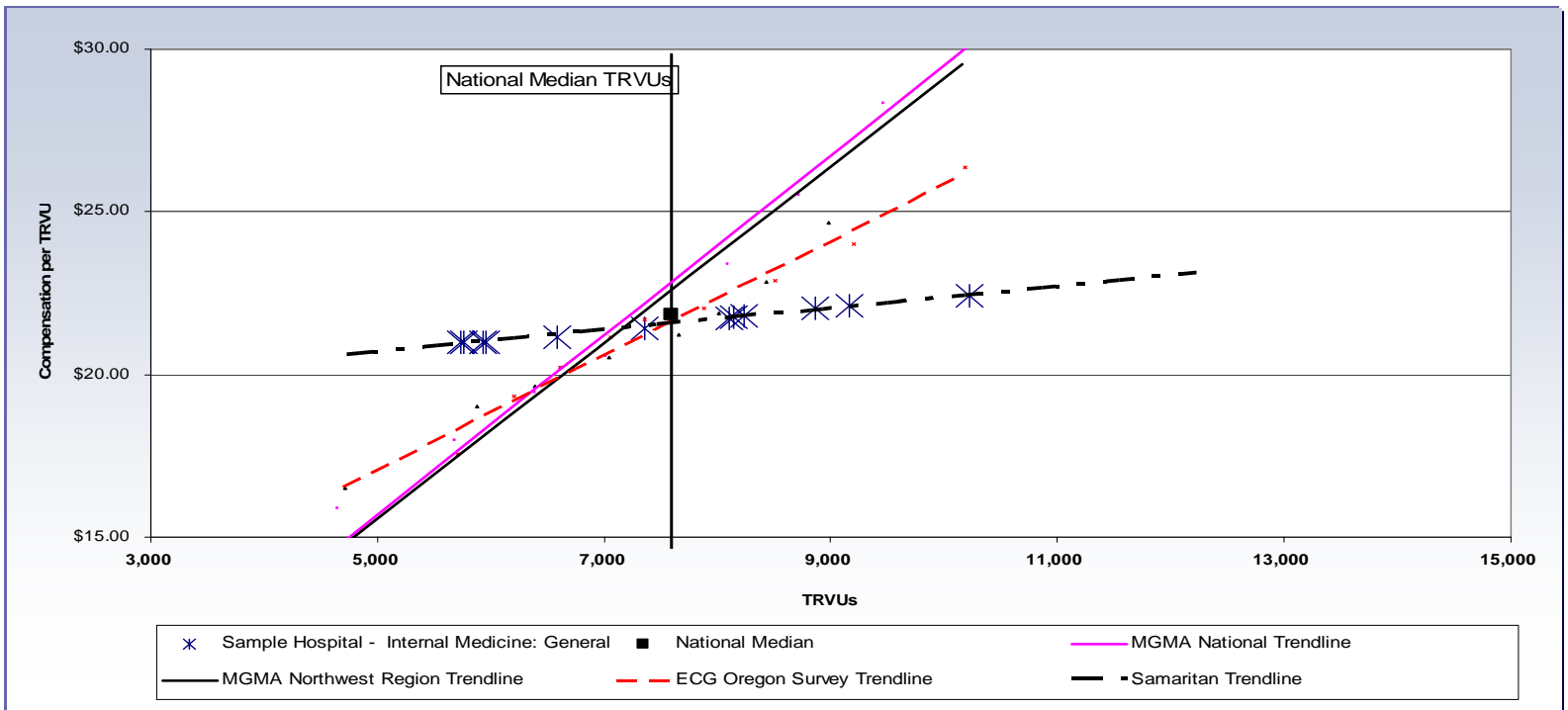
Benchmark	Advantages	Disadvantages	Bottom Line
MGMA	High overall sample size; familiarity.	Self-reported data; small sample for key metrics (e.g., statewide compensation per WRVU).	Everybody uses this, and your physicians will expect to see it.
AMGA	Additional samples; focused on large, multispecialty groups; addresses multispecialty dynamic.	Self-reported data; less relevant for solo/small practices.	Useful if you don't trust MGMA.
Regional Surveys (e.g., ECG)	Familiarity with survey participants; verified quality; strong sample sizes; adjunct reporting (CPT codes).	Relatively expensive; less familiar to physicians; not available in all locations.	Useful for adjusting to regional variation or if high-quality data is required.
Others (Hay, Sullivan and Cotter)	Additional non-MGMA sample size.	Less familiar to physicians; smaller sample than MGMA/AMGA.	Useful if you don't trust MGMA.

III. Physician Compensation Benchmarking

Sample Benchmarking – Internal Medicine

Results – Internal Medicine: General	25th Percentile	50th Percentile	75th Percentile
MGMA – National TRVU	6,088	7,591	9,111
Comp/TRVU Results by Survey			
MGMA – National (n= 1250)	\$18.71	\$21.83	\$26.69
MGMA – Regional (n= 204)	\$19.41	\$21.23	\$23.35
ECG – State (n= 186)	\$18.05	\$20.06	\$21.77
Survey Average Comp/TRVU	\$18.72	\$21.04	\$23.94
Sample Hospital	\$21.00	\$21.00	\$21.33
Percentage Variance From Average	12.2%	-0.2%	-10.9%

This analysis against multiple benchmarks indicates that internal medicine physicians below median productivity were generally compensated above benchmark levels, while those at above median were generally below benchmarks.





IV. Physician Compensation Models

IV. Physician Compensation Models

Range of Compensation Models

The following pages describe five common compensation models that span the range of typical hospital/physician employment arrangements.



Guaranteed Compensation

- Limited downside risk for physicians.
- Less upside potential for physicians.
- Weaker incentives to alter physician behavior.
- Reflects a typical employer/employee arrangement.

