Physician Compensation Plan Design: Balancing the Needs of Multi-Specialty Groups in an Evolving Reimbursement World

J. Michael Scalzone, MD, MHCM
Executive Vice President Medical Affairs
The Guthrie Clinic

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Presentation Overview

• About The Guthrie Clinic
• Compensation Redesign Process
• Initial Planning Steps
• Qualitative and Quantitative Data Review
• Guthrie Compensation Principles
• Direction for Compensation Formula Design
The Guthrie Clinic--Dr. Donald Guthrie

- Trained at the Mayo Clinic in Rochester, MN
- Became the Surgeon-in-Chief and Administrator of the Robert Packer Hospital in 1910
- Formed One of the First Multi-Specialty Group Practices in the United States
- A Founder and One of the 13 Original Members of the American Board of Surgery
- Today, We are One of the Oldest Multi-Specialty Group Practices in the United States
About The Guthrie Clinic

Physician led non-profit integrated health system

- Northern Tier of PA and Finger Lakes Region of NY
- 5500 Employees
- 1.2 Million Out-Patient Encounters

Guthrie Medical Group

- Multi-Specialty Group Practice of 300 physicians, 500 total Providers
- Regional Office Network of Specialty and Primary Sites in 25 Communities Across the Northern Tier of Pennsylvania and the Southern Tier of New York

Guthrie Hospitals

- Robert Packer Hospital – Academic Tertiary Care Hospital
- Troy Community Hospital – Critical Access Hospital
- Corning Hospital – Corning, New York
- Memorial Hospital – Towanda, Pennsylvania
Medical Practice in a Rural Service Area

Guthrie Values: Patient-centered, Teamwork and Excellence
Geography

Drives Competitive Environment
Determines Insurance Landscape
Affects Reimbursement
Compensation Redesign Process
Compensation Redesign Process

Initial Planning
- Project scope
- Objectives
- Timeline
- Stakeholder identification
- National trends

Data Analysis
- Compensation
- Production/wRVU
- Current formulas
- Stakeholder input
- Local market metrics

Compensation Plan Design
- Philosophy
- Conceptual models
- Testing & validation
- Refinement
- Transition planning

Approvals & Implementation
- Approving body
- Communication plan
- Implementation plan
- New plan(s) documented
The Foundation of Physician Compensation

- Emphasis in Previous Revisions
- Emphasis in Current Revision

1. Operating Mechanics
2. Compensation Plan Methodology
3. Compensation Philosophy and Guiding Principles
4. Physician Compact
5. Culture Mission, Vision and Values
Initial Planning Steps
Guthrie Compensation Planning Goals

- Better understand how market changes are impacting compensation and how groups similar to Guthrie are responding
- Evaluate the compensation *approaches* at Guthrie relative to the broader market (most specialties today are based on a formula driven by net collections)
- Evaluate the compensation and production *levels* at Guthrie relative to the national market
- Develop guiding principles for this work
- Commit to an engaged, data-based process
- Adopt compensation plan(s) for Guthrie that prepare us well for the future
Successful Practice Based on Engaged Physicians

• Compensation is just one part of total rewards
• Value-Based Incentives can drive or deter engagement

• **Challenges to Engagement**

  Asymmetrical Rewards (purpose in medicine)
  Loss of Autonomy
  Cognitive scarcity (mastery of knowledge)
Smith spoke of the example of a pin factory, where **specialization of labor** contrasts with the model of one pin-maker making a single pin by themselves. The specialization of the individual workers in the pin factory was used to support the idea that the metal cutter, pin drawer, roller, finisher, etc all worked together **in order to increase productivity**, over the solitary, isolated pin maker, who completed all tasks and produced an entire product by himself.

However, **Smith's pin factory is also used as an example of how the specialization and rigors of specialized factory life produce negative effects upon the workers' intellects and psyches.** (Karl Marx wrote about this extensively)

Smith describes the idea of **alienation of the worker in activities designed to be predictive (reliable) and accurate (routine).**
• "The man whose whole life is spent in performing a few simple operations, of which the effects are perhaps always the same, or very nearly the same, has no occasion to exert his understanding or to exercise his invention in finding out expedients for removing difficulties which never occur. He naturally loses, therefore, the habit of such exertion, and generally becomes as stupid and ignorant as it is possible for a human creature to become. The torpor of his mind renders him not only incapable of relishing or bearing a part in any rational conversation, but of conceiving any generous, noble, or tender sentiment, and consequently of forming any just judgement concerning many even of the ordinary duties of private life."
Compensation Committee Members

- President, Guthrie Medical Group
- Executive Vice President Medical Affairs
- COO, The Guthrie Clinic
- COO, Guthrie Medical Group
- CFO, The Guthrie Clinic
- Administrative Vice President, Guthrie Medical Group
- Director, Finance
- Chairs: Surgery, Medicine, Anesthesia, Radiology, Primary Care
- Three associate physician members
National Trends and Directions

• After we established our committee and objectives, we spent some time educating the compensation committee members.

