New Compensation Model for Multispecialty Physician Group

Case Study

Submitted By
Melissa Dishong CPA, MBA, FACMPE

This case study manuscript is being submitted in partial fulfillment of the requirement for ACMPE Fellowship
Statement of the Problem

The Health System’s physician group transformed from being a predominately Primary Care centric group to a large multispecialty physician group over a three to five year time period. Due to the inconsistencies in contract language and significant growth in specialties within the organization (Medical Oncology, Plastic Surgery, Primary Care, General Surgery etc.), the physician leadership team and hospital administration determined a consistent compensation model needed to be developed and administered. The current compensation model was largely guaranteed salary with an incentive if the practice made a profit at the bottom line. This was based on individual physician allocations and production. There were inconsistent percentages used for the sharing of the bottom line revenue ranging from fifty percent (50%) to one hundred percent (100%). Physicians who were employed under the same group practice (OB/GYN for example) had different contract language as it pertained to base compensation and incentive compensation. Incentive opportunities were different for physicians with the same credentials/board certifications and education, seeing shared patients within the same practice. This created competition within the group and hard feelings among practice partners. Some practices within the group had straight base salary agreements, so there was no incentive to perform at a higher level, while other practices had wRVU (worked relative value units) target incentive opportunities.

While hospital administration, physician group leadership and the employed physicians had a good working relationship, all parties were aware that the compensation plan needed restructured for the physician group to be a sustainable subsidy. The physician group had
also sustained increased operating losses due to the guaranteed salary language that existed within many of the individual contracts. Minimum productivity and quality standards needed developed along with updating the compensation methodology to reflect how insurance companies were beginning to pay hospitals and providers. No quality component existed in the contracts yet hospitals began to lose reimbursement for readmissions, excessive lengths of stay and the high conversion of cases from Inpatient to Observation status. Patient satisfaction was also identified as a risk area in the future. Like hospitals, reimbursement from government payers was expected to be based on patient surveys, and without having physician compensation tied to this type of measure there would be no incentive for physicians to change behavior. With the transparency of survey data, it was felt that individual physician targets should be set and included as a metric within the quality component of compensation.

Physicians and administration identified the above as a key initiative for the group and set a specified timeframe for completion. However, this initiative did not have a simple solution with the amount of different specialties and current compensation language differences that existed within the physician’s contracts. This was also considered a major undertaking for a relatively “young” physician led group. The physician governance structure had only been in place for less than one year. Therefore a multi-disciplinary compensation committee was formed that included Primary and Specialty care physician representation, physician practice administrators, the groups finance director, a well-known compensation consultant from the mid-west and senior level hospital executives including the chief financial officer and chief medical officer. Having those with the
historical knowledge of the current plans and how they were administered as well as valuable input from the consultant on current industry trends and involving the physician leaders of the group was critical to the success of the plan.

**Alternative Decisions Considered**

The alternative decisions considered included doing nothing and continuing the current contracts with various compensation models across the specialties or developing a completely new compensation model/philosophy that would be consistent across all employed physicians. The only perceived benefit to keeping things status quo was to avoid push back from physicians who were considered key to the Health System’s success. The downsides to this alternative were plentiful considering they would perpetuate inconsistent contracts, continue the difficulty to accurately administer the various contracts, and breed physician dissatisfaction with “unfair” compensation models within like practice groups.

Some problems that occurred over the years with the existing contracts included substantial losses due to the guaranteed base compensation language. When a Physician’s productivity declined there was no provision for an adjustment to salary. This also put the organization at risk for overpaying and being outside of fair market value for salary. In regard to the inconsistency of the contracts, it was very difficult to ensure each contract was being administered correctly because the way incentives were calculated were different across every specialty and even within the same specialty. Different bonus percentages were used, expense allocation methodologies varied, and timing of payments also differed. This was
a result of how the contracts were written and made managing the contracts a full time job when it didn’t need to be.