Variable Compensation

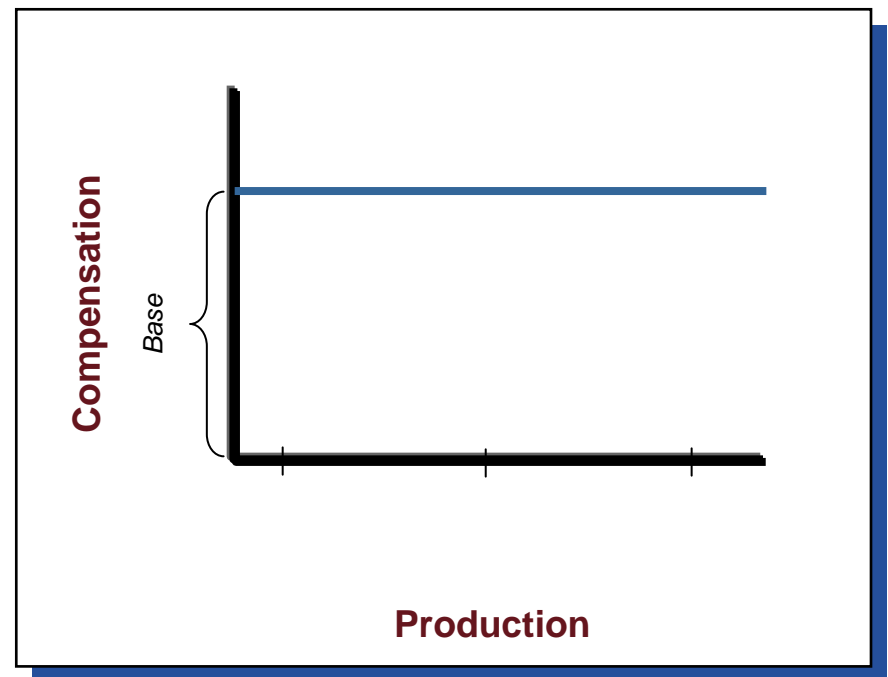
- Greater downside risk for physicians.
- Greater upside potential for physicians.
- Stronger incentives to alter physician behavior.
- Reflects the economics of private practice.

IV. Physician Compensation Models

Base Salary

The base salary compensation model is comfortable to many physicians but provides little incentive to maintain or increase productivity.

- Limits the physicians' downside risk by placing a floor on compensation levels.
- Provides the same income regardless of physician productivity levels.
- Accordingly, provides little incentive for physicians to maintain or increase productivity.
- Is an increasingly uncommon plan, except for newly recruited physicians.

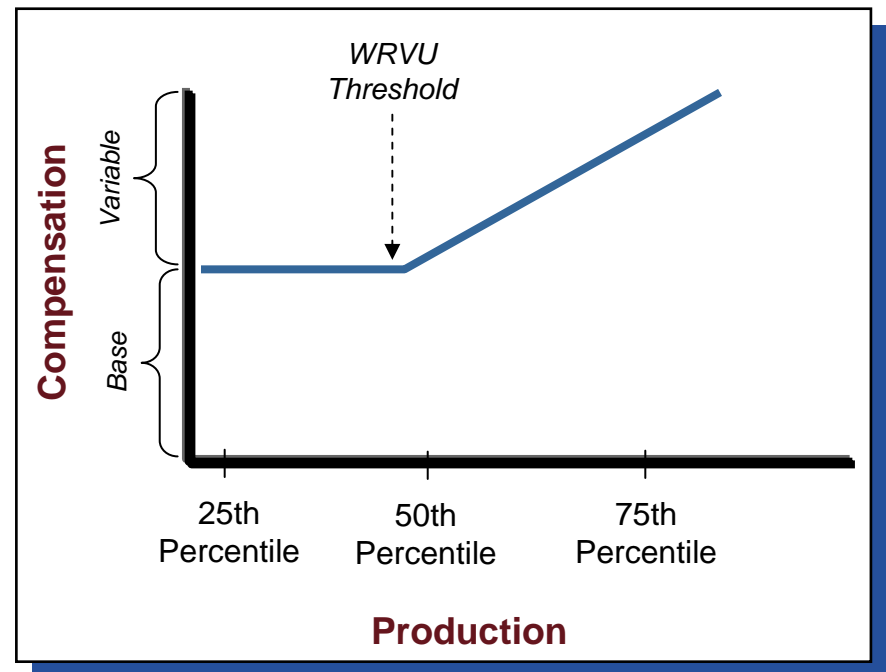


IV. Physician Compensation Models

Base Salary With Incentive

The base salary with incentive model provides physicians with moderate incentives to increase productivity if they are producing near or past the threshold level.

- Limits the physicians' downside risk by placing a floor on compensation levels.
- Provides additional income for any productivity that physicians generate above a given threshold.
 - » Provides moderate incentives for high producers.
 - » May place the incentive potential out of reach of lowest producers.
 - » Tends to underpay high producers and overpay low producers.
- May not provide a meaningful incentive if the base salary is set too high.

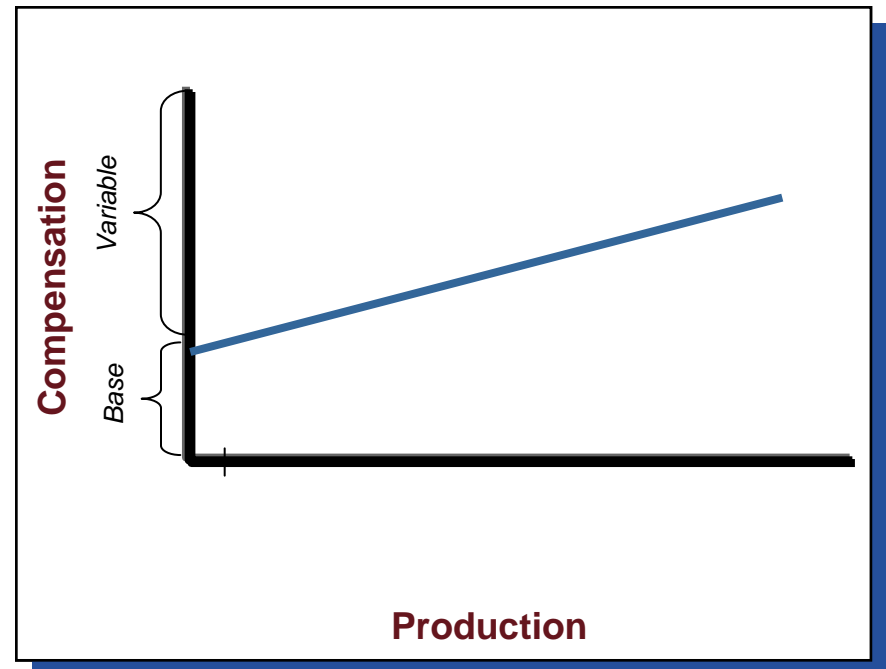


IV. Physician Compensation Models

Base Salary With Incentive (continued)

Alternatively, a lower base salary and a lower payment per WRVU bonus would decrease the guarantee and provide an enhanced incentive.

