

group practice journal

PUBLICATION

OF THE AMERICAN MEDICAL

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Compensation 2011: A Time of Consolidation and Shifting Incentives

Results from the AMGA 2011 Medical Group Compensation and Financial Survey

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BY BRADLEY S.J. VAUDREY, M.B.A., CPA

The goal of the American Medical Group Association (AMGA) Medical Group Compensation and Financial Survey is to provide objective, comprehensive data about compensation to help individual medical groups understand broader compensation trends as well as the societal issues driving those trends. It also identifies key shifts and emerging issues within the profession. The data enables individual medical groups to make more informed decisions about their own compensation methodologies. Working with the accounting firm of RSM McGladrey, AMGA recently completed the 2011 survey. It shows a profession adapting to continuing demographic changes and looming regulatory changes by implementing innovative new models of care and forming new business combinations.

About the Survey

The survey was sent to more than 2,700 medical groups across the country in January 2011. McGladrey's consulting group received valid responses from 239 medical groups, representing approximately 51,700 providers. The survey results encompass 120 physician specialties, 32 other provider specialties, and 27 executive and director administrative positions.

Data are broken down by region and organization size. They include information on such related topics as group legal structure and business model, fringe benefits, and financial indicators both clinic-wide and broken out by specialty. A separate

summary addresses compensation and production within the distinctive setting of academic facilities.

The overall weighted average increase in compensation was approximately 2.4%.

General Findings

While healthcare reform is top of mind, the implementation of reform has been phased in over time and, in many cases, so delayed that its effect on compensation may not be felt for several years. A case in point, the recently released proposed accountable care organization (ACO) regulations have been widely criticized and there are indications that changes are being considered. With so many unknowns and so much confusion, many groups are hesitant to put their organization through the stress of making the significant changes to their physician compensation models that would be necessary to embrace these reforms.

Other, more imminent issues are having an effect on compensation. These include an aging population, the increase in mergers and acquisitions in the industry, the continued adoption of the medical home model, and a slow, uncertain economic recovery.

The overall weighted average increase in compensation from 2010 was approximately 2.4%. This paced ahead of the 1.6% Consumer Price Index for inflation, but does trail the percentages of compensation

increases seen in the past. This is an overall average; however, when looking at individual specialties, the changes vary. We will be discussing this in some detail in the next section.

Another reason for the lower compensation percentage change is the level of productivity. Productivity, as measured in RVUs, was flat at -0.4%, with a substantial decrease in surgical specialties (-2.13%). Primary care and medical specialties stayed flat at 0.51% and 0.49%, respectively. When considering collected charges or revenue collected for physician services, we saw similar results with an overall decrease of 0.8%.

When comparing compensation and RVUs, it is interesting to note that the growth of surgical specialties compensation was depressed by a loss of RVUs. Although the surgical compensation levels were for the most part flat, at times the compensation-per-RVU rate was higher than last year. Part of this trend of a productivity decrease in surgical specialties was expected due to the elimination of consultation codes by the Centers for Medicare and Medicaid Services (CMS). These codes allowed consults by physicians to be charged at a higher rate than the typical office visit. It cannot be assumed, however, that these decreases are attributed solely on government measurement changes. One cannot trend on one year's data alone, and only time will tell if this becomes a pattern.

When reviewing changes in compensation, it is important to note

TABLE 1
Comparison of the 2011 and 2010 AMGA Medical
Group Compensation and Financial Survey