• There was general awareness of the trends, but the detailed statistics were informative.

• One question to ask the committee is how the members expect the market changes will impact the organization in terms of operations, practice style and other factors.
Why the Market is Changing

Reimbursement at the federal and local levels is changing:

- MACRA: MIPS and APMs
- ACO Models
- Shared Savings Programs
- Employer-Driven Contracts
- General cost pressures

Regardless of the program, the focus is on VALUE
How the Market is Changing

According to the 2016 AMGA Medical Group Compensation and Productivity Survey:

• In 2009, about 41% of groups responded that some amount of their physician compensation was based on the achievement of value-based metrics (VBM)

• By 2016, about 60% of groups responded that some amount of their physician compensation was based on the achievement of value-based metrics (VBM)

• The role of VBM will continue to grow...
### How the Market is Changing

#### Value-Based Pay as a Percent of Total Compensation

<table>
<thead>
<tr>
<th>Specialty Type</th>
<th>Physician FTEs</th>
<th>Percent Quality and Discretionary Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Groups</td>
<td></td>
<td>6.7%</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 150</td>
<td></td>
<td>5.9%</td>
</tr>
<tr>
<td>150 to 300</td>
<td></td>
<td>6.2%</td>
</tr>
<tr>
<td>More than 300</td>
<td></td>
<td>9.4%</td>
</tr>
<tr>
<td>All Groups</td>
<td></td>
<td>7.0%</td>
</tr>
<tr>
<td><strong>Radiology/Anesthesiology/Pathology</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 150</td>
<td></td>
<td>5.1%</td>
</tr>
<tr>
<td>150 to 300</td>
<td></td>
<td>6.7%</td>
</tr>
<tr>
<td>More than 300</td>
<td></td>
<td>9.0%</td>
</tr>
<tr>
<td>All Groups</td>
<td></td>
<td>7.0%</td>
</tr>
<tr>
<td><strong>Specialists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 150</td>
<td></td>
<td>5.2%</td>
</tr>
<tr>
<td>150 to 300</td>
<td></td>
<td>6.4%</td>
</tr>
<tr>
<td>More than 300</td>
<td></td>
<td>7.4%</td>
</tr>
<tr>
<td>All Groups</td>
<td></td>
<td>6.2%</td>
</tr>
</tbody>
</table>

*Only includes groups that reported quality or discretionary compensation represented some amount of total cash compensation.*
### How the Market is Changing

#### Value-Based Incentives and Discretionary Compensation

<table>
<thead>
<tr>
<th>Category</th>
<th>2016</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction</td>
<td></td>
<td>71%</td>
</tr>
<tr>
<td>Clinical Outcomes</td>
<td>12%</td>
<td>49%</td>
</tr>
<tr>
<td>Individual Financial Goals</td>
<td>37%</td>
<td>43%</td>
</tr>
<tr>
<td>Access</td>
<td>11%</td>
<td>30%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>11%</td>
<td>23%</td>
</tr>
<tr>
<td>SCIP/Core/ACO Measures</td>
<td>0%</td>
<td>22%</td>
</tr>
<tr>
<td>Peer Chart Review</td>
<td>17%</td>
<td>21%</td>
</tr>
<tr>
<td>Citizenship</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Dept RVU Goals</td>
<td>18%</td>
<td>29%</td>
</tr>
<tr>
<td>Dept Budget / Goals</td>
<td>17%</td>
<td>31%</td>
</tr>
<tr>
<td>Hospital Utilization</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>Cost Containment</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Clinic Administrative Duties</td>
<td>0%</td>
<td>11%</td>
</tr>
</tbody>
</table>
How the Market is Changing

• The review of these data points led to discussion of how do we plan effective, fair and compensable incentives.....
Newtonian physics runs into problems at the sub-atomic level. Down there in the land of hadrons and quarks and Schrödinger’s cat—things get freaky. The cool rationality of Isaac Newton gives way to the bizarre unpredictability of Lewis Carroll.

-Daniel Pink
Qualitative and Quantitative Data Review
Qualitative and Quantitative Data Review: Input

• Qualitative
  
  – Initial discussion at Medical Staff membership Meeting with break out sessions: Approximately 80 participated.
  
  – This segment of the process began by conducting individual stakeholder interviews with more than 30 physicians and leaders
  
  – Next, we conducted an online provider survey to seek input from every willing member of the group
  
  – We had a retreat with the compensation committee

• Quantitative
  
  – Then, we reviewed compensation and production levels for all the providers in our group
Interview Comments

Knowledge about Healthcare Reform and Move from Volume to Value

- Guthrie is still heavily **fee-for-service** and most physicians expressed a **limited to fair understanding** of how current reforms will impact care delivery.