- Limits the physicians' downside risk (although not as much as the example on the previous page) by placing a floor on compensation levels.
- Provides additional income for any productivity that physicians generate – physicians receive a payment per WRVU bonus for each WRVU produced.
- Provides for a more achievable incentive than the example on the previous page but may not enable physicians to maintain their current compensation level.

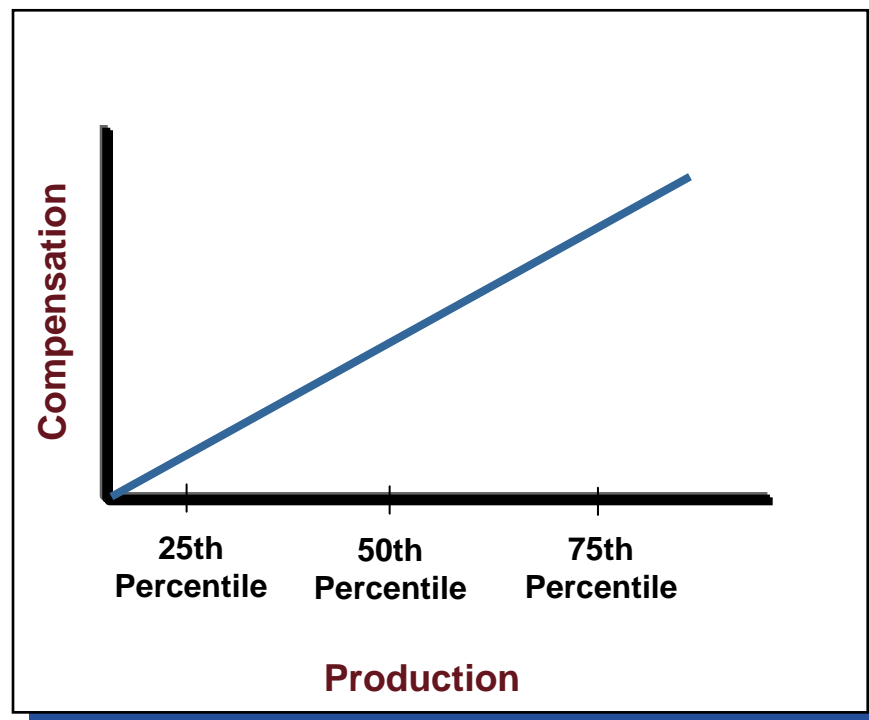


IV. Physician Compensation Models

Flat Incentive

The flat incentive model provides physicians with significant incentives to maintain or increase productivity but tends to underpay high producers and overpay low producers.

- Includes no base compensation; therefore, under this model physicians' earnings would be entirely dependent on productivity.
- Exposes low-producing physicians to considerable downside income risk.
- Provides strong productivity incentives, regardless of the physicians' current productivity level.
- Tends to skew overall compensation:
 - » The highest producers tend to be underpaid.
 - » The lowest producers tend to be overpaid.

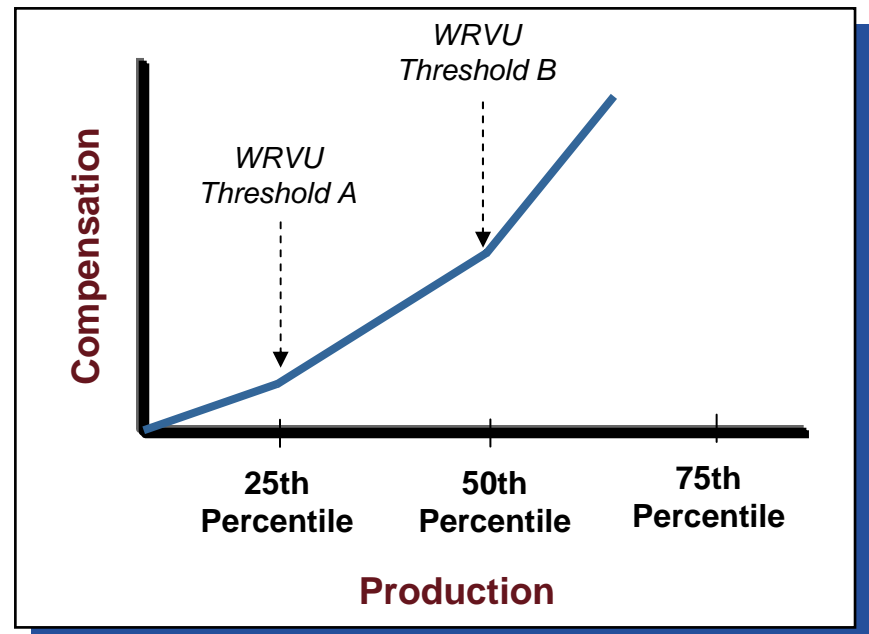


IV. Physician Compensation Models

Tiered Incentive

The tiered incentive model provides physicians with significant incentives to maintain or increase productivity and brings overall compensation in line with market levels.

- Includes no base compensation.
- Exposes low-producing physicians to considerable downside income risk.
- Provides stronger incentives at every level of productivity.
- More closely approximates market-level compensation:
 - » The model reduces the undercompensation/overcompensation of flat incentives.
 - » Tiered compensation provides greater incentives at the margin for high producers.
- Additional tiers can be added to increase incentives (a curve is also sometimes utilized rather than multiple tiers).
- Highest tiers are often out of reach for most physicians.

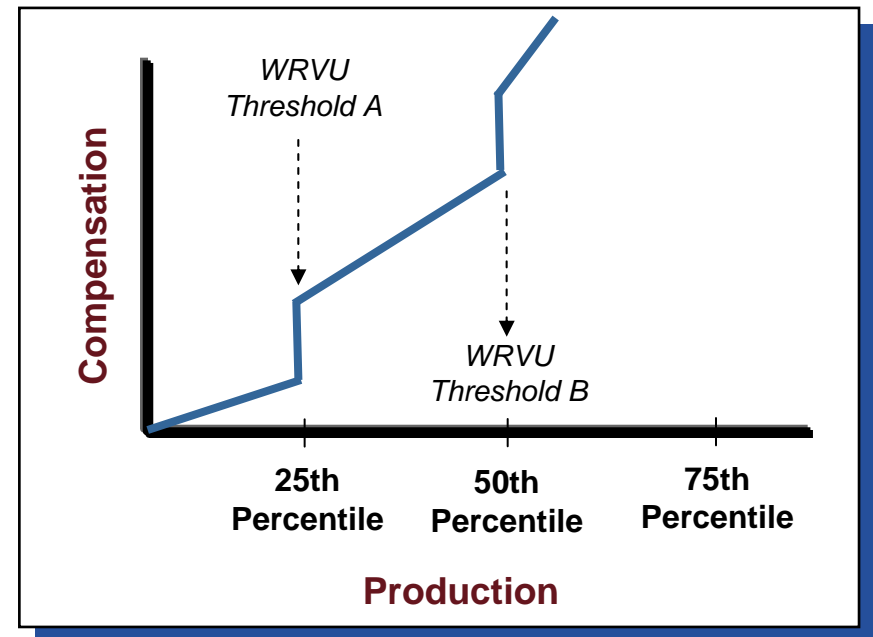


IV. Physician Compensation Models

Tiered Incentive Plus Bonus

The tiered incentive plus bonus model provides physicians with significant incentives to maintain or increase productivity and brings overall compensation in line with market levels.