| Specialty | 2011 Median Compensation | % Change 2010 to 2011 | 2011 Work RVU Median | % Change 2010 to 2011 | 2011 Comp per Work RVU Median | % Change 2010 to 2011 | 2011 Net Collections Median | % Change to 2011 | 2011 Comp to Net Collections Median | % Change to 2010 to 2011 |
|------------------------------------|--------------------------|-----------------------|----------------------|-----------------------|-------------------------------|-----------------------|-----------------------------|------------------|-------------------------------------|--------------------------|
| Dermatology | \$386,068 | 2.90% | 7,440 | 4.10% | \$54.56 | 2.6% | \$915,812 | -8.3% | 48.39% | -3.2% |
| Endocrinology | \$233,000 | 6.50% | 4,446 | -2.30% | \$51.94 | 9.2% | \$377,073 | 3.2% | 57.98% | -3.7% |
| Family Medicine | \$208,658 | -0.10% | 4,977 | 1.30% | \$39.87 | -2.1% | \$431,553 | 0.3% | 47.09% | -1.8% |
| Family Medicine with Obstetrics | \$215,450 | 2.8% | 5,064 | 0.7% | \$42.41 | 3.9% | \$462,815 | 1.1% | 50.82% | 5.0% |
| Gastroenterology | \$415,872 | 2.70% | 8,073 | -1.10% | \$55.94 | 2.5% | \$831,646 | 2.9% | 57.32% | 1.9% |
| Hypertension & Nephrology | \$259,776 | 0.00% | 5,980 | 1.4% | \$45.05 | 5.0% | \$409,460 | -0.9% | 69.40% | 3.2% |
| Internal Medicine | \$219,500 | 2.40% | 4,838 | 3.70% | \$44.22 | -1.7% | \$414,448 | 3.2% | 53.09% | -3.9% |
| Neurology | \$246,500 | 4.20% | 4,868 | -1.20% | \$51.53 | 3.8% | \$389,820 | -3.5% | 63.08% | 5.6% |
| Pediatrics General | \$213,379 | 1.70% | 5,089 | -2.70% | \$40.24 | 3.0% | \$468,853 | -1.7% | 45.13% | -3.7% |
| Psychiatry | \$217,169 | 1.10% | 3,681 | 3.70% | \$58.50 | -0.2% | \$231,070 | 8.3% | 91.02% | -2.1% |
| Rheumatologic Disease | \$231,579 | 3.4% | 4,654 | 1.1% | \$49.16 | -1.4% | \$419,557 | 1.6% | 55.05% | 3.3% |
| Urgent Care | \$230,239 | 3.30% | 5,022 | 1.90% | \$42.06 | -4.2% | \$457,102 | -0.5% | 47.76% | 2.5% |
| Cardiac and Thoracic Surgery | \$532,567 | -0.1% | 9,612 | -8.6% | \$52.70 | 5.0% | \$648,388 | -2.9% | 79.32% | 0.7% |
| General Surgery | \$367,315 | 2.90% | 7,081 | -2.30% | \$52.43 | 6.4% | \$601,630 | -3.8% | 62.75% | 6.8% |
| OB/GYN-General | \$302,638 | 2.30% | 6,639 | -1.70% | \$45.45 | 2.9% | \$671,783 | 4.2% | 46.19% | -1.9% |
| Ophthalmology | \$356,339 | 3.60% | 8,821 | 2.80% | \$41.33 | 2.9% | \$804,535 | 5.3% | 46.15% | -2.8% |
| Orthopedic Surgery | \$501,808 | 0.20% | 8,026 | -4.10% | \$64.11 | 5.7% | \$841,841 | -2.3% | 60.33% | 0.6% |
| Plastic and Reconstructive Surgery | \$405,635 | 4.0% | 6,703 | 1.5% | \$60.54 | 0.5% | \$732,227 | -4.5% | 52.90% | -1.8% |
| Urology | \$413,746 | 0.00% | 7,503 | -4.90% | \$54.17 | 5.8% | \$768,289 | -7.4% | 54.63% | 4.9% |
| Pathology | \$354,917 | 0.00% | 7,260 | -0.40% | \$50.79 | 0.4% | \$495,456 | 1.3% | 63.15% | -3.5% |

that the compensation-to-production ratios (i.e., compensation-per-RVU rate or compensation-to-net collections ratio) will take into account both the compensation and production changes, therefore showing the net market demand impact for the specialty.

Table 1 provides a sample of the individual changes that occurred between the 2011 and 2010 survey on an individual specialty level.

Compensation: Top and Bottom Five Specialties

Figure 1 provides the top five notable increases in compensation in the 2011 report. Also shown is the corresponding change in work RVU. In two specialties, surgical podiatry and allergy, at least a portion of the

compensation increase could be attributed to increased work effort. We have seen higher than average increases in allergy in the past, and given the physician shortages, the high average physician age among allergists (meaning more retirements), and a high demand for this specialty, this trend could continue. For the other three specialties, increased work effort does not appear to be as relevant. Specifically, endocrinology saw a noticeable decrease in RVUs paired with the higher compensation shift. Endocrinology has been relatively flat for several years, so this, along with other factors, forecasted a spike in compensation.

Hospitalists and emergency medicine continue to experience increasing compensation and high demand.

The RVUs are not as important in these specialties, as typically their compensation plans are not RVU-based. A “shift” or hourly work payment is most common; however, we are beginning to see an emphasis on production and quality components as a consideration for bonuses.

Other specialties with percentage increases of mention are critical care medicine, neurosurgery, and geriatrics.

