Trends in Physician and Advance Practice Clinician Compensation

HFMA Lone Star Central Texas Winter Institute

February 22, 2013

Agenda

I. Introduction
II. ECG Survey Overview
III. Physician Performance Trends
IV. APC Performance Trends
V. Value-Based Compensation Considerations
VI. Potential Compensation Models

Questions and Answers
I. Introduction

*Physician compensation and performance incentives are undergoing a fundamental shift as healthcare providers embrace value-based delivery models.*

**Disruption Due to Payment Reform Will Be Impactful**

Regardless of your beliefs about the long-term effectiveness of payment reform, physician organizations, including hospital-based and independent medical groups, will need to adapt to a payment environment that rewards value over volume.

**Physician Alignment Is Critical to Future Success**

As payment models shift toward a focus on value and reimbursement becomes increasingly linked to measurements of quality and efficiency, physician organizations will need to drive this new focus down to the day-to-day actions of their physicians.

**Value-Based Compensation Plans Are Seen as a Key Lever**

The most effective mechanism to drive higher quality and a lower cost is to modify today’s physician compensation structures to better align with organizational goals in a value-based payment environment.
I. Introduction

Impending Physician Reimbursement Changes

- CMS has proposed to phase in the application of a value-based modifier (VBM) for physician services in 2015.
  - It uses existing PQRS and EHR meaningful use measures, along with select total per capita cost measures, to measure physician performance.
  - There are a total of 62 preliminary measures for the VBM program.
- Application of the modifier will start in 2015 for select groups of physicians with 25 or more eligible professionals, based on performance during 2013.
- All physician groups over the minimum size threshold will be subject to the VBM in 2017.

Proposed Calculation of the VBM Using Quality Tiering Approach

<table>
<thead>
<tr>
<th>Quality/Cost</th>
<th>Low Cost</th>
<th>Average Cost</th>
<th>High Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>+2.0X^1</td>
<td>+1.0X^1</td>
<td>0.00%</td>
</tr>
<tr>
<td>Medium Quality</td>
<td>+1.0X^1</td>
<td>0.00%</td>
<td>-0.50%</td>
</tr>
<tr>
<td>Low Quality</td>
<td>0.00%</td>
<td>-0.50%</td>
<td>-1.00%</td>
</tr>
</tbody>
</table>


- X is undefined because the program must be budget-neutral and therefore will depend on the total sum of negative adjustments in a given year.

Implications for Compensation

Physician organizations generally recognize that production-driven plans will need to evolve to reflect changing economics, but there is a reluctance to move too far ahead of reimbursement changes.

State of the Art (Circa 2011)
- Physician productivity is the primary incentive.
- Tiers are included to disproportionately reward high producers and provide strong incentives at the margin.
- Smaller incentives are associated with nonproductivity elements.

State of the Art (Circa 2016)
- Productivity remains an important element of compensation, although less money is tied to it.
- Nonproductivity metrics are expanded and drive a larger portion of total compensation.
- Base salary may be included, tied to minimum performance thresholds/work standards.
II. ECG Survey Overview

**ECG’s Custom Surveys**

ECG’s custom surveys emerged from our experience working with medical groups and academic departments to redesign their compensation plans. Today, our custom surveys are a core service and encompass a wide range of areas.

- National Provider Compensation, Production, and Benefits Survey (13 years).
- National Pediatric Subspecialty Physician Compensation, Production, and Benefits Survey (5 years).
- Faculty Practice Plan Physician Reimbursement Survey.
- ECG/Healthcare & Science business of Thomson Reuters Cardiovascular Service Line Management Survey – Key Findings and Implications, year 2009 based on 2008 data.
- ECG/AMGA Capitation and Risk Contracting Survey.
- Emergency Department Call Coverage Survey.
- ECG/AMGA 2006 Pay-for-Performance Survey.

www.ecgmc.com/custom-surveys-proprietary
II. ECG Survey Overview
Geographic Representation and Expansion

Our 2012 compensation survey encompasses nearly 15,000 providers from around the country.