- Is similar to the tiered incentive model, with the addition of a bonus that is paid when a WRVU threshold is reached.
- Includes no base compensation.
- Exposes low-producing physicians to considerable downside income risk.
- Provides stronger incentives at every level of productivity, including a bonus when a certain level of productivity is reached.

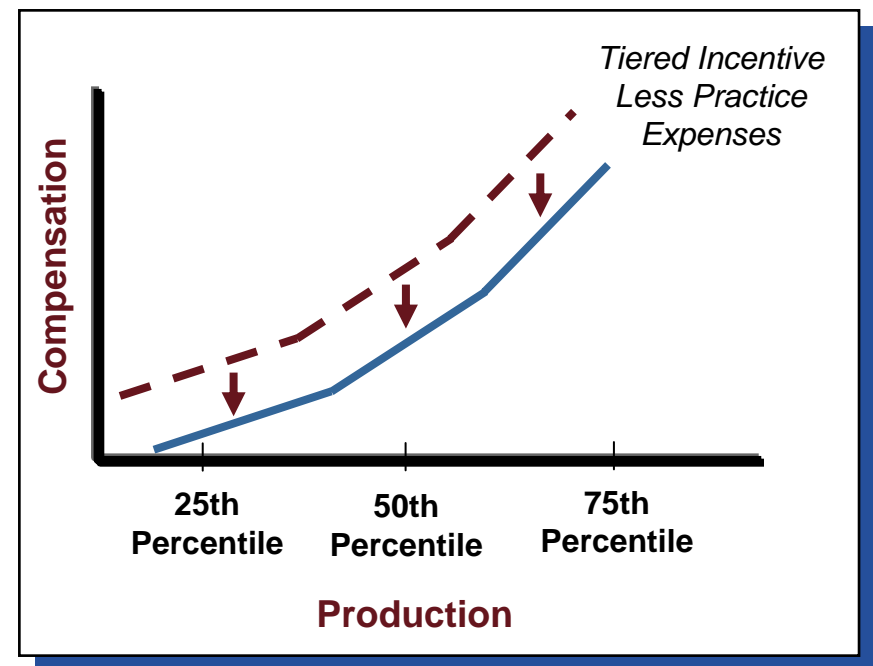


IV. Physician Compensation Models

Expense Charge-Back

An expense charge-back is not a model in and of itself, but it can be incorporated into a compensation model to create nonproductivity physician incentives.

- This feature applies to practice expenses that are readily manageable and under the control of physicians.
- Typically, this is limited to direct staffing costs, transcription costs, and one or two other expense categories.
- Generally, physicians are charged for only a portion of their expenses.
- In some cases, the charge-back may apply only to expenses that exceed a budgeted amount.

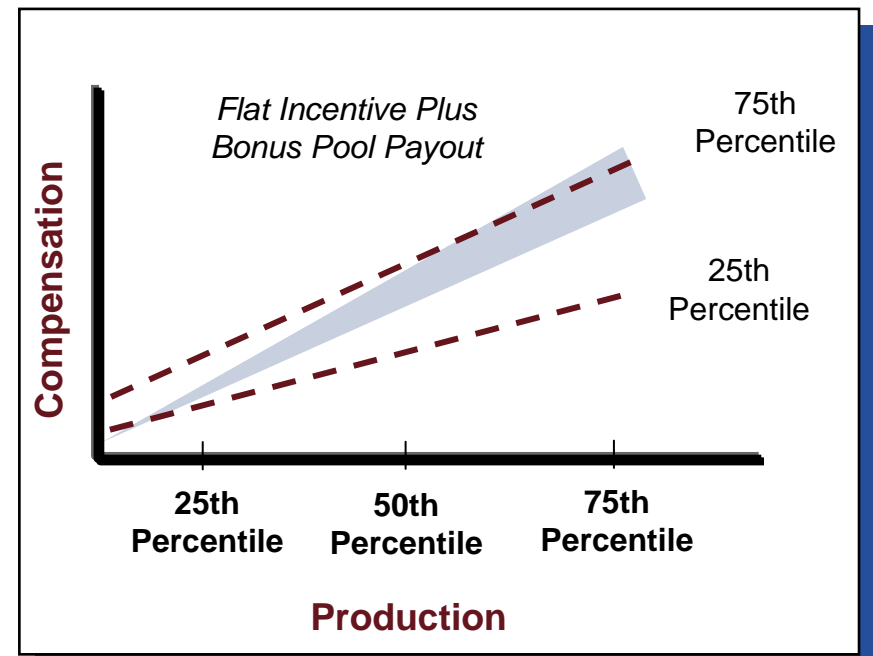


IV. Physician Compensation Models

Bonus Pool

Bonus pool features can also be incorporated into the compensation model to create nonproductivity physician incentives.

- Provides funding for incentives such as cost control, citizenship, program development, and clinical quality.
- Provides physicians with an opportunity to earn above the market-determined rate of compensation.
- Requires management discipline and restraint to avoid becoming a giveaway to physicians.



IV. Physician Compensation Models

Transition Plans

Often, productivity-based compensation models are phased in over several years, allowing physicians time to adjust their practice styles.

- Constructing a transition plan provides physicians with sufficient time to fully understand the impact of the new arrangement and to adjust their behavior accordingly.
- Transitions to productivity-based compensation arrangements can be of varying lengths and include various incentive features.
- The table below provides an example of how a transition might work for a physician currently paid on a salary basis.

Time	Compensation Formula	
	Base	Production
Year 0 (current)	100%	0%
Year 1	50%	50%
Year 2	25%	75%
Year 3	0%	100%

IV. Physician Compensation Models

Special Considerations for Supply Issues

In the design of the compensation formula, hospitals must consider local market factors that may alter the basic approaches to compensation planning.

