HSG | ADDING VALUE TO **PHYSICIAN COMPENSATION**

A COMPREHENSIVE GUIDE TO ALIGNING PROVIDER COMPENSATION WITH VALUE-BASED REIMBURSEMENT

9900 Corporate Campus Drive • Suite 2000 • **Louisville, Kentucky** 40223
P: 502.814.1180 • F: 502.814.1181
HSGadvisors com

INTRODUCTION

The evolving physician compensation landscape

Recently, HSG was engaged in another of many in-depth conversations about physician compensation and challenges, this time the Executive Director of a large, and still growing, employed physician group. The director commented, "At any given point in time, I could tell you about three compensation plans: last year's plan, which didn't work; this year's plan, which nobody likes; and next year's plan, which will fix all our problems."

"At any given point in time, I could tell you about three compensation plans: last year's plan, which didn't work; this year's plan, which nobody likes; and next year's plan, which will fix all our problems."

That comment highlights the changing nature of physician compensation. For many organizations, physician compensation plans have been following a steady pathway of evolution.

During the rush of practice acquisitions and physician employment over the past decade, many organizations adopted compensation plans based on whatever it took to get the deals done. For practices that were struggling financially, this might have meant a small premium over historic physician salaries. For practices in highly competitive markets, however, many physicians received large guaranteed salaries combined with signing bonuses and/or other incentive packages.

These deals often resulted in physician compensation that was inconstent with market values and set off a second wave of compensation changes to deal with mounting practice losses. This time, health systems focused on right-sizing their compensation packages and implementing wRVU-based plans to align compensation with productivity.

Today's concerns about physician compensation are the result of the changing healthcare environment. The transition to value is slow, but finally becoming a reality. Proactive hospitals want to ensure that provider incentives are properly aligned with ever-increasing value-based demands.

This report focuses on the three big questions HSG receives about adding value to physician compensation:

- Why are organizations redesigning their provider compensation plans?
- What elements and parameters must be part of successful compensation plans?
- How are organizations implementing compensation changes?

The Big Question

Why are organizations redesigning their provider compensation plans?

The Short Answer

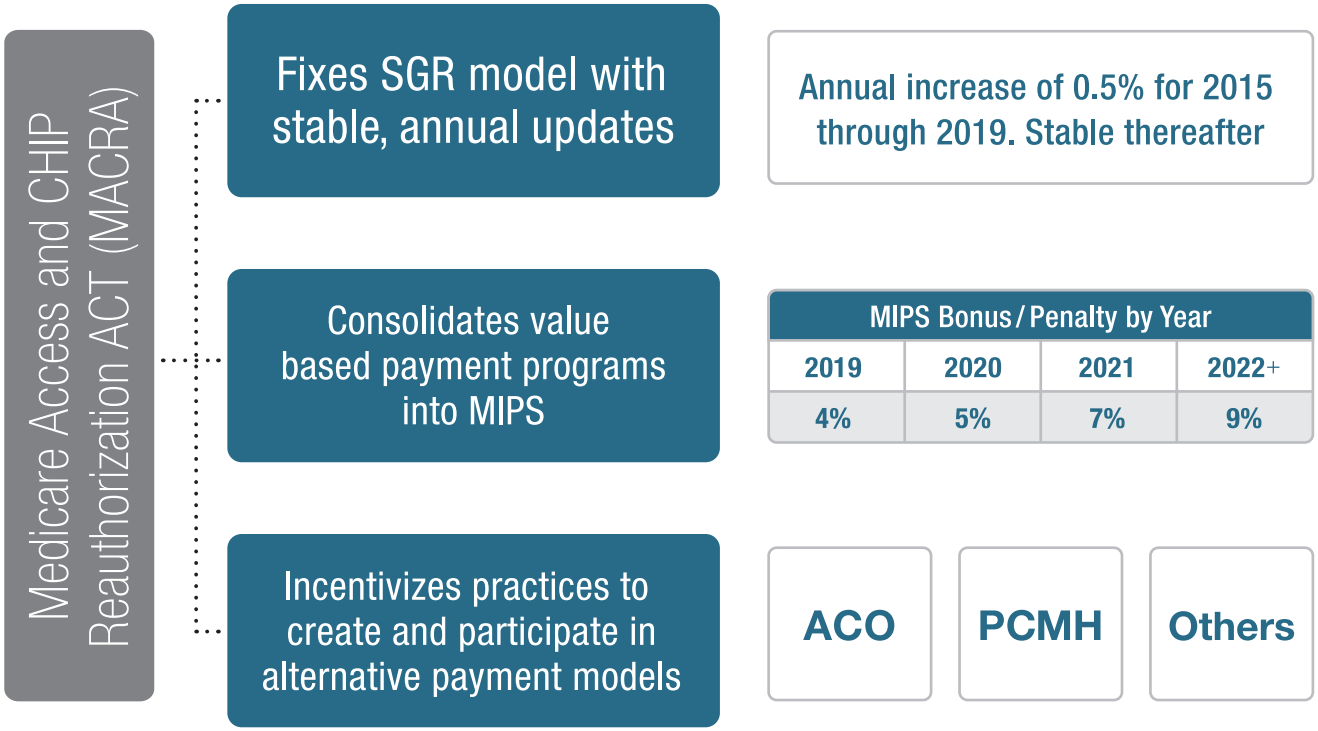
Given recently redesigned CMS payment programs and some private payer initiatives, many providers and practice executives now believe the long-awaited transition to value is becoming a reality.