2012 Location of Members

2012 – New Regions/States

- 900-physician medical group in the Rocky Mountain states.
- 100-physician medical group in the Upper Midwest.
- Integrated health system in the Northeast employing 400-plus physicians.
- Medical center in the Plains states employing 80 physicians.
- Midsize tertiary care facility in the South employing 25-plus physicians.
- Large health system in the East employing 400-plus physicians.

Physician performance data was submitted by 69 organizations, encompassing 15,075 providers. After the elimination of outlier data points, 14,746 providers, composed of 13,329 physicians and 1,417 APCs, remained in the final national data set.

Organizational Characteristic | Number of Organizations | Number of Providers | Percentage of Providers
---|---|---|---
Integrated Health System | 57 | 12,836 | 87%
Independent Medical Group | 12 | 1,910 | 13%
Total | 69 | 14,746 | 100%
East | 5 | 1,779 | 12%
Midwest | 18 | 3,749 | 25%
Southern | 9 | 1,114 | 8%
Western | 37 | 8,104 | 56%
Total | 69 | 14,746 | 100%
New | N/A | 1,562 | 11%
Established | N/A | 13,184 | 89%
Total | 69 | 14,746 | 100%

Of the providers in the 2012 survey, 71% work within organizations with more than 250 physicians.
III. Physician Performance Trends

Providers’ Response – Loss Per Physician

Health system-sponsored organizations in our national database have reported increased losses in the physician enterprise over the last 4 years.

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss</td>
<td>$(92,602)</td>
<td>$(138,724)</td>
<td>$(148,791)</td>
<td>$(148,025)</td>
</tr>
</tbody>
</table>

Source: ECG 2012 surveys.
III. Physician Performance Trends
Reimbursement

On average, adult organizations are being reimbursed at 170% of Medicare for their commercial business, while 176% is the average targeted rate.

**Commercial Contract Rates as a Percentage of Medicare**

<table>
<thead>
<tr>
<th>Source: ECG 2012 surveys.</th>
</tr>
</thead>
</table>

Organizations attempt to offset lower Medicaid and Medicare reimbursement by targeting commercial rates at 176% of Medicare. Actual commercial rates; however, average 170%.

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III. Physician Performance Trends
Reimbursement (continued)

On average, a majority (53%) of survey members have less than 10% of business, measured in gross revenue, at risk for utilization, cost, or outcomes, while nearly 60% indicated that they participate in P4P programs.

<table>
<thead>
<tr>
<th>Percentage of Gross Revenue at Risk</th>
<th>Percentage of Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than 10% of Gross Revenue Generated From Risk Business</td>
<td>53%</td>
</tr>
<tr>
<td>10% to 25% of Gross Revenue Generated From Risk Business</td>
<td>27%</td>
</tr>
<tr>
<td>25% to 49% of Gross Revenue Generated From Risk Business</td>
<td>20%</td>
</tr>
<tr>
<td>50% to 100% of Gross Revenue Generated From Risk Business</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participation in P4P Programs</th>
<th>Percentage of Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in Internal P4P Programs</td>
<td>14%</td>
</tr>
<tr>
<td>Participate in External P4P Programs</td>
<td>17%</td>
</tr>
<tr>
<td>Participate in Both Internal and External P4P Programs</td>
<td>29%</td>
</tr>
<tr>
<td>Do Not Participate in P4P Programs</td>
<td>40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACOs and Patient-Centered Medical Homes</th>
<th>Percentage of Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in a Patient-Centered Medical Home (PCMH) Pilot</td>
<td>55%</td>
</tr>
<tr>
<td>Percentage of Pilots Accredited by NCQA</td>
<td>53%</td>
</tr>
<tr>
<td>Working Toward Developing ACO</td>
<td>49%</td>
</tr>
<tr>
<td>Developing ACO in Partnership With Payor</td>
<td>60%</td>
</tr>
</tbody>
</table>

Nearly half of survey members reported that they are working toward developing an ACO, with 60% of these members partnering with a payor in this effort.
III. Physician Performance Trends

Key Physician Metrics

Compensation for PCPs and specialists increased from 2011 to 2012. As a result of work RVU (WRVU) production decreasing for primary care, compensation per unit of work for PCPs continues to rise, although modestly.