In reviewing the five lowest compensation changes, three of the five (infectious disease, pulmonary, and colon & rectal surgery) were clearly driven by the decreases in productivity (see Figure 2). In each of these cases, the productivity percentage was lower than the compensation decrease, meaning

the demand of the market protected the specialties. For some, we even see increases in the compensation-per-RVU rate. Most likely these specialists will be on the flatter side for the next few years as they have seen substantial increases in the last decade, and much of the current attention and reform seems to be geared toward the primary care and generalist physician segments.

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The most surprising specialty on this list is family medicine. All indications show this specialty will continue to be in demand and will see increasing compensation levels in the future. It should be noted that in the prior three years, compensation of family medicine physicians increased an average of 4.1% per year.

Other specialties with percentage decreases of note were trauma surgery, neonatology, and urology.

Figure 3 indicates that the other top five specialties based on the survey's population all fall between 1.5% and 3.0% in compensation change. Internal medicine has a higher than average increase in RVUs. This is partially due to the increase in values for office visits that CMS established last year. We believe that internal medicine, similar to family medicine, will see higher than average compensation hikes in the future.

Pediatrics and OB/GYN both showed declines in work efforts, accompanied with low-to-average increases in compensation. It is interesting that these two specialties are near the top for the number of part-time physicians reported to the survey, which brings more dynamics when developing a compensation and benefits formula to fit the different demands and lifestyles of these physicians.

As in the past four years, general surgery has shown above average increases in compensation. The pull of surgeons into more specialized

FIGURE 1
Top Five Specialties: Increasing Compensation

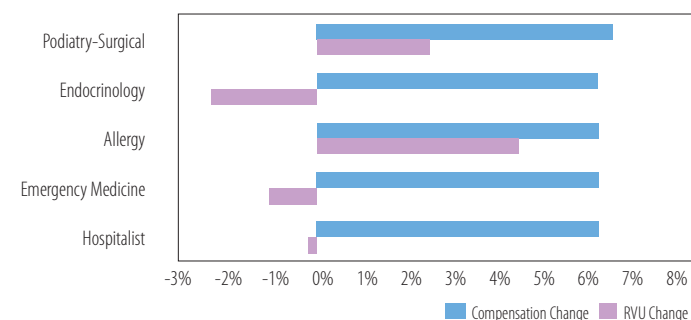


FIGURE 2
Lowest Five Specialties: Flat or Decreasing Compensation

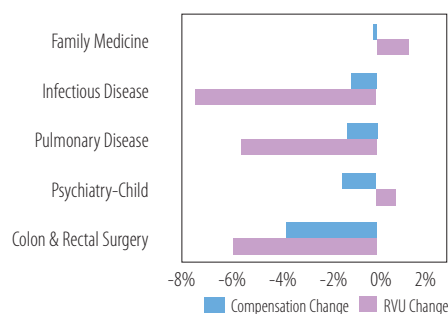
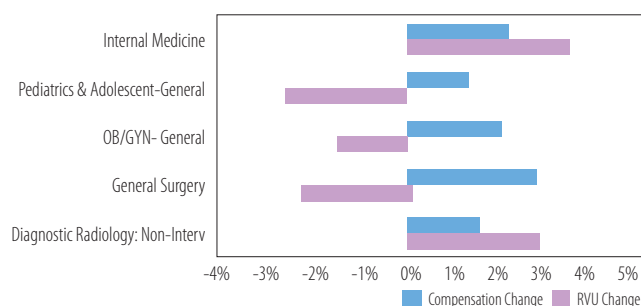


FIGURE 3
Top 5 Other Specialties: Largest Population



Note: These lists exclude some specialties that had low population sizes, were newly collected or other factors that may have created larger shifts from the prior year outside of typical market demand or productivity.

fields while demand is still high for the general services will continue to fuel higher compensation adjustments.

Five Reasons Physician Groups Are Changing Compensation Plans

As we work with groups across the nation, a common theme is loud and clear: "It is not that we want to, but the dynamics of our industry are forcing us to assess our physician and

provider compensation plan." We took a recent poll of medical groups with more than 150 physician FTEs, and found that over 75% stated that they are significantly changing their compensation model or will be in the next two to three years. This is not an easy endeavor, and why a change is needed varies from group to group; however, there are five common reasons we are seeing this surge.

1. Business Model Issues: Medical Home Models and ACOs

Every shift in business models has implications for compensation, and we are seeing these implications as care shifts from traditional autonomous physician models to the medical home and ACO models.

