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THOUGHT LEADERSHIP

PHYSICIAN COMPENSATION MODELS

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INTRODUCTION

Leaders of many employed physician networks think there must be that one best physician compensation model that addresses current realities and moves organizations forward on the journey to value-based care and its reimbursement. In reality, there is not a "best" physician compensation model. The best model for the organization will depend on where the organization is, where it wants to go, how it wants to get there, what culture it embraces, and other considerations. These factors impact compensation model components and determine which might be best for that moment in time – and how the model will need to evolve over time. It is not a matter of choosing a model and being done. The model, or at least its components, needs to evolve as the organization – and the healthcare industry – evolves.

STRAIGHT SALARY

The Straight Salary Model was the one most commonly utilized in the 1990s physician acquiring/hiring boom. Many experts cite that compensation model as one of the largest lessons learned coming out of the boom, specifically, to never make that mistake again. A widespread experience with the Straight Salary Model in the 1990s was many physicians seemed to "slow down" and were not as productive as they had been previously, and not as productive as they needed to be in independent private practices. Hospitals and health systems frequently experienced unexpected financial losses, the scapegoat of which became the Straight Salary Model. The thought has historically been the physicians were no longer motivated (or incentivized) to be productive, which led to the employed practices' downfalls. There were actually many reasons the newly acquired or developed practices did not succeed in the 1990s, only one of which may have been the compensation model.

The Straight Salary Model is making a comeback in select organizations that are steeped in tradition and supported by strong infrastructures that ensure effective productivity and extensively support quality care, patient satisfaction, and operational efficiencies. A culture that allows the Straight Salary Model to flourish is one backed by explicit expectations, limited contract lengths (often year-by-year), and non-renewals if the expectations are not met or exceeded. These organizations are uncommon and this physician compensation model is not likely to be a successful one for most networks.

In contrast, many organizations compensate their APRNs and PAs through a Straight Salary Model and experience the pitfalls associated with the model. Progressing to a more advanced model for these individuals is often thwarted by inequitable business practices which do not utilize or support the APRNs and PAs at the top of their licenses and capabilities and do not fairly capture or attribute workload credit.

Incentives	Potential Pitfalls
• Minimum Contractual Requirements	• If the physician is not internally driven, this may only meet (or marginally exceed) minimum expectations of the contract • May require centralized management of patient scheduling • May not encourage engagement in organizational initiatives

REVENUE MINUS EXPENSES

The Revenue Minus Expenses model replicates the experience with which many independent private practice owners/partners were/are familiar – and a primary reason that many of these individuals sought/seek employment. They prefer that others worry about ever increasing expenses, worsening payer mixes, and the nuances of practice management that impact both revenue and expense.

Although favorable to the bottom line, organizations utilizing this model frequently complain about the degree of micromanagement the physicians exhibit and the degree of resistance encountered when operational changes are proposed. This model does not adequately support organizational transformation from fee-for-service to value-based care and its reimbursement. Early investments increase expenses more rapidly than realized revenue – and the physicians directly feel that pain.

This model also does not dovetail well with the not-for-profit tenet of taking care of all patients regardless of their ability to pay. This mantra would have been antithetical to survival when the physicians were independent (and they therefore often intentionally limited exposure to poor payers like Medicaid). Embracing the concept of taking care of all patients regardless of the ability to pay flies in the face of the direct, adverse impact on their individual income. The two philosophies are very misaligned.

The Revenue Minus Expenses Model also does not promote physician involvement in any organizational initiatives that take the physician away from wRVU generating (revenue generating) functions. As is recounted in multiple articles, organizational progress in the current, and anticipated future healthcare environment, requires active, intimate physician involvement in organizational initiatives and pursuits that interfere with wRVU generation. Unless physicians receive some other form of compensation for the time dedicated to these pursuits, they are unlikely to step forward due to the adverse impact on their income.

Incentives	Potential Pitfalls
• Increased Revenue (Effort) • Minimize Expenses	• Tends to be favorable for "bottom line" • Disincentivizes physician from engaging in non-revenue generating activities • Requires proper expense tracking and allocation • May cause physician to micromanage practice • Physicians may be penalized if payer mix isn't ideal or revenue cycle is inefficient

STRAIGHT PRODUCTIVITY

The Straight Productivity model is also favorable to the bottom-line financial performance of the group – as long as the rate per wRVU is reasonable. Similar to the Revenue Minus Expenses Model, this model also does not promote physician involvement in organizational initiatives that take the physician away from wRVU generating (revenue generating) functions – although the model does eliminate concerns about expenses.