Percentage Change of Key Metrics From 2011 to 2012

<table>
<thead>
<tr>
<th>Metric</th>
<th>PCPs</th>
<th>Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation</td>
<td>1.6%</td>
<td>3.1%</td>
</tr>
<tr>
<td>WRVUs</td>
<td>-1.4%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Total RVUs</td>
<td>-1.1%</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Net Professional Collections</td>
<td>4.9%</td>
<td>-4.0%</td>
</tr>
<tr>
<td>Compensation Per WRVU</td>
<td>0.6%</td>
<td>-1.5%</td>
</tr>
<tr>
<td>Compensation to Net Professional Collections</td>
<td>-0.7%</td>
<td>-3.4%</td>
</tr>
<tr>
<td>Net Professional Collections Per Total RVU</td>
<td>7.4%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Net Collections Per Total RVU</td>
<td>1.8%</td>
<td>-7.2%</td>
</tr>
</tbody>
</table>

Source: ECG 2012 surveys.

NOTE: All RVU calculations in the 2012 survey are based on the 2011 Medicare Physician Fee Schedule (PFS) published in October 2011, unless otherwise noted.

This represents multiple consecutive years of increased compensation coupled with decreased WRVU production for primary care.

III. Physician Performance Trends

Primary Care Trends by Organization Type

Since 2008, PCP compensation has increased by more than 15%. Interestingly, PCP WRVU production is 10% lower within integrated health systems; however, compensation is more than 15% lower.

Median Primary Care Compensation and WRVU Trends From 2008 to 2012

Source: 2012 ECG surveys (ECGVault).

NOTE: All RVU calculations in the 2012 surveys are based on the 2011 Medicare PFS published in October 2011, unless otherwise noted.

Compensation for PCPs has increased steadily since 2008, while WRVU production has plateaued.
III. Physician Performance Trends
Specialist Trends by Specialty Category

**Compensation and WRVUs increased across all specialty categories, while compensation rates decreased. Meanwhile, net collections per total RVU has stayed flat or decreased over the same period.**

### Percentage Change of Key Metrics From 2011 to 2012 – By Specialty Category

<table>
<thead>
<tr>
<th>Metric</th>
<th>Hospital</th>
<th>Medical</th>
<th>Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation</td>
<td>4.7%</td>
<td>4.9%</td>
<td>1.2%</td>
</tr>
<tr>
<td>WRVUs</td>
<td>8.0%</td>
<td>1.4%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Total RVUs</td>
<td>-1.9%</td>
<td>1.4%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Compensation Per WRVU</td>
<td>-1.7%</td>
<td>-2.4%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>Compensation Per Total RVU</td>
<td>-2.6%</td>
<td>-1.9%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Net Professional Collections Per Total RVU</td>
<td>0.3%</td>
<td>-1.1%</td>
<td>-0.9%</td>
</tr>
<tr>
<td>Net Collections Per Total RVU</td>
<td>0.7%</td>
<td>-12.6%</td>
<td>-4.2%</td>
</tr>
</tbody>
</table>

Source: ECG 2012 surveys.

NOTE: All RVU calculations in the 2012 survey are based on the 2011 Medicare PFS published in October 2011, unless otherwise noted.

**Specialist compensation is not keeping pace with work effort.**

### Median Specialist Compensation and WRVU Trends From 2008 to 2012

**On average, compensation for specialists working within independent medical groups is 20% higher than compensation paid to specialists working within integrated health systems. However, in order to achieve these compensation levels, independent physicians are generating 26% more WRVUs.**

Source: 2012 ECG surveys (ECGVault).