- For specialties with an appropriate supply of physicians, hospitals should consider tying a productivity formula to market survey benchmarks.
- However, an oversupply may exist in certain specialties for a variety of reasons, such as call coverage requirements or insufficient scale.
- As a result, it may be difficult or impossible for physicians to reach established productivity benchmarks.
- Therefore, a production compensation plan for these physicians may need to incorporate a higher payment per productivity unit or some other form of support.

IV. Physician Compensation Models

Special Considerations for Supply Issues (continued)

Currently, Market A shows an oversupply of physicians in certain employed specialties, namely ENT and general surgery.

Specialty	Market Demand	Market Supply	Surplus/(Deficit)
Internal Medicine	5.1	4.0	(1.1)
Family Practice	7.3	6.0	(1.3)
General Surgery	1.1	2.0	0.9

- Regardless of the compensation model chosen, hospitals should consider paying physicians in specialties with an appropriate supply of physicians based on market benchmarks—no adjustment is necessary.
- However, for physicians with excess supply in the market, you may want to consider paying with a base salary and/or a payment per productivity unit level that is higher than the market median.

IV. Physician Compensation Models

Other Complicating Factors

- Ancillary or technical fee income.
- Outside income (e.g., medical directorships/research).
- Credit for midlevel provider production.
- Income protection for newly recruited physicians.
- Physicians who leave or join at midyear.
- Part-time physicians.
- Shared practices.
- Don't forget benefits.



V. Sample Compensation Planning Process

V. Sample Compensation Planning Process

Review of Compensation Models – Typical Compensation Principles

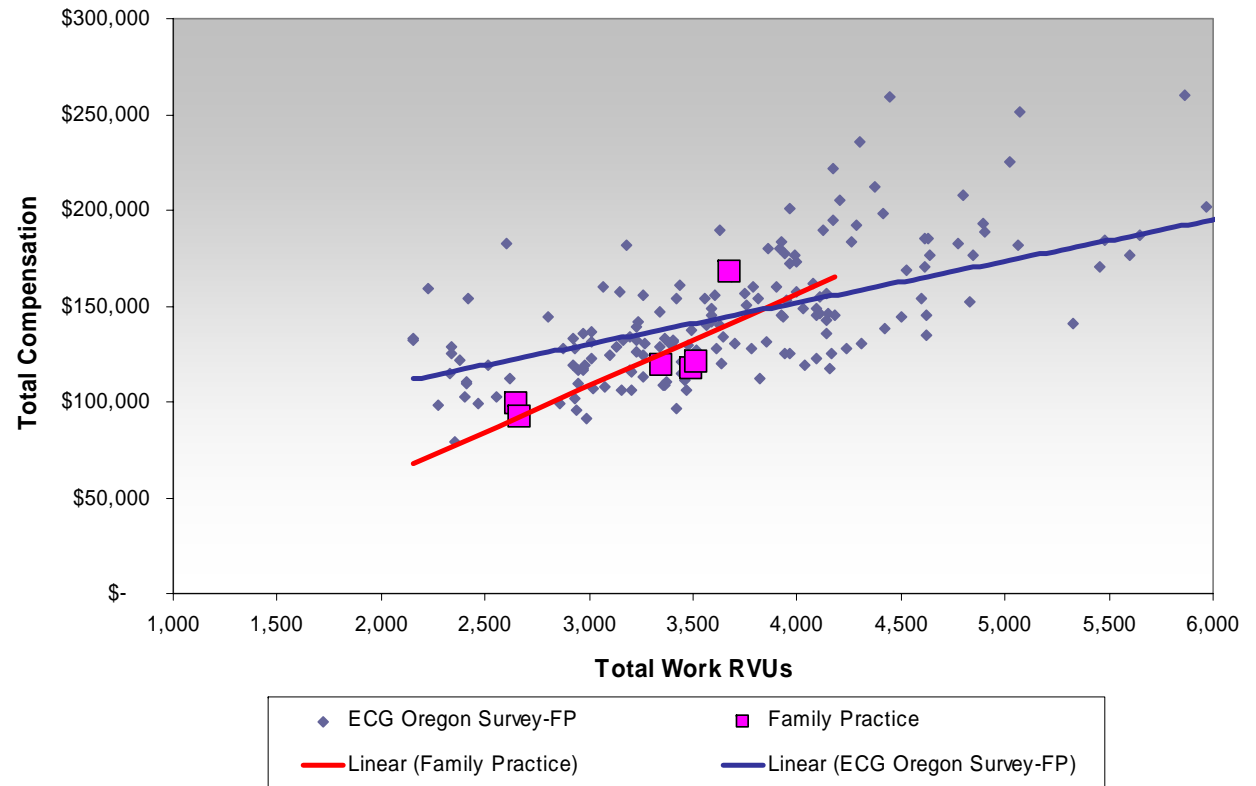
The design and development of a new compensation model should be guided by a set of principles to achieve the desired outcomes. We typically propose principles similar to those outlined below to guide development of a compensation model.

- **Mission** – Support the district’s mission of meeting the health needs of the local community.
- **Market Relevance** – Support the need to recruit and retain quality physicians by offering a compensation and benefits package that is commensurate with individual productivity levels and consistent with the market.
- **Productivity** – Provide appropriate incentives for physicians to increase their level of productivity without compromising patient care.
- **Practice Economics** – Allow physicians to have flexibility in determining their work effort but structure the compensation formula so that it reflects the economics of the practice.
- **Quality of Care** – Ensure that all incentives created by the compensation formula are compatible with the highest standards of quality care.
- **Nonfinancial Considerations** – Encourage other activities that benefit the district.
- **Administrative Efficiency** – Base physician compensation on a formula that is simple to calculate and understand, with effective reporting of relevant data inputs.
- **Regional Factors** – Adjust productivity targets in compensation plan to reflect regional realities. (Note: these may include physician shortages, physician oversupply, recruitment or retention difficulties, poor payor mix, etc.)

V. Sample Compensation Planning Process

Benchmarking Analysis – Compensation to WRVU: Family Practice

- Five out of six physicians are below the 25th percentile for compensation on ECG's *Oregon Provider Compensation, Production, and Benefits Survey*, year 2004 based on 2003 data.
- All six physicians are below the ECG survey median for total WRVUs.