The medical home model, which has been with us since 1967 but has recently gained considerable ground, seeks to promote quality care through a single point of contact—usually the primary care physician—and an integrated team, often including behavioral professionals and advanced clinical practitioners.

While the model has been around for a long time, its widespread adoption is a recent phenomenon. Since implementation is so affected by other decisions about process and structure, physician compensation is a key, but often one of the lagging items implemented.

One effect of both the medical home and ACO models is the greater emphasis on team performance. They require the physician to manage the team he or she oversees, the patient, and quality and financial outcomes—necessitating revised compensation models if they currently emphasize personal RVUs. These revisions will, unfortunately, bring complexity to the plan. It should be noted that although the medical home model is having a considerable impact on primary care specialties, it has not yet had as much impact on surgical specialties, where compensation continues to be based on more traditional models of individual performance.

Another arising issue is how best to compensate advanced clinical practitioners with this new structure. Based on our research, if practitioners act independently in their patient care role, their plans typically compensate them similar to physicians. If they work as physicians' direct assists, they are usually compensated under a salary-plus-bonus model. This usually is re-evaluated if there is a change to the physicians' plan.

2. Focus on Quality Goals

Whether or not the group is redefining its business model around medical home, there is a recognition that the industry is heading toward some form of reimbursement for quality measures and outcomes. This movement also has re-energized the thinking that high quality is a core mission for a practice. In the past, the term "high quality" was at times vague and often groups assumed they delivered it. Now that groups have become more advanced in the ability to capture and measure information, physicians and administrators can be provided with better output and data regarding quality so that they can determine what initiatives will drive quality improvement. Tying these results to compensation is becoming the common next step. Our findings now show that one-third of the groups have a quality component in their plans, with the average incentive amounting to 10% of the physician's compensation.

Clearly, each group is unique in its ability to implement and define quality in the form of compensation, but we do see this as a driver for years to come.

3. The Role of Mergers and Acquisitions

In addition to changes in their business models, many practices are facing the tactical challenges brought about by mergers and acquisitions. Physicians have good reasons for wanting to be part of a larger organization—such organizations make it easier to realize efficiencies, physicians have reliable compensation during this time of lower reimbursement, etc. Organizations, on the other hand, are willing to acquire practices to contain revenue sources and streamline operations, among other reasons.

With the extremely high number of transactions going on today, these systems are finding that they have multiple plans as a result of multiple mergers, and these are not sustainable in the future. Oftentimes the

acquired group will be provided with some compensation protection, but when that expires, there needs to be a plan that is consistent among all groups, as well as a method of transition.

4. Being in Compliance of Fair Market Value

Many groups have been actively involved in taking steps to ensure their organization is paying fair market value and the plan is commercially reasonable. Having steps in place to ensure the group is not paying excessive compensation is critical. It is common for groups to have an occasional outlier, and the compensation committee will take steps to ensure that particular case has the support to maintain that level or make adjustments.

We now see that instead of groups being reactive to a plan that provides an end product of excessive compensation, the new plans have built-in protections to avoid it. They come in many different forms, such as the creation of a compensation pool between the integrated health system and the medical group, as part of a professional services arrangement between a hospital and a separate practice, or in the compensation plan between the clinic and the employed physicians.

Although this kind of protection will never guarantee an excessive compensation case won't arise, it helps avoid a chronic issue.

5. Obsolete Plan, Too Many Special Deals, Not Fiscally Sustainable

This may seem like a laundry list of different reasons, but often they can be linked. No administrators like to go through a significant compensation plan change, and hopefully a group's plan can maintain a desired culture for many years. But as a plan gets older, particularly in a changing environment, the incentives become misaligned with the organization's initiatives. This will lead to a myriad of special deals or create an environment that is not fiscally sound.

We are now seeing a time where organizations require multiple plans to manage their needs, bringing more complexity. It may require groups to consider having a physician compensation specialist position within the organization. In the end, there should be a recognized difference between a patched-up plan with special deals and an organized plan defined and understood by the physicians and administrators.

Conclusion

Amid demographic changes and looming regulatory changes, medical groups continue to explore innovative new models of care and new business combinations that will inevitably lead them to revising their compensation model. Armed with the AMGA Medical Group Compensation and Financial Survey

data, they will be able to make informed decisions about sound compensation strategies, no matter what form they must take to enable the groups to succeed in this challenging economic environment.

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For more information on the *AMGA 2011 Medical Group Compensation and Financial Survey*, visit www.amga.org.