NOTE: All RVU calculations in the 2012 surveys are based on the 2011 Medicare PFS published in October 2011, unless otherwise noted.

**Overall, increases in compensation significantly outpaced changes in WRVU production.**
III. Physician Performance Trends

Physician Compensation Plan Types

A majority of physicians are compensated under a production-based compensation plan. In the next few years, we expect a shift in compensation models to better align incentives with value-based care that will reward a combination of physician production, resource management, and, ultimately, health outcomes.

The increase in the insured population coupled with the physician shortage will require compensation plans to maintain production-based components.

Compensation Plan Key Performance Indicators

81% of organizations are utilizing WRVUs within their physician incentive calculations, with nearly 87% of compensation at risk for this measure. Meanwhile, 5% of compensation is at risk for quality measures within 37% of organizations.

<table>
<thead>
<tr>
<th>Attribute</th>
<th>2011 Percentage of Organizations</th>
<th>2011 Median Percentage of Total Compensation Derived From Indicator</th>
<th>2012 Percentage of Organizations</th>
<th>2012 Median Percentage of Total Compensation Derived From Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>WRVUs</td>
<td>76%</td>
<td>95.0%</td>
<td>81%</td>
<td>87.0%</td>
</tr>
<tr>
<td>Quality</td>
<td>27%</td>
<td>10.0%</td>
<td>37%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Other</td>
<td>22%</td>
<td>4.4%</td>
<td>35%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>20%</td>
<td>5.0%</td>
<td>33%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Provider Profitability</td>
<td>14%</td>
<td>9.0%</td>
<td>23%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Net Professional Collections</td>
<td>24%</td>
<td>55.0%</td>
<td>21%</td>
<td>24.4%</td>
</tr>
<tr>
<td>Organization Profitability</td>
<td>14%</td>
<td>43.1%</td>
<td>19%</td>
<td>57.0%</td>
</tr>
<tr>
<td>Citizenship</td>
<td>20%</td>
<td>2.5%</td>
<td>14%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Other common measures being utilized include patient satisfaction, net professional collections, and profitability.

Source: ECG 2012 surveys.
III. Physician Performance Trends
Nonproduction Compensation Plan Components

52% of organizations have recently, or are in the midst of, modifying their compensation plans to incorporate nonproduction-based metrics. Of these organizations, the most common nonproduction-based metrics to be incorporated are quality (86%) and patient satisfaction (76%).

<table>
<thead>
<tr>
<th>Nonproduction-Based Metric</th>
<th>Percentage of Organizations Adding Metric to Physician Compensation Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>86%</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>76%</td>
</tr>
<tr>
<td>Physician Satisfaction</td>
<td>14%</td>
</tr>
<tr>
<td>Cost</td>
<td>19%</td>
</tr>
<tr>
<td>Access</td>
<td>29%</td>
</tr>
<tr>
<td>Utilization</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>19%</td>
</tr>
</tbody>
</table>

Addition of Nonproduction-Based Metrics to Compensation Plan

Planned Measures of Quality to Determine Physician Incentive

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Percentage of Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>External Clinical Protocols</td>
<td>24%</td>
</tr>
<tr>
<td>Internal Clinical Protocols</td>
<td>29%</td>
</tr>
<tr>
<td>HEDIS Measures</td>
<td>24%</td>
</tr>
<tr>
<td>Other Clinical Protocols</td>
<td>29%</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>71%</td>
</tr>
<tr>
<td>Physician Satisfaction</td>
<td>12%</td>
</tr>
<tr>
<td>Other Measures</td>
<td>30%</td>
</tr>
</tbody>
</table>

Source: ECG 2012 surveys.

IV. APC Performance Trends
IV. APC Performance Trends

**Growth of APCs**

The number of APCs is growing faster than the number of physicians due to the shorter length of training required.

