As healthcare reimbursement transitions from traditional fee-for-service payment (volume to value-based reimbursement), medical practices are working to align their physician compensation plans. Beyond clinical productivity, quality and cost measures are at the forefront of payer reimbursement strategies and value contracts with providers. This suggests a review of your current compensation plans (likely productivity based) and consideration of a hybrid productivity and value plan.

In this special segment on physician compensation, industry experts Bruce A. Johnson, JD, MPA, of Polsinelli, P.C., Denver, and Deborah Walker Keegan, PhD, of Medical Practice Dimensions, Inc., Asheville, N.C., discuss the categorization of compensation plans along a continuum from individualistic to team oriented plan architectures and how to begin the transition to value-based physician compensation plans.

Note: Variations of the basic formula in this report must be addressed depending on practice setting, e.g., physician-owned, hospital-owned or hospital-affiliated practice, in order to promote regulatory compliance.
Physician compensation arrangements can be arrayed along a compensation plan continuum ranging from individualistic models to team-oriented models, with a vast middle ground in between. The compensation plan continuum permits analysis of physician compensation structures by reference to:

- The general impact that the plan structure has on practice culture
- How the plan considers revenues and expenses
- The means by which incentives linked to the changing value-based payment environment are likely to be expressed in the plan
Individualistic physician compensation structures tend to focus on the performance of each individual physician in a medical practice. At their most extreme, individualistic models focus on individual production and expense allocation in a manner that may promote a practice culture that is consistent with a collection of individual practices that are co-located.

Under individualistic models, each physician is expected to generate sufficient production to cover not only his/her compensation, but also, his/her allocated portion of practice expenses. At the extreme end of the compensation continuum of these models:

- Revenue is tracked at the physician level, e.g., based on net collections
- Expenditures are allocated to each physician based on utilization, using strict cost accounting of individual expense categories
Individualistic plans seek to allocate revenues and expenses directly to the individual physician responsible for their generation in order to promote individual accountability. Likewise, external payments for care management and similar fees for care coordination and transitional care are directly allocated to the individual physician, along with an allocation of practice operating costs associated with care coordination-type functions.

TRANSITION TO A VALUE-BASED COMPENSATION PLAN: As a medical practice with an individualistic architecture transitions to a value-based compensation plan, the portion of external reimbursement that is linked to individual provider value-based metrics (e.g., patient satisfaction, quality measures, etc.) is directly incorporated into the individual physician’s compensation. Where funds are earned (or not earned), they are directly allocated to the physician.
In many instances the practice does not have external reimbursement linked to value-based measures at the individual physician level. In these situations, the practice can impose an internally defined incentive structure in which funds are retained and allocated internally. The funding is typically viewed as another item of assigned overhead, with funds redistributed within the practice based on practice-defined, value-based performance goals. A portion of funds ranging from 5% to 20% of expected or historical compensation is set aside and awarded based on how the physician scores on the practice-defined, value-based measures.

**Value-based individualistic compensation plan example**

**Revenue**
- Pure production-based allocation of revenues
- A portion of the revenue may be set aside and awarded based on physician value-based metrics

**Expense**
- Strict cost accounting expense allocation based on utilization
Between the individualistic and the team oriented extremes on the compensation plan continuum is the vast middle ground of compensation plans. **Most medical practices have a middle-ground compensation architecture.** These plans:

- Combine different aspects of individualistic and team oriented approaches
- Commonly include an explicit “sharing” of revenues or expenses as part of the compensation structure

Middle ground models typically **involve a compensation methodology in which a portion of the practice’s revenues and/or expenses are shared to some degree**, and therefore not allocated directly (or precisely) to individual providers. When a middle ground model transitions to a value-based compensation plan, revenue, such as that received from shared savings, may be allocated in different ways.

**On the expense side**, a transition to a value-based compensation plan may involve **“group” investment in new resources, technology and/or systems** such as the overhead required to support care coordination.

**Shared savings allocation example**

- A portion directly allocated to each physician based on the patients who are attributed to the physician for treatment purposes
- A portion allocated on an equal basis to each physician
Other middle ground models may allocate practice income through work RVUs without expressed expense allocation. Such models reward and encourage clinical service production while balancing out payer and patient mix without direct allocation of practice expenses as part of the compensation structure. These models can involve characteristics of team-oriented plans as illustrated in the example in this document and at mgma.org/example-comp-plan.
A team oriented physician compensation plan is typically found in medical practices that view themselves as a fully integrated practice. At the most extreme end of the team-oriented continuum is a plan that:

- Pays the majority of practice expenses “off the top” out of available practice revenues to create a compensation pool that is allocated among practice physicians.

- Focuses on distribution of the compensation pool through a base salary with incentive or similar mechanisms, rather than focusing direct attention on how practice expenses are allocated.

- Tends to treat the practice as a single economic unit that must involve some level of “sharing” and financial teamwork rather than a collection of separate individual physician profit-and-loss centers.