- Most said that Guthrie is positioned well for future success in a value-based care world since cost of care is thought to be low relative to the market.

- A few questioned whether enough is being done with the care delivery model.

- Guthrie has 26 PCMH Practices and hired care coordinators, chronic care nurses, etc, relatively recently; other infrastructure to manage value-based care is being developed.

- As there is more than one approach to compensation at Guthrie, some physicians were unable to assess how well the plans link to a value-based world.
Interview Comments

Compensation Plans

– Many physicians said they don’t understand how the compensation model works today

– Some felt the financial reports they are provided don’t tie well to their compensation
  
  • (Fiscal year budget versus compensation cycle, etc)

– Pay for “work effort” was a consistent theme; most felt there was some divergence between work effort and collections (net revenue versus wRVU’s)

– Many said *patient satisfaction/experience* was important but that it shouldn’t be over-emphasized in terms of compensation

– *Transparent, fair and predictable* were common desires related to pay

– The last compensation model implementation was disappointing for most of the physicians interviewed; the “bonus” was perceived as a “withhold”
Interview Comments

Other Compensation Comments

– Some physicians talked about considering productivity at the department/group level versus individual

– A number of physicians expressed a desire to use work RVUs instead of collections as the driver of compensation; years of service was also thought to be important

– Some physicians thought that teaching pay needs to be revised

– Seems to be more satisfaction with “what” providers are paid and less satisfaction with “how” providers are paid
Online Survey Results

• A series of Likert-style questions were asked along with demographic and open-ended questions

• Scales ranged from 1 to 5:
  
  o 1 = Very Dissatisfied or Strongly Disagree
  
  o 5 = Very Satisfied or Strongly Agree

• The survey was conducted during November 2016

• There were 188 participants, of whom 109 were physicians, 59 were NP/PAs and 20 were other providers
Demographics: Physicians Only

<table>
<thead>
<tr>
<th>Years at Guthrie Count</th>
<th>Count of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Null</td>
<td>8</td>
</tr>
<tr>
<td>0-2</td>
<td>34</td>
</tr>
<tr>
<td>3-8</td>
<td>23</td>
</tr>
<tr>
<td>9-14</td>
<td>12</td>
</tr>
<tr>
<td>15-20</td>
<td>9</td>
</tr>
<tr>
<td>21+</td>
<td>23</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Response</td>
</tr>
<tr>
<td>25-34</td>
</tr>
<tr>
<td>35-44</td>
</tr>
<tr>
<td>45-54</td>
</tr>
<tr>
<td>55-60</td>
</tr>
<tr>
<td>61+</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Response</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
</tbody>
</table>
Methodology

• On the following graphics, the **top axis** shows the average Likert scale score and applies to the circles

• The **gold** circles represent the **Guthrie** average score for each question; the gray circles represent the norm average score for each question taken from the summer 2016 survey (14,875 respondents); the light blue circles represent Guthrie’s previous average score for each question

• The **bottom axis** shows the percent of the total Guthrie responses for each Likert value, including null or no response, and applies to the colored bar next to each question
Top 10 Questions: Highest Average Value
Physicians Only

<table>
<thead>
<tr>
<th>Question</th>
<th>Average Value 0.0</th>
<th>Average Value 1.0</th>
<th>Average Value 2.0</th>
<th>Average Value 3.0</th>
<th>Average Value 4.0</th>
<th>Average Value 5.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your relationships with patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of care you are able to provide</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am NOT likely to leave Guthrie in the next twelve months.**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your overall medical practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alignment of group’s organizational values with your values**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volume of patient load or panel size*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount of time you are able to spend with each patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group’s focus on improving the patient experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group’s focus on providing quality care across specialties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing of information and ability to participate in issues impacting your group</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
## Survey Questions: Compensation
### Physicians Only

### Overall Provider Satisfaction or Agreement

<table>
<thead>
<tr>
<th>Question</th>
<th>Average Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>The relative weight of system financial performance in the current compensation program</td>
<td>2.98</td>
</tr>
<tr>
<td>Citizenship (service to the group/committee work) as a factor in the current compensation program</td>
<td>2.97</td>
</tr>
<tr>
<td>The relative weight of productivity in the current compensation program</td>
<td>2.89</td>
</tr>
<tr>
<td>Efficiency or cost-related goals as a factor in the current compensation program</td>
<td>2.85</td>
</tr>
<tr>
<td>The alignment of the physician compensation program with current and anticipated health care reforms</td>
<td>2.99</td>
</tr>
<tr>
<td>The current compensation structure</td>
<td>2.83</td>
</tr>
<tr>
<td>The relative weight of clinical quality/clinical outcomes in the current compensation program</td>
<td>2.81</td>
</tr>
<tr>
<td>Equitable treatment of compensation, resources and scheduling across specialties*</td>
<td>2.76, 3.01, 1.21</td>
</tr>
<tr>
<td>The relative weight of patient satisfaction/patient engagement in the current compensation program</td>
<td>2.73</td>
</tr>
<tr>
<td>The involvement of physicians in determining compensation approaches</td>
<td>2.69</td>
</tr>
</tbody>
</table>
This graph shows that across individuals there was much variation between production level (measured by collections) and compensation level.
Guthrie Compensation Principles
Guthrie Compensation Principles