Since the Affordable Care Act (ACA) passed in 2010, consultants, healthcare leaders, and policy experts have been touting the transition to value. Pilot programs for Accountable Care Organizations, Shared Savings Programs, and Bundled Payments were launched after the ACA's implementation. These programs were designed to change the way hospitals and physicians provide care, manage patients' health, and generate revenue. Many experts advocated that organizations prepare for such programs by immediately redesigning their physician compensation plans to reflect new reimbursement methodologies.

There was only one problem: most physician organizations were still being paid under fee-for-service (FFS) and changes to reimbursement weren't swift, nor were they expected anytime soon. Without mandated enrollment and/or a concrete pathway to participation, hospitals and physician organizations were hesitant to seek out value-based payment programs. Therefore, there was little motivation to introduce non-productivity-related incentives into physician compensation plans.

That's beginning to change, partly fueled by recent government actions. In April 2015, Congress repealed the sustainable growth rate (SGR) formula and introduced the Merit-Based Incentive Payment Program (MIPS). When it goes into effect in 2019, MIPS will replace three existing value-based programs and provide a clearer roadmap for how CMS will pay for value. In addition to MIPS, CMS proposed an aggressive bundled payment initiative for joint replacement patients. Details on these key CMS programs can be found in figures 1 and 2.

Figure 1: The SGR Fix and Bundled Payments



The Big Question

Why are organizations redesigning their provider compensation plans?

CONT.

In addition to government action, hospitals, payers, and employers are further influencing the reimbursement and compensation landscape. By pursuing the actions shown in Figure 3, these entities can accelerate the pace of the transition to value within a specific market.

In conclusion, the combined actions of government and other entities are providing concrete and defined pathways toward value-based reimbursement. Many physicians and hospital/group practice executives are no longer skeptical or in disbelief about their future revenue streams. And they are taking steps to re-align provider compensation by creating the right incentives to maximize value-based revenue.

Figure 2

Key Highlights of the Medicare Proposed Hip and Knee Initiative

- Proposal formally announced in July 2015 with comment period open until September 2015. Final rule will follow.
- Applicable to any healthcare provider in one of the 75 designated geographic areas
- Hospital is held accountable from time of surgery through 90 days after discharge
- Depending on quality and cost performance, hospital will receive additional payment or be required to pay Medicare

Figure 3

System/Hospital Driven	• Formation of new narrow networks or CINs • Increased adoption of risk/value based contracts • Creation of provider-owned health plans, participation in alternative payment models
Payer Driven	• Administration of full and limited risk based contracts • Increased utilization of pay-for-performance measures in contracts • Increased enrollment in Medicare Advantage products
Employer Driven	• Rapid growth in private exchanges • Purchasing of services directly from providers (narrow networks) • Increasing number of self-funded employers

The Big Question

What elements and parameters will be part of successful compensation plans?

The Short Answer

Successful compensation plans must deemphasize wRVUs to **encourage physician leadership and incorporate value-based measures.** Additionally, the plan must **allow for team-based provision of care** by offering group incentives for teams with multiple physicians and/or advanced practitioners.