- Currently, there are about 80,000 physician assistants (PAs) and 140,000 nurse practitioners (NPs) in the U.S.¹
- Further projections indicate that 30,000 additional PAs and over 110,000 additional NPs will be active by 2025, partially helping to fill a shortage of approximately 45,000 physicians for a similar time frame.²
- Only 12,000 physicians are expected to be entering primary care specialties between 2010 and 2025.
- APCs improve efficiency in healthcare by providing routine or less complicated care, while allowing physicians to address more complex issues.
- APCs can also provide care in a number of medical and surgical subspecialties.
- The savings from employing an APC, relative to a physician, are causing most health systems to strongly consider them as an alternative.


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**APC Employment**

NPs and PAs are the most common types of APCs employed by survey organizations.

**Employment of APCs**

<table>
<thead>
<tr>
<th>Profession</th>
<th>2011 Survey</th>
<th>2012 Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>NP</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>PA – Nonsurgical</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>PA – Surgical</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Midwife</td>
<td>68%</td>
<td>74%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>30%</td>
<td>41%</td>
</tr>
<tr>
<td>Medical Social Work</td>
<td>41%</td>
<td>44%</td>
</tr>
<tr>
<td>CRNA</td>
<td>44%</td>
<td>37%</td>
</tr>
<tr>
<td>Other</td>
<td>41%</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>38%</td>
<td>26%</td>
</tr>
<tr>
<td>Other</td>
<td>26%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Source: ECG 2012 surveys.
IV. APC Performance Trends

APC Employment Rationale

Organizations reported that the primary reason they have increased the number of APCs within their organization is because it is an effective strategy to address the physician shortage and lower-cost option.

Primary Reason for Hiring APCs

<table>
<thead>
<tr>
<th>Reason</th>
<th>2010 ECG Survey</th>
<th>2011 ECG Survey</th>
<th>2012 ECG Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>APCs are easier to recruit</td>
<td>31%</td>
<td>36%</td>
<td>57%</td>
</tr>
<tr>
<td>APCs are needed to address the physician shortage</td>
<td>45%</td>
<td>51%</td>
<td>73%</td>
</tr>
<tr>
<td>APCs are a lower-cost option than physicians</td>
<td>20%</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>APCs are needed to address healthcare reform</td>
<td>0%</td>
<td>20%</td>
<td>40%</td>
</tr>
</tbody>
</table>

NOTE: All RVU calculations in the 2012 survey are based on the 2011 PFS published in October 2011, unless otherwise noted.

IV. APC Performance Trends

Key Metrics

Compensation and WRVUs increased for NPs and PAs over 2011 benchmarks. As result of varying rates of increase, compensation per WRVU changed inconsistently year over year.

Percentage Change of Key Metrics Medians From 2011 to 2012

<table>
<thead>
<tr>
<th>Metric</th>
<th>NPs</th>
<th>PAs – Nonsurgical</th>
<th>PAs – Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation</td>
<td>5.5%</td>
<td>6.2%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Compensation Per WRVU</td>
<td>3.7%</td>
<td>3.2%</td>
<td>-15.2%</td>
</tr>
<tr>
<td>WRVUs</td>
<td>1.9%</td>
<td>4.7%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

Source: ECG 2011 and 2012 surveys.

NOTE: All RVU calculations in the 2012 survey are based on the 2011 PFS published in October 2011, unless otherwise noted.

Nonsurgical PAs earn less per WRVU than NPs, while surgical PAs are earning more than $40 per WRVU.
IV. APC Performance Trends

Compensation Plan Types

In general, more APCs were being paid under compensation plans based on provider productivity in 2012 than in 2011.

2011 APC Compensation Plan Types

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Midwife</th>
<th>Nurse Practitioner</th>
<th>Optometrist</th>
<th>PA - Nonsurgical</th>
<th>PA - Surgical</th>
<th>Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>32.3%</td>
<td>59.5%</td>
<td>46.5%</td>
<td>44.0%</td>
<td>51.0%</td>
<td>38.0%</td>
</tr>
<tr>
<td>2012</td>
<td>67.0%</td>
<td>41.0%</td>
<td>58.0%</td>
<td>56.0%</td>
<td>42.0%</td>
<td>61.0%</td>
</tr>
</tbody>
</table>

Source: ECG 2011 and 2012 surveys.