• **Fair and Transparent**
  – Understandable, easily explained and *predictable*
  – Clearly defined work expectations (production, quality and other factors)
  – Metrics set in advance and supported by accurate and *timely reporting*

• **Aligned With Organizational Strategy**
  – Consistent with Guthrie’s organizational values and long-term strategy
  – Supports transition to value-based care and Guthrie’s care delivery model
  – Values factors in addition to productivity such as medical education and administration

• **Sustainable**
  – Financially viable/affordable for the organization
  – Adaptable to changes in the market (e.g., weighting of productivity versus non-productivity metrics, conversion factors)
Guthrie Compensation Principles

• Supports Recruitment and Retention of Physicians
  – Consistent with market pay practices, which may differ by specialty
  – Provides competitive compensation levels

• Citizenship
  – Values unique contributions of individuals
  – Promotes teamwork and collaboration
Direction for Compensation Formula Design
**Modeling Approach by Specialty**

### Guthrie Production Specialties
- Allergy/Immunology
- Bariatric Surgery
- Cardiac/Thoracic Surgery
- Cardiology – Cath Lab (Invasive Interventional)
- Cardiology – Electrophysiology Pacemaker
- Cardiology – General
- Dermatology
- Dermatology – Mohs
- Endocrinology
- Family Medicine
- Family Medicine With Obstetrics
- Gastroenterology
- General Surgery
- Hematology and Medical Oncology
- Infectious Disease
- Internal Medicine
- Nephrology Only
- Neurological Surgery
- Neurology
- OB/GYN – General
- Occupational/Environmental Medicine
- Ophthalmology
- Ophthalmology – Medical
- Ophthalmology – Retinal Surgery
- Oral-Maxillofacial Surgery
- Orthopedic Sports Medicine
- Orthopedic Surgery
- Orthopedic Surgery – Hand
- Orthopedic Surgery – Joint Replacement
- Orthopedic Surgery – Trauma
- Otolaryngology
- Pediatrics and Adolescent – General
- Physical Medicine and Rehabilitation
- Plastic and Reconstruction
- Podiatry – Medical
- Psychiatry
- Pulmonary Disease (Without Critical Care)
- Radiation Therapy (MD Only)
- Rheumatologic Disease
- Trauma Surgery
- Urology
- Wound Care/Hyperbaric

### Salary-Based Specialties
- Anesthesiology
- Diagnostic Radiology (MD Interventional)
- Diagnostic Radiology (MD Non-Interventional)
- Emergency Medicine
- Hospitalist – Family Medicine
- Hospitalist – Internal Medicine
- Pathology – Combined (MD Only)
- Trauma Surgery
Compensation Model #1: Performance Bands

- The performance band model allows varying levels of compensation for different levels of work effort, measured by wRVU, for the production-based specialties.
- Initial modeling used an allocation of approximately 90% productivity and 10% value-based incentive.
- Compensation for administrative and other duties could be added in addition to these categories.
Committee Feedback on Performance Bands

• The general structure of a performance band model was presented to the committee in January

• After some discussion, feedback on the model was generally positive for the following reasons:
  – It fits our draft compensation principles
  – It meets our expectations of where the market is going
  – It allows for flexibility
Compensation Model #2: Salary-Based Approach

- Two straightforward approaches for salary-based specialties were considered for select specialties
- The first approach valued wRVU (or ASAs in anesthesia) at the market median
- The second approach started with median cash compensation from the market data not linked directly to wRVU / ASA production
- After the committee meeting in January, the second approach was thought to provide the most continuity to current state and was more consistent with the care delivery in these specialties
- Factors that merit varying the incentive portion of the salary, such as high productivity, quality or citizenship are in place
Mechanics Still Being Examined

- Where should compensation be set within the market for each band? Median?

- How many performance bands are necessary?

- How should the performance band widths be determined? Essentially, which range of wRVU production with have the same potential compensation level?

- How will physicians who are impacted positively or negatively, to a material degree, by the model be addressed?

- What happens when production changes throughout the year?
Yet to Come

• Define Affordability
• Timing and Transition
• Plan for Evolution
Questions and Comments