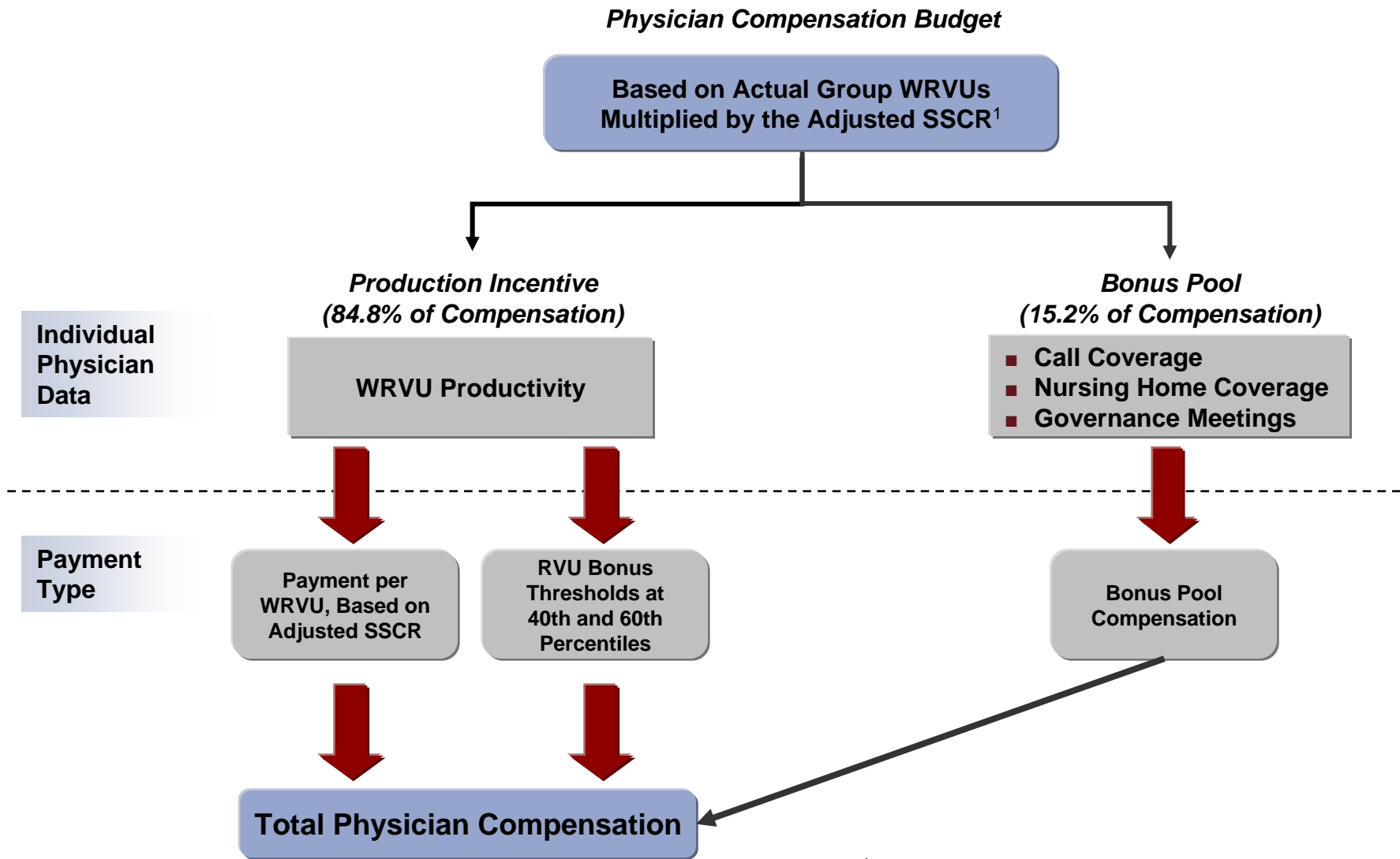


Group Average Compensation per Physician = \$119,307			
Percentile	MGMA Northwest	MGMA National	ECG Oregon Survey
25th Percentile	\$123,821	\$125,907	\$122,597
Median	\$147,000	\$150,267	\$141,646
75th Percentile	\$170,708	\$185,844	\$167,115

Group Average WRVU per Physician = 3,226			
Percentile	MGMA Northwest	MGMA National	ECG Oregon Survey
25th Percentile	3,340	3,266	3,159
Median	4,024	3,923	3,820
75th Percentile	4,740	4,671	4,332