ENCOURAGE PHYSICIAN LEADERSHIP

Under FFS methodologies, hospitals consider their busiest physicians as their most valuable physicians. The FFS environment encourages productivity-based compensation schemes that ensure high-volume physicians receive high-dollar salaries. However, in a value-based reimbursement environment, hospital and practice revenue is less dependent on volume and more dependent on:

- Quality
- Appropriateness (Right Care-Right Time)
- Experience
- Efficiency

To maximize performance in these areas, hospitals and health systems must leverage the clinical expertise of their employed physicians. Compensation structures should reward physicians for their leadership, management, and input. If these value-added contributions divert time or effort away from a physician's clinical schedule, appropriate adjustments should be made to avoid penalizing the physician for decreased wRVU production.

It's also important to ensure the level of physician contribution is consistent with the compensation methodology. Roles and involvement vary significantly between physicians. For example, one physician may contribute on ad-hoc quality improvement committees, while another has administrative ownership of care-process redesign. In these cases, different compensation methods should be used.

To the right, HSG has outlined some common methods used to pay for physician leadership. Descriptions of each method and recommended uses are included.

Designated Administrative Time

Physician contract explicitly states that a portion of time will be dedicated to administrative duties and wRVU expectations are prorated accordingly.
This method is best used for physicians who have on-going administrative duties.

Medical Directorships

Provides hourly rate or stipend for directorship duties. Can be a separate contract or included as part of an employment contract.
Best used for situations in which the physician has a defined role with hours that vary by week or month.

Co-Management Style Agreements

Portion of service line management is assigned to group of physicians, who receive compensation for management time and performance incentives.
Best used in key service lines like orthopedics, oncology, or cardiology where physician input can drive service line enhancement.

As-Needed Payments

Employed physicians are awarded dollars or wRVUs for participation in specific programs or committees that may otherwise take time out of clinical schedule.
Ideal for participation on ad-hoc committees or infrequent meetings.

The Big Question

What elements and parameters will be part of successful compensation plans?

CONT.

INCORPORATE VALUE-BASED MEASURES

Tying compensation to quality, patient experience, or efficiency is no easy task. Unlike productivity, where the wRVU is the gold standard unit of measurement, there exists a deluge of potential value-based indicators. These measures fall into many different categories, with each category having subsets based on specialty, measure design, and/or endorsing agency. Case in point: the current inventory of PQRS measures alone consists of more than 250 quality metrics. Adding to this complexity is the level of IT support required to properly measure, report, and manage these indicators.

Additionally, you must understand the clinical processes that contribute to results in a particular measure. You don't want to implement a measure that the physician cannot control or at least influence. That's why HSG recommends using a systematic and inclusive approach when adding non-productivity-based incentives to compensation plans. Specifically, we find our clients are more likely to have success using the following guidelines:

- **Involve your physicians in selecting clinical quality measures:** Physicians are uniquely qualified to tackle clinical issues. They will have relevant ideas and opinions regarding the usefulness and practicality of key measures.
- **Start easy:** Focus on measures that are easy to track and manage, so your organization can build quality measurement capabilities at a realistic pace. Start with measures physicians feel they can influence directly. For example, it may be better to start with process-orientated measures and then move onto outcome-based measures, as in the examples at right.
- **Start slow:** Compensation is a touchy subject and because quality payments are new to most physicians, they will probably feel hesitant about these changes. Plan to increase quality dollars across the contract term to allow management and physicians to identify issues before large dollar amounts are at risk. This also ensures that the amount of compensation dedicated to quality measures doesn't exceed the rate at which your physician reimbursement is transitioning from FFS to value.

Starting Easy Cardiology Group Example

Start with these

- Fibrinolytic Therapy - Received within 30 minutes of hospital revival
- Primary PCI received within 90 minutes of hospital arrival
- Proportion of patients with aspirin prescribed at discharge

Evolve to these

- AMI 30 day mortality rate
- Proportion of PCI procedures with access site injury
- Proportion of PCI procedures that were appropriate

The Big Question

What elements and parameters will be part of successful compensation plans?

CONT.

INCORPORATE VALUE-BASED MEASURES (CONT.)

Starting Small

Examples of Phasing in Quality Payments

Approach #1

	Year 1	Year 2	Year 3
Base pay per wRVU	$48	$46	$44
Quality pay per wRVU	$0	$2	$4

Approach #2

	Year 1	Year 2	Year 3
Quality Withholding	0%	3%	6%

Approach #3

	Year 1	Year 2	Year 3
Productivity Base	$180,000	$170,000	$160,000
Quality Base	$0	$10,000	$20,000

In Approach #1, the total compensation per wRVU is kept constant each year, but an increasing portion of the wRVU payment is allocated toward quality.