TRANSITION TO VALUE-BASED COMPENSATION PLAN: A medical practice that currently has a team oriented compensation plan will typically set aside a portion of the compensation pool — for example 10% to 20% — to be distributed based on value. This separate pool of funds is distributed on a combination of quality, patient satisfaction, cost and other measures. The precise measures are typically aligned with value-based payer contracts that place reimbursement at risk based on value metrics.
Value-Based, Team-Oriented Compensation Plan Example

Practice Revenue – Practice Expenses = Compensation Pool

**Practice Revenue – Practice Expense**
- No express expense treatment to individual physicians

**Compensation Pool**
- Base salary component of compensation is budgeted and paid from compensation pool
- A portion of the compensation pool is set aside to create incentives and reward value-based measures

**Note:** Variations of the basic formula in this report must be addressed depending on practice setting e.g., physician-owned, hospital-owned or hospital-affiliated practice, in order to promote regulatory compliance.
## Family Medicine (w/o OB)

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Doc A</th>
<th>Doc B</th>
<th>Doc C</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Determine market median compensation per work relative value unit (wRVU) for each specialty</td>
<td>$40.00</td>
<td>$40.00</td>
<td>$40.00</td>
<td></td>
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<tr>
<td>2</td>
<td>Assign compensation per wRVU for practice at 90% of market median</td>
<td>$36.00</td>
<td>$36.00</td>
<td>$36.00</td>
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<tr>
<td>3</td>
<td>“Draw” and “compensation credit” based on production</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Actual wRVUs during compensation period</td>
<td>4,500</td>
<td>3,700</td>
<td>3,900</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actual wRVUs during compensation period X assigned compensation per wRVU</td>
<td>$162,000</td>
<td>$133,200</td>
<td>$140,400</td>
<td>$435,600</td>
</tr>
<tr>
<td>4</td>
<td>Amount used for monthly (or bi-weekly) draw</td>
<td>$162,000</td>
<td>$133,200</td>
<td>$140,400</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Determine each physician percent of total wRVU production</td>
<td>37%</td>
<td>31%</td>
<td>32%</td>
<td>100%</td>
</tr>
<tr>
<td>6</td>
<td>Value-based compensation based on performance and production</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Example: Additional $2 per wRVU for performance on quality, cost and patient satisfaction measures (total of $6 per wRVU possible)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Quality ($2 per wRVU of physician production when quality targets met)</td>
<td>$9,000</td>
<td>$0</td>
<td>$7,800</td>
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<tr>
<td></td>
<td>Cost management ($2 per wRVU of physician production when cost management targets met)</td>
<td>$0</td>
<td>$7,400</td>
<td>$7,800</td>
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<td></td>
<td>Satisfaction ($2 per wRVU of physician production when satisfaction targets met)</td>
<td>$9,000</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td></td>
<td>Subtotal</td>
<td>$18,000</td>
<td>$7,400</td>
<td>$15,600</td>
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<td>7</td>
<td>Production plus value-based comp (Step 4 + Step 6)</td>
<td>$180,000</td>
<td>$140,600</td>
<td>$156,000</td>
<td>$476,600</td>
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<tr>
<td>8</td>
<td>Determine compensation pool based on practice financial metrics</td>
<td></td>
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<tr>
<td></td>
<td>Practice net collections</td>
<td>$2,050,000</td>
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<tr>
<td></td>
<td>Less practice total operating expenses (including physician draw + value-based compensation paid) and reserves</td>
<td>$1,931,600</td>
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<tr>
<td></td>
<td>Practice net income (available for additional compensation)</td>
<td>$118,400</td>
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<tr>
<td>9</td>
<td>Physician-owned practices — allocate practice net income based on physician % of wRVU production (to ensure budget neutrality)</td>
<td>$44,033</td>
<td>$36,205</td>
<td>$38,162</td>
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<tr>
<td>10</td>
<td>Total compensation per physician in physician-owned practice (Step 7 + Step 9)</td>
<td>$224,033</td>
<td>$176,805</td>
<td>$194,162</td>
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</tbody>
</table>

**Note:** Calculations may be inexact due to rounding and other variables.
Whether your current compensation plan is individualistic, middle ground or team oriented, it may be time to begin realignment from productivity-driven to value-based plans to ensure future success. This segment presents the fundamental building blocks for a successful transition.

Source: This segment is based on writings and teachings by two industry experts on physician compensation, Bruce A. Johnson, JD, and Deborah Walker Keegan, PhD. For more information please contact them at BruceJohnson@polsinelli.com and deborahwalkerkeegan@msn.com.

Check out compensation examples within the MGMA Member Community's compensation discussion group archives and look at other compensation issues that members have discussed.
MGMA Resources: Value-Based Applications for Your Practice

**Featured**

*Value-Based Compensation: An MGMA Research and Analysis Introduction*
mgma.org/store, Item E8818

**Practice**

*Patient Satisfaction Benchmarking Tool*
data.mgma.org/ptsat/

*Decision Pathways: Creating a Physician Compensation Plan*
mgma.org/decision-pathways-phys-compensation

**Read**

*Strategies for Value-Based Physician Compensation*
mgma.org/store, Item 8652

*Tips for implementing value-based physician compensation*
mgma.org/VBC-blog

*Objective Advice: Can bundling compensate physicians, align their interests and performance?*
mgma.org/bundling-advice

**Interact**

*PQRS/Value-Modifier Survival Guide*
mgma.org/PQRS-VM-SurvivalGuide

*Physician Compensation and Production DataDive*
mgma.org/store, Item 8751

**Value-Based Compensation Links**

*MGMA Government Affairs: Federal quality reporting programs*
mhma.org/federal-quality-reporting

*Physician Quality Reporting System (PQRS)*
mhma.org/physician-quality-reporting-system

*National Committee for Quality Assurance (NCQA)*
www.ncqa.org

*Meaningful Use*

*Healthcare Effectiveness Data and Information Set (HEDIS)*
www.ncqa.org/HEDISQualityMeasurement.aspx

*Hospital value-based purchasing*

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*Preparing your group for the 2016 Value-based Payment Modifier: On Demand*
mhma.org/store, Item O15GA2

*Strategies in Physician Compensation Planning*
mhma.org/store, Item O14WEB5

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It is **critical to benchmark** your physician compensation plans **annually** against similar practice sizes and specialties in the industry to ensure **adequate reimbursement levels**.

**MGMA compensation benchmarking data** is available to help you succeed. Find **more compensation and other reports** like these here:

[mgma.com/industry-data/research-and-studies-overview](http://mgma.com/industry-data/research-and-studies-overview)