Similar to trends in physician compensation planning, organizations are slowly migrating to production-based compensation plans for APCs.

V. Value-Based Compensation Considerations
V. Value-Based Compensation Considerations

Compensation Design Tied to Network Maturity

Compensation design and the adoption of new incentives are largely dependent on where organizations are in terms of physician network evolution.

Four Phases of Physician Network Evolution

- **Phase 1 – Recruitment**
  - Meet Community Need

- **Phase 2 – Growth**
  - Secure Market Share

- **Phase 3 – Service Expansion**
  - Expand Clinical Expertise

- **Phase 4 – Value-Based Network**
  - Manage Population

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V. Value-Based Compensation Considerations

Overview

There are several important aspects of redesigning physician compensation plans that all organizations must consider.

- **Group Culture** – A group’s culture plays a significant role in determining what type of compensation incentives are both feasible and needed.

- **Compensation Plan Elements** – There are a multitude of productivity and nonproductivity metrics that can be included in evolving compensation models. Establishing the most appropriate mix and weighting of metrics will be crucial in establishing a fair and flexible plan.

- **Process and Infrastructure** – Developing value-based compensation models will require a more robust planning process and demand a greater degree of internal capabilities to track and report on various nonproductivity measures.

- **Transition Planning** – Managing the transition to a new compensation plan will be critical to its acceptance and future success.
V. Value-Based Compensation Considerations

Group Culture

Group culture is an important factor that influences a physician organization’s ability to implement changes to compensation design.

<table>
<thead>
<tr>
<th>Cultural Element</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long History, Shared Beliefs</td>
<td>• Group/team incentives possible.</td>
</tr>
<tr>
<td></td>
<td>• Production incentives less important.</td>
</tr>
<tr>
<td>Collection of Individuals Recently Acquired</td>
<td>• Production incentives critical.</td>
</tr>
<tr>
<td></td>
<td>• Desired behavioral norms need to be incentivized.</td>
</tr>
<tr>
<td>Federation Model, Shared Infrastructure</td>
<td>• Group/team incentives will be challenging.</td>
</tr>
<tr>
<td></td>
<td>• Specialty-specific work expectations/standards could substitute for production incentives.</td>
</tr>
</tbody>
</table>

“There is a saying: “Culture eats strategy for lunch.” How does this impact compensation and incentive design?”

“Ignoring the health of your culture is like letting aquarium water get dirty.”

– Fast Company

Cultural Questions

• Do we need to use incentive design to support or shape culture, or do we rely on culture to shape our compensation plan?
• How important is group culture in succeeding in a value-based delivery and reimbursement environment?
• What role can group culture play in moving to a compensation plan with a greater degree of quality and nonproductivity metrics?
• What are physician leaders doing with regard to either shaping or using culture to influence compensation plans?
V. Value-Based Compensation Considerations

Compensation Plan Elements

Determining the appropriate mix of compensation plan elements and the percentage of total compensation associated with them can be challenging.

Alternative Compensation Models/Approaches
- Provider organizations have recently been considering alternative compensation models as they accept non-FFS contracts with health plans.
- Some of these models segregate funding based on the type of payor contract.

Productivity Metrics
- Traditional measures of physician productivity will continue to be an important factor for reimbursement as well as compensation in the near term.
- The extent that productivity measures constitute total compensation is difficult to determine and is highly dependent on an organization’s overall strategy and payor contracting approach.

Nonproductivity Incentives
- Identifying incentive measures requires significant time and effort, and it can be difficult to reach consensus.
- The use of data already being collected, as well as measures sponsored by professional societies, can help make the selection process more efficient.

In general, there is no “best” or “right” design, so long as the compensation plan rewards desired behaviors.