Approach #2 withholds an increasing percentage from the physician's earned compensation. These withholdings would then be paid back yearly or quarterly based on the physician's performance against quality metrics.

In Approach #3, the physician has an increasing dollar amount dedicated to quality performance. This is accompanied by a decrease to productivity base salary, which would likely translate to a decrease in wRVU targets or a decrease in the wRVU compensation rate.

Sources for Quality Measures

CMS Value Based Purchasing Measures

- Process of Care
- Outcomes: Readmission/ Details
- Satisfaction: HCAHPS

- Physician Quality Reporting System (PQRS)
- Specialty Professional Societies
- Metric endorsers/aggregators: NQF/NQMC

The Big Question

What elements and parameters will be part of successful compensation plans?

CONT.

ALLOW FOR TEAM-BASED PROVISION OF CARE

As we move toward value-based care and ultimately, population health management, team-based medical care will become a critical competency. One physician working in a silo cannot effectively manage the health of a large population.

We train, hire, and pay doctors to be cowboys. But it's pit crews people need.
Surgeon and Public Health Researcher, Atul Gawande, MD, MPH

Teamwork in a health care setting between physicians and non-physician practitioners is important as the medical community works to better coordinate care to ensure patients get the best possible care.
AMA President, Ardis D. Hoven, MD

Compensation plans must allow for and encourage providers to collaborate and work together. Many healthcare systems are incorporating team-based incentives in their compensations plans to ensure physicians are properly rewarded for team-based care. This is particularly true in hospital-based settings such as the emergency department, med/surg units and ICUs where hospitalists and intensivists live. The table below details four different approaches to setting up team-based incentives.

Example Approaches to Team-Based Incentives

Group Scoring for Quality/Satisfaction Measures	Quality and/or patient satisfaction compensation is based on the scores of the entire group rather than individual physicians.
Group wRVU Bonus Pool	Physician wRVUs are aggregated and compared to group targets. Physicians share bonuses for wRVUs above the group targets.
Citizenship Bonuses	Hospital awards discretionary bonuses to physicians who promote teamwork, participate in multidisciplinary team meetings, and help achieve group goals.
Bonus Tiering	Physician incentives are bifurcated, with some dollars based on individual performance and some dollars based on team performance.

The Big Question

What elements and parameters will be part of successful compensation plans?

CONT.

ALLOW FOR TEAM-BASED PROVISION OF CARE

As patient demand increases and a physician shortage looms, advanced practitioners (AP) can provide additional primary care access by extending the clinical reach of a physician network. APs are also a natural fit for reform-focused practice settings such as Patient Centered Medical Homes, urgent care centers, and retail clinics.

Given these benefits, many organizations have increased or are planning to increase the rate of hiring for APs. If your organization includes APs, don't make the following compensation mistakes:

Advanced Practitioner Growth by the Numbers

In primary care, cardiology, and orthopedic surgery practices, the ratio of advanced practitioners per physician has increased each of the last five years.

68 percent of those practices selected for inclusion in MGMA's survey of successful medical groups employ advanced practitioners.

Jobs for advanced practice nurses are projected to grow 31 percent between 2012 and 2022.

- **Treating advanced practitioners like office staff:** Place advanced practitioners on the same operational level as physicians. This means AP policies regarding contracting, annual evaluations, and benefits should mirror physician policies.
- **Assuming a per-provider-per-month stipend is the best way to pay for supervision.** Successful organizations are thinking outside the box when it comes to paying physicians for AP supervision. Many are creating incentives related to AP quality, performance, and/or productivity.
- **Not tracking AP incremental impact on total productivity (see example below)**

Traditional Approach

Benchmarking Physician wRVUs

Analysis	Outcome
Physician produces 9,500 wRVUs compared to MGMA Median of 8,241 Independent wRVUs generated by the PA are not analyzed	**Meeting target. Management is happy.**

Holistic Approach

Benchmarking Total Provider wRVUs

Analysis			Outcome
Provider	wRVU Production	MGMA Median	**Combined providers are not meeting the combined target. Management is not happy.**
Physician	9500	8241	
PA	550	3085	
Total	**10050**	**11326**	

Comparison of productivity measurement methodologies. In the Traditional Approach, shown on the left, the orthopedic surgeon appears to be meeting the production target. However, this may be misleading, because the PA may be directly or indirectly contributing to the surgeon's wRVU generation. To properly measure the impact of the PA, HSG recommends measuring productivity using the Holistic Approach presented on the right. This approach sums PA and physician benchmarks and compares the combined provider wRVUs to the aggregate median.