Since the Straight Productivity model is all about generating individual wRVUs, it tends to create a "my" or "mine" mentality that usually precludes sharing patient care or supporting newly recruited physicians. For many, it is all about me and the income that I can generate in my allotted clinical time. This can create a culture of individualism (versus team) and separatism (rather than unity)

Incentives	Potential Pitfalls
• Increased Effort/ Productivity	• Tends to be favorable for "bottom line" • Disincentivizes physicians from performing non-revenue generating activities • Disincentives physicians from facilitating recruitment or supporting recruits • May lead to over-coding or overusing care (regular audits may be necessary) • Physicians may not control expenses or practice operations improvement

BASE SALARY PLUS INCENTIVES

The Base Salary Plus Incentives Model is a popular option – though its myriad of potential variations means that, unlike those described above, it is not really a single model. It can behave like a Straight Salary Model when there are no disincentives for not meeting threshold wRVU expectations, i.e., the base is not decreased if the wRVU threshold expectation is not met. In this instance, a physician may be satisfied with the base compensation and not care about pursuing incentive bonuses. In fact, they prefer a straight guaranteed salary.

The Base Salary Plus Incentives model can also behave like a Straight Salary model if the incentive targets are perceived to be unrealistic or unachievable. In this instance, the physician will strive to achieve the threshold expectation but is not motivated to perform beyond that minimum expectation. The circumstance plays out just like the Straight Salary model – even if there is a potential downward readjustment of the base included in the model. With only individual productivity incentives, the Base Salary Plus Incentives model can behave like the Straight Productivity model as physicians individually pursue wRVU target achievement.

So, when does a Base Salary Plus Incentives Model behave in a way that motivates physicians to achieve higher levels of performance that are aligned with organizational goals and objectives? It does so when it contains downward adjustments if base threshold expectations are not met, contains non-productivity incentives in addition to productivity incentives, and/or contains additional group incentives. These components tend to counter-balance the potential pitfalls noted above and align individual focus with organizational goals and objectives. This is particularly true when group incentives are introduced.

Incorporating non-productivity incentives into the compensation model necessarily introduces annual review of the included measures, metrics, and targets to ensure that each continues to represent opportunities for improvement and continues to align with organizational goals and objectives. Other aspects of the model could be reviewed at the same time, such as the percentages of total compensation dedicated to the non-productivity incentives.

How quickly compensation models move to include all of the above incentive components depends on the starting point. Incorporating all of these incentive components can make a compensation model rather complex and might be too challenging to undertake in a single implementive effort. Adopting incremental changes over time may be preferable, or necessary, to allow progressive acceptance by the physicians and progressive increases in administrative resources to adequately support the model components.

The path to finding the best physician compensation model will likely lead most employed networks to a Base Salary Plus Incentives Model that progressively incorporates a diverse, evolving mix of individual and group productivity and non-productivity incentives aligned with organizational goals and objectives. The process is truly a journey – a journey sprinkled with progressive gains and beneficial outcomes.

Incentives	Potential Pitfalls
• Increased Effort/ Productivity • Dependent On Specific Incentives and Targets (Group vs Individual Basis)	• Flexibility in model may lead to overcomplication • Requires right mix of base salary, productivity targets/rates, and non-productivity incentives (if included), with added risks if targets are unrealistic • Organization must be willing to adjust base salaries to ensure continued alignment with physician productivity levels

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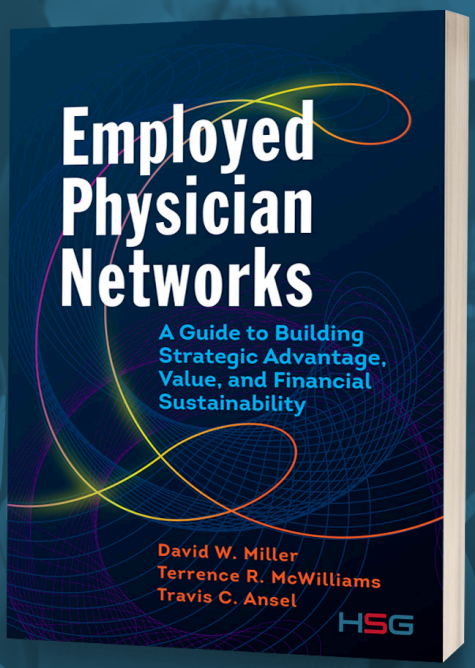

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