Various compensation methodologies were discussed and then modeled to see the impact on each practice. One model that was explored used MGMA median base salaries as the starting base compensation, but this added too much cost to the organization. Due to the economics of the region including cost of living, the physician group had been able to recruit new physicians to the area without having to pay the national rates. The one selected was based on a percentage of historical earnings of the physicians; including a base plus incentive compensation structure with an “at risk” component to foster buy-in to the model. The benefits of this model included eliminating legacy contracts, having only one compensation methodology to administer, internal equity within like specialty practices, right-sizing of compensation within practices based on productivity over time, providing incentives for physicians to remain productive as they would now have a vested interest in performing to their targets, and group incentive pools versus purely individual bonus language. The disadvantages of this model included a change in compensation to physicians (some would see an increase and others a decrease in total compensation), renewal of at least one hundred fifty contracts at once, and pushback from physicians due to the new group language being proposed.

**Procedures Used to Select Solution**

The first task at hand was for the Compensation Committee to determine the guidelines the group must work within to obtain the desired results. Next a detailed action plan would
need to be developed outlining the steps necessary to put the plan into effect; considering all of the alternative possibilities for a viable compensation plan; and establishing an estimated timeline for completion of the selected plan. The procedures used to select the solution included the Health System engaging a Consultant to educate the group on national physician compensation trends; and to also provide guidance and examples of various compensation models. The Committee set goals and parameters for the new compensation model including minimum standards for expense and productivity. The overall expectation was that total compensation would not increase but that it would be distributed fairly and equitably over the employed physician population. The Director of Finance completed a Fair Market Value Analysis on current compensation. Actual WRVU (Worked relative value unit) production times the applicable MGMA Survey Compensation rate per WRVU by specialty was compared to total actual compensation (base plus incentive). Another test that was performed was to compare actual total compensation to the MGMA percentiles for total compensation to see who was being paid above the 90th percentile as this was another compliance risk.

The Committee tested various compensation formulas to see what fit best based on established parameters. For example, different base compensation percentages and withhold percentages were modeled against every physician in the group to validate the effect of the compensation methodology in the “real world”. This was a very important step as several models failed as they created too drastic of a change too quickly which could have led to unwanted physician turnover. Regular Compensation Committee meetings and special Leadership meetings were held throughout the eighteen month long
process to vet the results of the testing and consider further changes to the plan. These meetings included members of the Physician Group at large and sought input while laying the framework for the new model. All physicians within the group were invited to these meetings and encouraged to attend to voice their opinions. No one could say that the new compensation structure was done in a vacuum without input. Everyone’s opinion was important, not just the committee members.

**Decision**

The Compensation Committee in conjunction with the Finance Committee presented the Compensation Plan to the Leadership Committee (Pseudo Board to the Physician Group). The final Compensation Plan that was agreed upon was structured as follows:

1. New Base Compensation was calculated based on ninety percent (90%) of the prior years’ total compensation (Base plus incentive compensation). This was chosen as to not significantly impact any physician in the first year. Base compensation could be adjusted each year to keep up with actual physician productivity from year to year. This was a way to foster consistent work ethic.

2. The remaining ten percent (10%) was held as a withhold and distributed back to the physician based on two components, quality scores at five percent (5%) and meeting productivity targets at five percent (5%). Patient satisfaction was chosen as the quality target for the first year of the plan. The production targets were commensurate with the base pay that was used referencing MGMA productivity.

3. Incentive Compensation was based on a bottom line profit or loss (the same as in the old plan), but new physicians who had been in practice for less than two years
were carved out of the expense allocation unless they had already hit their productivity target.

4. If a profit remained after expenses, eighty five percent (85%) of the profit was shared within the group of physicians based on their individual productivity to total group productivity and the remaining fifteen percent (15%) stayed with the Physician Group.

5. For those physicians that did not hit their productivity target in year one, they did not earn back their compensation withhold. In year two their base would be reset at ninety percent (90%) of the prior year compensation. This method would allow for an annual adjustment to compensation to keep up with the actual work being performed.