Performance Categories

For most organizations, a range of metrics exist that could incentivize higher-quality, more efficient care.

<table>
<thead>
<tr>
<th>Category</th>
<th>Considerations</th>
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<tbody>
<tr>
<td>Productivity</td>
<td>Continues to be an important element in compensation plans.</td>
</tr>
<tr>
<td></td>
<td>Is extremely common, relatively easy to measure, and better understood by physicians.</td>
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<tr>
<td></td>
<td>Includes a variety of potential metrics, including WRVUs, patient visits, or panel size.</td>
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<tr>
<td>Clinical Quality</td>
<td>Supports a major goal of all healthcare organizations.</td>
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<tr>
<td></td>
<td>Aligns with anticipated changes in the reimbursement environment.</td>
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<tr>
<td></td>
<td>Can lead to lengthy debates around “best practice” care protocols.</td>
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<tr>
<td>Patient Satisfaction</td>
<td>Is typically a strategic goal for organizational healthcare providers.</td>
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<tr>
<td></td>
<td>Aligns with publicly reported hospital data.</td>
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<tr>
<td>Access</td>
<td>Supports a major patient satisfier.</td>
</tr>
<tr>
<td></td>
<td>Tends to be relatively easy to measure.</td>
</tr>
<tr>
<td>Teamwork/Citizenship</td>
<td>Recognizes and values physicians’ time spent on cross-specialty collaboration and relationship-enhancing functions.</td>
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<td></td>
<td>Typically includes different incentives for physician leadership positions and physicians attending meetings or participating in ad hoc committees.</td>
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<tr>
<td>Expense Reduction</td>
<td>Supports organizational goals to improve operating efficiency and create a greater level of value for patients and payors by:</td>
</tr>
<tr>
<td></td>
<td>Creating and following evidence-based care pathways.</td>
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<tr>
<td></td>
<td>Streamlining costs through adherence to standards.</td>
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<tr>
<td></td>
<td>Introducing process/work flow/patient care innovations.</td>
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</tbody>
</table>
V. Value-Based Compensation Considerations

Performance Measures Characteristics

*In general, performance measures used for compensation purposes should embody a series of desirable characteristics.*

**Desirable Characteristics**

- **Controllable**
  - Measures focus on processes or outcomes that physicians can personally control and that entail realistic targets. For example, quality measures should be specialty-specific, while others, such as patient satisfaction, may be used across multiple specialties.

- **Attributable**
  - Data for each measure can be accurately attributed to medical group physicians based on actual scope of care provided (e.g., care delivered by a consulting physician versus attending physician).

- **Timely**
  - Results can be reported within a reasonable time frame (e.g., quarterly) to show early trends and enable physicians to make midstream changes in performance.

- **Statistically Valid**
  - Performance measures are adjusted for patient acuity where necessary and contain sufficient sample sizes to support conclusions.

Discussion Questions

**Alternative Compensation Models/Approaches**

Is it feasible to pay physicians under separate compensation models depending on the type of payor contract? What are the pros/cons?

**Productivity Metrics**

- Of total compensation, what percentage should be attributed to traditional productivity metrics versus nonproductivity incentives?
- How are organizations coordinating this with their payor contracting strategy?

**Nonproductivity Metrics**

- How many nonproductivity measures should be included?
- What is the right balance between clinical and nonclinical incentives measures?
- Should nonproductivity incentives be established for departments, individual physicians, or both?
- What percentage or level of compensation is needed to make an incentive meaningful?
V. Value-Based Compensation Considerations

Process and Structure

**Process**
- The process by which a compensation plan is redesigned will directly affect the future success and acceptance of the model.
- Traditional compensation planning committees may need to be expanded to gain insight from additional stakeholders/departments (e.g., quality, business intelligence, process improvement departments, payor contracting).