The Big Question

How are organizations implementing compensation changes?

The Short Answer

Large scale compensation changes must be driven by a systemic process that involves education, data analysis, and collaboration with key stakeholders.

The world's best compensation plan won't ever see the light of day if your most influential physicians shoot it down.

That's why it's incredibly important to approach any compensation redesign from a process perspective. Form a compensation committee to help design and guide the compensation planning process. This committee should include physicians who are respected and trusted by their peers, since implementation of the final plan will rely on these physicians gaining support and addressing concerns from their colleagues.

Once the right members have been chosen, the committee should focus on executing a process that properly evaluates the status quo, establishes goals for the new plan, and then systematically builds, tests, and implements the new compensation plan with collaboration from the committee members. Although different organizations may have different needs, the following timeline outlines the basic building blocks of a successful compensation redesign process.

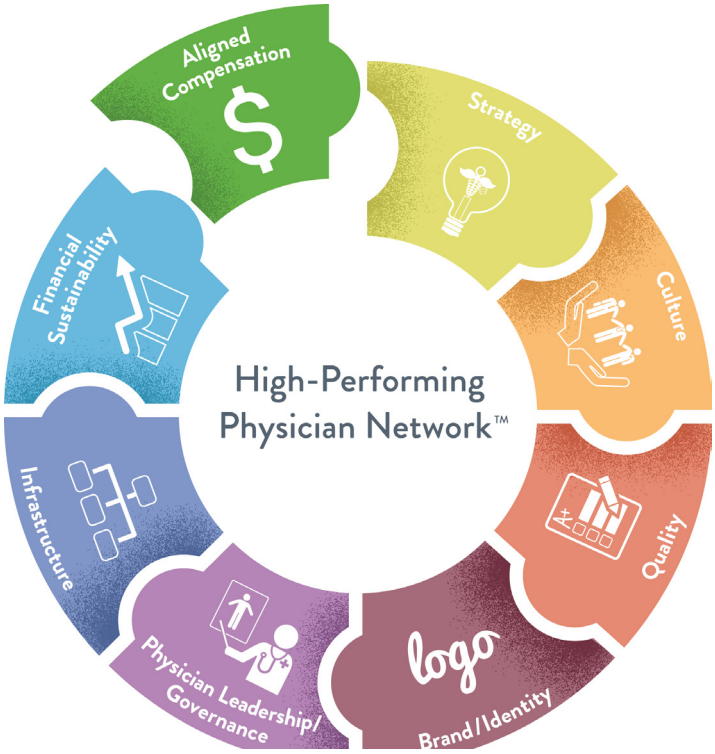
	Discovery Phase	Building Phase	Testing & Implementation
Key Questions to be Answered	What are the goals of the new compensation plan? When do the current contracts expire and how will this impact implementation? Will physicians need education on the market forces driving the need for a new compensation plan?	What compensation methods are considered to be best practice? What are advantages and disadvantages of different methods? Which methods will work with our group?	How will the selected compensation affect each physician? Will the plan be financially sustainable for the organization? When and how will the plan be rolled out across the physician groups?
Action Items	Contract review, including cataloging expiration dates and key parameters Interviews/discussion with key stakeholders Data review and benchmarking analysis	Research and presentation of best practices Facilitation of educational sessions Facilitation of collaborative meetings designed to evaluate and select options for each major plan component.	Financial modeling at physician and organizational level. Creation of roll-out timeline based on contract review dates Creation of regular transition reports showing performance under future plan parameters.

An Even Bigger Question

How can HSG help your organization with compensation planning?

HSG is among the nation's leading experts on physician compensation – one of the eight keys to developing a High-Performing Physician Network. Whether you have six employed physicians or 600, we can help you create compensation packages that:

- Tie total physician compensation to performance in terms of both productivity and quality
- Allow base salary to be reduced if a physician doesn't meet minimum performance standards
- Contain clear, measurable quality/outcome metrics that further the organization's goals and objectives
  by rewarding physicians for improved performance
- Are standardized across the network to make administration easier
- Are in sync with the realities of today's healthcare market and the shift from volume to value
- Promote a shared group culture



Effective compensation plans tie total compensation to performance in terms of both productivity and quality; contain clear, measurable quality/outcome metrics that further the organization's goals and objectives; are standardized across the employed network; and promote a shared group culture.

Neal Barker is HSG's expert on provider compensation and productivity.
Reach him at 502.814.1189 or nbarker@HSGadvisors.com