V. Sample Compensation Planning Process

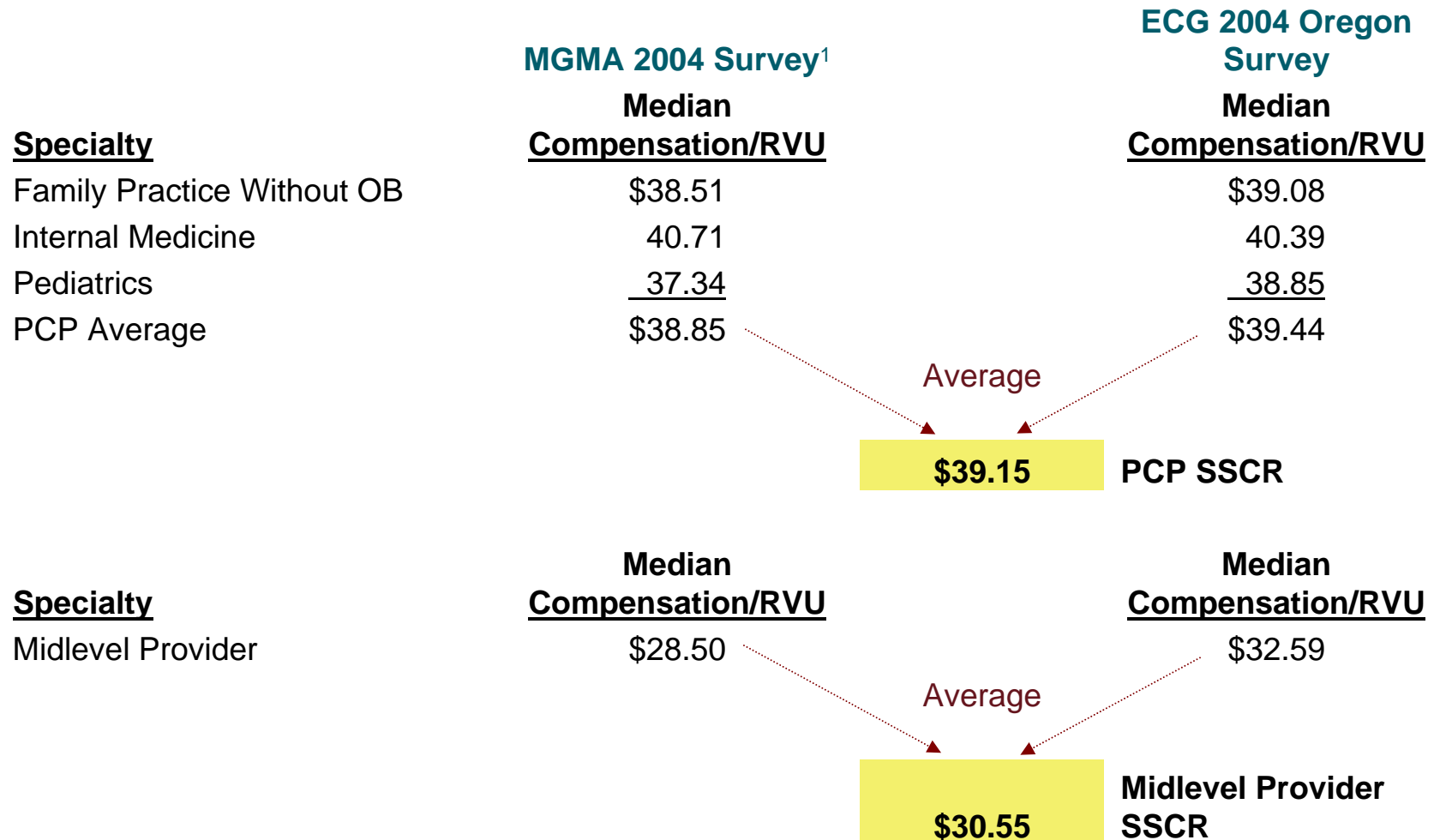
Overview of the Model



¹ Specialty-specific compensation rate.

V. Sample Compensation Planning Process

Compensation Formula – Calculation of SSCR



¹ MGMA 2004 figures were extrapolated using a linear formula between given points at 25th, 50th, 75th, and 90th percentiles.

V. Sample Compensation Planning Process

Compensation Plan – Bonus Pool: Incentive Options

In modeling incentive options, the group elected to allocate 15% of total compensation to the bonus pool. This percentage amounts to approximately \$230,000 based on the projected compensation.

Incentive Options

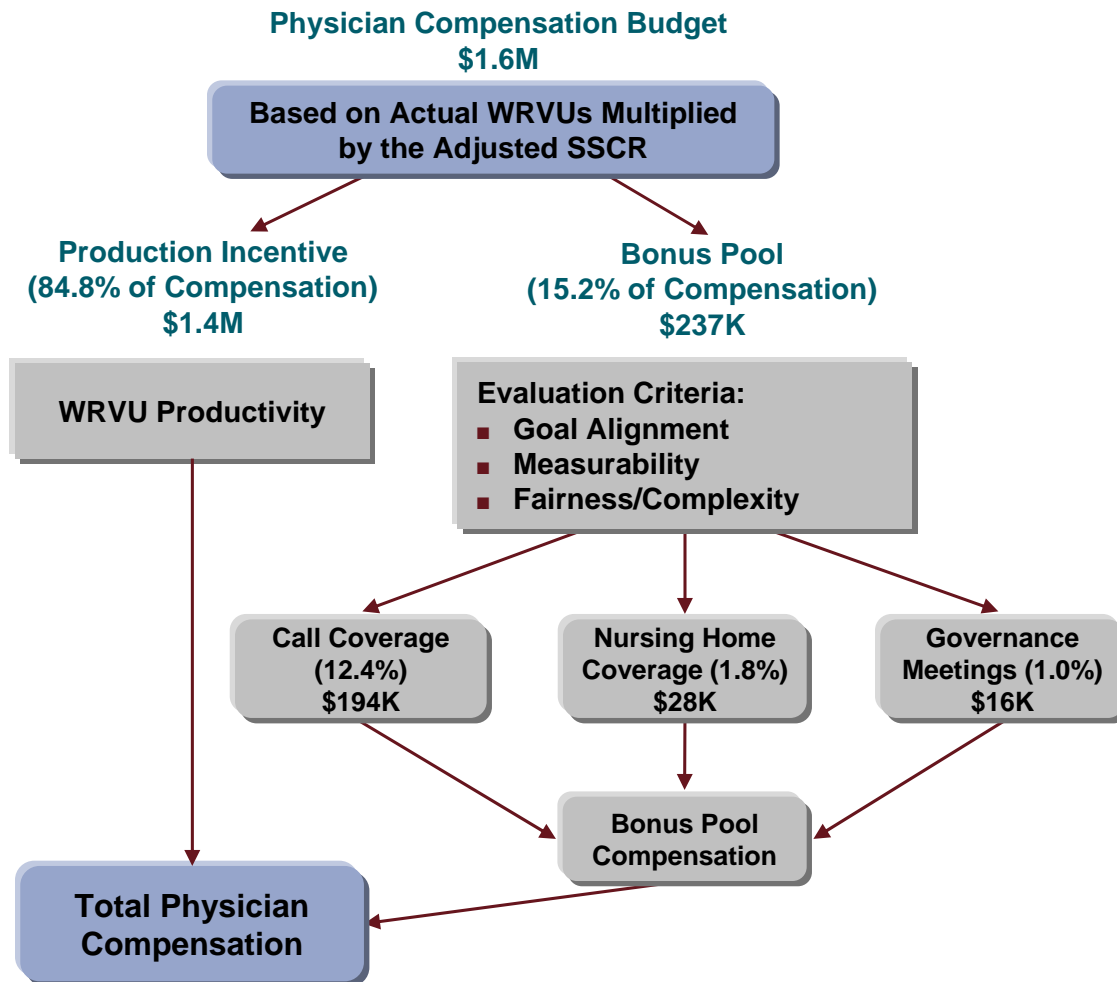
- Administration – Completed charts.
- Administration – Staff overtime.
- Administration – Transcription costs.
- Governance/meetings.
- Call coverage.
- Nursing home coverage.
- Midlevel provider supervision.
- Community outreach.
- Teaching.
- Mentorship.
- Patient access.
- Patient satisfaction.

We have developed a model for the bonus pool for discussion on the following page.

V. Sample Compensation Planning Process

Bonus Pool – Bonus Pool Structure

The steering committee has identified three incentive components for the bonus pool structure, which is summarized below.