Upon the approval of the plan by the Physician Group committees, it was then presented to the Health System Board who also served as the Physician Group Board. Final approval of the plan occurred prior to the end of the fiscal year and within the eighteen month timeframe established by the committee. The rollout of the new compensation methodology was set to occur over the following twelve to eighteen month timeframe based on contract renewals.

**Implementation**

After all approvals were received, a special meeting was held with all employed physicians to educate them on the new compensation plan and to provide them with “real-world” examples of how they individually, and from a group perspective, would be impacted by the new plan. A test group of physicians were selected to early adopt the plan to work out
any issues that would arise that had not been identified in testing. A detailed roll-out schedule was created that listed each physician by specialty and date of expected implementation. Each physician was personally notified of their respective date to allow for any timing adjustments. Those with current renewal dates were identified first, followed by those who had one to two years remaining in their contracts. The intent was that all physicians within the group would be under the new compensation model by the end of the following fiscal year.

As the first practices were implemented, the Compensation Committee held follow up meetings throughout the roll-out period to address any issues identified and make adjustments/clarifications to the language in the Plan. OB/GYN was one of the first early adopters as they had several discrepancies with their original contracts and felt they needed to move on to a new plan or otherwise would flounder as a group. Some of the items that were further clarified through the first wave of rollouts included WRVU targets used for incentive purposes and identifying the expense allocation allotted to new physicians in a group, as the model included an acceptable loss provision for start-up physicians.

**Significance of Outcomes and Lessons Learned**

A new compensation model was the first major group initiative with the newly implemented physician leadership structure. The physicians’ focus was for the good of the group not just for their individual gain. Heath System Administration was comfortable with delegating the authority of creating a new compensation model within the physician group organizational structure. This spoke volumes to the level of trust between physicians
and administration. This could not have occurred if the group was not tightly integrated with the hospital. Transparency among the group as to the compensation methodology and its consistent application to all physicians created trust from physician to physician and physician to administrator. It was apparent that the physicians on the committees gained a new respect for administration. Being on the “other side” and acquiring an understanding of the complexities of compensation allowed the physicians to better understand the challenges surrounding consistent application of a compensation plan. Administrators saw that physicians were willing to make tough decisions and make personal sacrifices for the good of the group. It was also noted that some physicians would never see the advantage of working as a group and coming to consensus on what was best for most. Their only concern was for themselves.

One of the most important things recognized through this process was that Physician compensation plans are unique and could have as many or as few components as the group would choose. If there are one hundred Physician Groups there are likely to be one hundred different compensation plans. What is important is that the methodology chosen fits the group culture.

A final lesson was that the plan needed to be kept as simple as possible. This was true for the person administering the plan but also for the physicians who had to understand it and buy into the model. There were times throughout the process where members of the Compensation Committee had a tough time understanding proposed components. When that occurred it was obvious that something needed reworked because if those that were
close to the information were challenged the general staff physician would likely have a hard time understanding. As the group continued to mature over the term of this project, their decision making processes and problem solving skills also developed.

**Recommendation for Other Managers**

Developing and implementing a consistent compensation plan was a huge undertaking, however the results reaped benefits beyond the value of a dollar saved or spent in the process. The top five recommendations for any Physician Group pursuing the redesign of their compensation plan are as follows:

1. Engage a reputable outside consultant or third party to provide an independent and unbiased assessment. This was key to the process and added a level of reassurance and neutrality to those who were hesitant to trust Administrators.

2. Involve a cross-section of physicians (Primary care and Specialty Care) to drive the process and communicate updates to the larger group. This accelerated physician buy-in to the Plan.

3. Be transparent with information. Do not enter into any special deals that fall outside of the compensation plan guidelines. Use the documented structure and plan design guidelines to address physician requests.

4. Be realistic with goals and implementation. While compensation drives many things, it cannot fix every problem with physicians. Ensure that the goals are well defined and that expected outcomes align with those goals.
5. Don’t make promises that can’t be delivered upon. Compensation is the number one most important contract issue with physicians and should be handled accordingly. When in doubt, analyze, analyze, and re-analyze until you are sure what you tell a physician or put in his/her contract is accurate.