**Infrastructure**
- Realistically assessing and addressing infrastructure capabilities and requirements (e.g., decision support staff, data capture, analytics and aggregation) will be critical.
- Developing appropriate infrastructure capabilities will also improve the plan’s ability to be flexible and evolve as adjustments are made or new metrics are incorporated.

Measure Selection and Implementation Process

As nonproductivity incentives become an increasingly common element of physician compensation arrangements, a physician-centric process for evaluating and selecting metrics takes on increasing importance.

1. Assemble Multidisciplinary Work Group
2. Determine Guiding Principles
3. Define Performance Categories
4. Prioritize Performance Measures
5. Assess Data Availability
6. Establish Performance Targets
7. Design and Test Reporting Tools
V. Value-Based Compensation Considerations

Discussion Questions

Process

• How are organizations incorporating support functions (e.g., payor contracting, decision support, business intelligence, quality department) into the physician compensation planning process?

• What are best practice approaches for developing nonproductivity plan elements?
  – Compensation committee-driven with standardization across specialties.
  – Department-/specialty-driven, but based on a common set of principles.
  – Use of pilot plans.

Infrastructure

• What internal capabilities (e.g., staff, IT systems, data aggregation) are necessary to manage the compensation plan and track physician/group performance on nonproductivity metrics?

• How are health systems evolving their organizational design and infrastructure to support new incentive systems?

Transition Planning

• Efforts to implement rapid and radical changes to the compensation plan will likely be met with failure.
  – Existing physician group/network compensation plans.
  – “Hospital employee” legacy compensation plans.

• A transition plan should consider an organization’s “starting point” as it redesigns its compensation plan.

• The transition plan should consider the reporting requirements of the new plan and the organization’s ability to accurately track and measure incentive metrics.

• The extent that the organization expects to implement alternative delivery models (e.g., PCMH, bundled payments, ACO) and accept risk-based reimbursement contracts also should be factored into the transition plan.

Organizations should seek to slowly phase in nonproductivity metrics over time and consider physician (and organizational) readiness for change.
V. Value-Based Compensation Considerations

Potential Migration From Current Plan

The graphic below depicts how a productivity-oriented group might consider embarking on a shift to a nonproductivity performance plan.

Example Transition From Productivity-Centric Plan

Current Plan

Years 1 to 2

Years 3 to 5

Years 5-Plus

- The plan is assumed at 100% production.
- A major cultural shift is required in the transition.
- Data collection and reporting is inadequate.

- 100% production plan continues.
- Performance measure data collected and tested.
- Shadow reports created.
- Work group created to identify nonproductivity metrics and tie them to compensation pools.

- Production compensation reduced.
- Funding established for nonproduction pools.
- Nonproduction incentives grow every year and are continuously evaluated and improved.

- Transition completed.
- Potential combination of production, nonproduction, and guaranteed salary components.

Discussion Questions

- What are the essential aspects to effectively managing the transition to a new compensation model?
- What types of incremental changes/adjustments should be considered in initial years?
  - Shadow plan/period.
  - Protection floors.
VI. Keys to Success

• **Find the Right Balance** – Effective incentive plans strike the right balance between clinical and nonclinical measures, as well as the total number of measures that are adopted. Too few measures may fail to properly address the strategic goals of the organization, while an excessive number of measures may result in too little emphasis being placed on any one measure by physicians.

• **Establish a Degree of Flexibility** – Development of a flexible plan, one that can easily accommodate new incentive metrics as the organization’s internal goals or market factors evolve, will ensure the long-term viability of the plan.

• **Leverage Existing Measures** – Physicians are naturally apprehensive about tying compensation to performance. These concerns can be partially mitigated by utilizing familiar measures (e.g., those already being collected by the organization) as a foundation for establishing the incentive plan. Newer measures can be phased in over time as physicians become more comfortable with the concept of performance-based compensation.

• **Develop Reporting Mechanisms** – The medical group should not be surprised by the level of incentive compensation it has earned when the payment date arrives. Ongoing performance reports should be distributed to each physician that summarize individual, specialty, and medical group performance within each category.