Bridging Employed Physician Compensation Plans Into a Value-Based World

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As the healthcare market moves from volume-driven to value-driven compensation, it is imperative that physician pay plans measure, report, and incentivize higher levels of qualitative, in lieu of quantitative, performance. Current compensation models and other considerations offer lessons for driving the shift toward plans that increasingly reward quality, service, and efficiency while reducing the emphasis on productivity and practice profitability.

Lessons From Current Compensation Planning

Even in today's predominantly fee-for-service world, the most balanced compensation plans for employed physicians avoid the more extreme pure base salary and pure individual productivity designs. Pure salary plans generally lack sufficient accountability for minimum work standards and do not provide motivation for above-minimum-work-standard performance. Pure productivity plans, meanwhile, provide significant accountability for financial performance for individual physicians but often fail to promote teamwork or sufficiently motivate quality, service, and other balanced performance behaviors.

The most predominant plans today include:

- Revenue less expenses
- Production based on work relative value units (wRVUs) as assigned by CMS, plus other incentives
- Base salary plus other performance incentives

Many revenue-less-expenses plans also include funding of other quality/service incentives, as well as adjustments to the credited revenue based upon averaged or guaranteed levels of collections to protect physicians from poor billing and collections support. These plans are often retained in markets with relatively higher levels of overall physician reimbursement from government and commercial payers.

wRVUs and Base Plus Performance

A growing number of employed compensation plans measure physician clinical activities based on CMS assignment of wRVUs. In effect, CMS assigns wRVUs for physician effort based upon their documented Current Procedural Terminology (CPT) codes. Both the level of assigned wRVUs and the CPT codes themselves are modified at least annually by CMS.

Although imperfect, the CMS system attempts to credit more wRVUs for higher documented levels of complex patient care services. This approach is considered "payer neutral" because physicians receive the same level of production credit regardless of a patient's insurance status, whether they are indigent or have the highest level of commercial coverage. Physicians who have concerns about declining reimbursement levels and the collections performance of the operations group supporting the practice increasingly prefer wRVU-based plans.

Base-plus-performance incentive plans are also increasingly used. These plans include significant accountability to earn base salary levels along with incentives for other quality/service and efficiency targets. They generally do not include production incentives.

Base-plus-performance plans are generally designed by hospitals for employed physicians who do not necessarily control their own volumes—and therefore are harder to hold accountable for higher levels of professional collections or wRVUs. These plans also are used when it is not in the hospital's best interest to incentivize increased utilization of patient care services. For instance, a base-plus-performance model makes sense for intensivist or hospitalist physician services where the primary goal is efficient management of care rather than extended hospital stays and consultant physician expenses.

Regardless of the compensation plan selected, expanded use and definition of minimum work standards (MWS) within the base salary or draw component of the compensation plan design is an effective approach for encouraging desired behaviors. Aside from minimum clinical production standards, appropriate MWS categories

may include documentation (medical records completion, submission of charges), accessibility (standard hours, clinical sessions per week), and EMR utilization (initial adoptions, meaningful use). Consequences for failing to meet the MWS thresholds, including potential disqualification from receiving other performance incentives, should be clearly defined and communicated to physicians.

Similarly, establishing targets for overall practice expense per wRVU can help safeguard against over-utilization of practice resources. Failure to meet the budgeted expense per wRVU may result in a reduced level of production incentive payments as well as ineligibility for other quality/service performance payments.

Bridging the Path

The pace of evolvement to the new hybrid compensation designs will depend on a market-by-market assessment. In many markets, hospitals are increasingly reluctant to guarantee not only the level of payment rates for clinical productivity (compensation per wRVU, compensation per professional collections) beyond three years for employed physicians, but also the basic compensation design itself.

Compensation plans for employed physicians in a fully implemented ACO world may radically reduce or eliminate typical productivity incentives and include much higher levels of shared savings, payment for performance, and other payments based upon efficiency and demonstrated service/quality.

Progressive health systems are requiring incremental demonstrations of patient-focused outcomes that will become mandatory in the future. The table above presents a range of interim considerations to help bridge a path to the new world.

Although the precise path and timing to that world is not yet clear, the time to begin designing compensation plans that recognize and reward the desired behaviors is now. Waiting to act risks an even more abrupt and challenging path to shared risk in the next phase of healthcare reimbursement reform.

Source:

Adapted from **Vance, R.L.** "Bridging employed physician compensation plans into a new world of ACOs," *Navigant Pulse*: Winter 2011.

Interim Considerations to a Typical Four-Component Plan

Component	Common Design Approach	Next Step Considerations
Base Salary	◆ Set as a % of total earned compensation (e.g., ≥ 85%) per clinical productivity ◆ Often includes limited minimum work standards (MWS) re: patient satisfaction, documentation, outcomes, etc.	◆ For primary care physicians, evaluate per expected patient "panel" size, medical home responsibility ◆ Expanded MWS for protocol adherence, EMR usage, expense control, other provider satisfaction, etc.
Production Incentive	◆ Additional compensation for each $ or wRVU above threshold to earn clinical base salary ◆ Specialty-specific pay rates ◆ Earned regardless of achievement of quality/service performance	◆ Likely eliminated or capped for increased number of subspecialties ◆ For others, likely reduced or disqualified payments for failure to meet MWS quality/service performance levels
Quality/ Service Incentive	◆ Typically limited to 5–15% of anticipated total compensation ◆ Frequently set at lower levels of demonstrated performance ◆ Often does not consider team performance for outcomes or efficiency	◆ Evolve to higher levels (≥ 20%) of anticipated total compensation ◆ Provide payout for higher "stretch" (well above median) performance ◆ Increased reliance upon team performance re: efficiency/service
Other Compensation	◆ May include distinct payments for call coverage, supervision of Allied Health Providers (AHPs), Medical Directorships, etc.	◆ Increased consideration of these activities within base salary performance standards; increased use and incentives for efficient use of AHPs

Source: *Navigant Pulse*