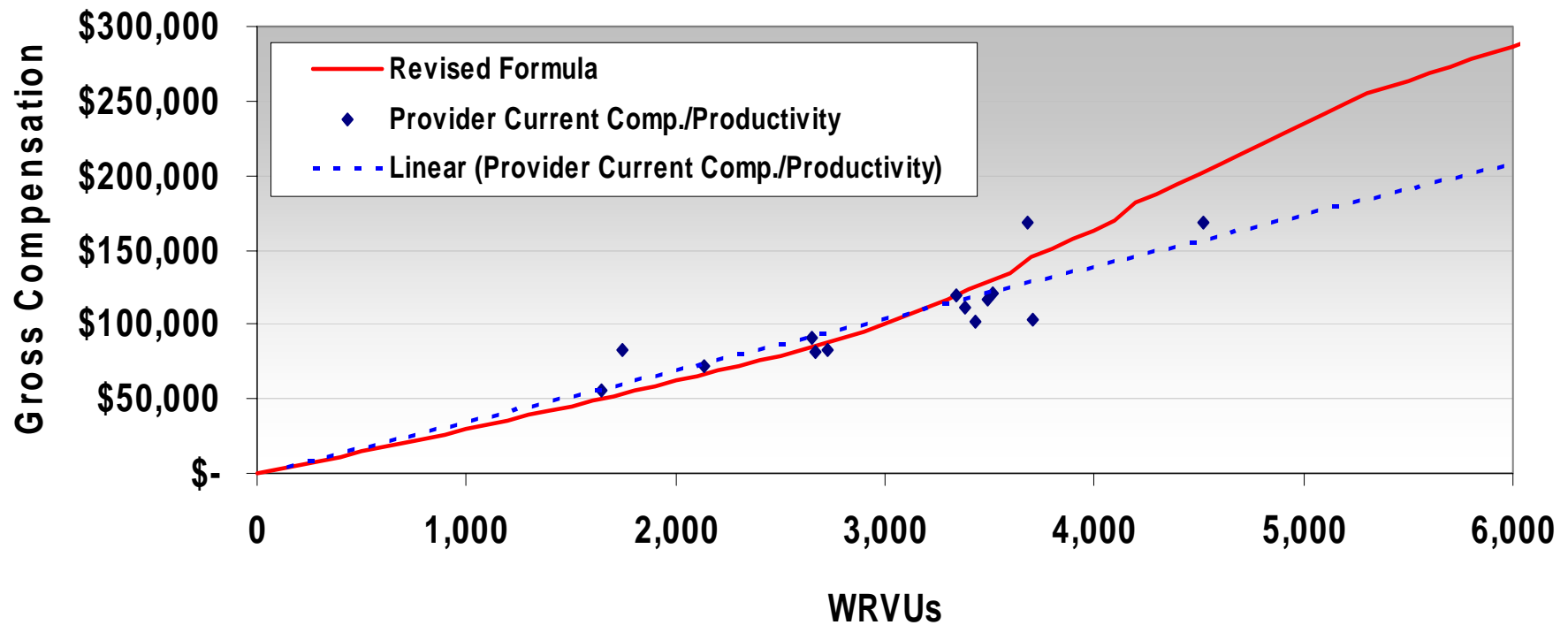
Incentive	Rationale	Proposed Payout
Call Coverage	Creates differentiation between full-service and outpatient-only practices.	Budgeted per night payment.
Nursing Home Coverage	Offers incentive to provide necessary community service.	Payment per WRVU.
Governance Meetings	Rewards time commitment from group participation.	Budgeted per meeting payment.

V. Sample Compensation Planning Process

Compensation Formula – PCP Payment Curve

On average, physician compensation will increase from current levels to match market levels.

Comparison of Current Trend and Revised Formulas – PCP





VI. Conclusions

VI. Conclusions

Keys to Success

- *Physician Direction* – Recruit opinion leaders to assist in the design of the compensation plan.
- *Market Relevance* – Pay competitive income for competitive work effort.
- *Flexibility* – Adopt a plan that allows for appropriate changes over time.
- *Communication* – Communicate fully and frequently to all physicians.
- *Simplicity and Objectivity* – Establish understandable, objective, and measurable incentives.
- *Alignment of Incentives* – Align physician and organization incentives.
- *Respect for Culture* – Respect differences in the decision-making process and organizational style within the medical group(s) and hospital(s).
- *Resist Making Special Deals* – Once the planning process is complete, stay true to decisions that were made by the committee.

Kevin's Top 10

Things You Never Hear in Compensation Planning

***Compensation planning is not for the faint of heart.
Expect to be challenged every step of the way.***

- 10- Wow, that's some good data you've got there.
- 9- It's funny, but everybody I know makes less than me for the same amount of work.
- 8- Are you SURE my RVUs are that high?
- 7- Of course my productivity is at the 10th percentile. I'm all about lifestyle.
- 6- And that guy at the 90th percentile? His quality is amazingly high.
- 5- I get all my referrals from my partners in the group and I don't mind paying for that.
- 4- I'm not particularly concerned about overhead.
- 3- Whatever you guys come up with is fine with me.
- 2- It looks like we're all in agreement.
- 1- This sure has been fun.



Appendix A
ECG Management Consultants, Inc.,
and Mr. Kevin M. Kennedy

ECG Management Consultants, Inc.

- ECG is a national consulting firm focused on providing strategic, management, and financial advice to healthcare providers.
- We are particularly known as experts in hospital/physician relationships, strategic and business planning, and process improvement.
- Our approximately 60 consultants operate out of offices in Seattle, Boston, San Diego, St. Louis, and Washington, D.C.
- We have been in existence for more than 30 years and are pleased to count many of the nation's leading health systems and cancer centers among our recent clients.
- More information is available at www.ecgmc.com.

Mr. Kevin M. Kennedy, Principal

- Mr. Kennedy is a principal with ECG. As a consultant since 1990, Mr. Kennedy has assisted healthcare clients nationwide in developing and implementing a variety of complex arrangements. His recent assignments include the following:
 - » Development of several hospital/physician joint ventures (JVs) in imaging, surgery centers, and cancer services.
 - » Negotiation of professional services agreements between hospitals and physicians.
 - » Numerous physician need studies and medical staff planning efforts.
 - » Operations and process improvement engagements for numerous hospital departments.
 - » Physician compensation and network improvement engagements.
- Mr. Kennedy holds an MBA from the University of Chicago.

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