Developing Effective Physician Compensation Plans

An HFMA Forum Networking Event

Thursday November 3, 2016

2:00 – 3:00 p.m. Central (12:00 – 1:00 p.m. Pacific/1:00 – 2:00 p.m. Mountain/3:00 p.m. – 4:00 p.m. Eastern)

Daniel P. Stech
Principal, Pinnacle Healthcare Consulting

Katie Gilfillan
Director, Healthcare Finance Policy,
Physician and Clinical Practice
HFMA

hfma™
healthcare financial management association

Themes

- The combination of physician integration and shifts in reimbursement mechanisms are creating new strategic, financial, and regulatory challenges for hospitals and health systems around the country.
- Fee-for-service physician compensation programs are increasingly stressed to generate value-based outcomes that promote quality and preserve the bottom-line while abiding by complex legal and regulatory constraints.
- This session will provide practical insights into compensation strategies being employed by health systems to address these challenges and establish the framework necessary to be successful as our health system continues to evolve.

Objectives

- Discover how physician compensation is changing in value-based healthcare environments
- Discuss regulatory constraints governing physician compensation arrangements
- Assess common value metrics and strategies to engage physicians in change initiatives
- Identify practical compensation models that facilitate transitioning from volume to value metrics
- Explore solutions to address common landmines that accompany changes in physician compensation
- Develop a dashboard for value-based performance

Compensation Trends

- Most employed compensation models still rely heavily on FFS methodologies
  - WRVU productivity
  - Professional fee revenue less expenses
- More systems incorporating non-production incentives into physician compensation
  - Citizenship
  - Patient satisfaction/experience
  - Quality (limited, but increasingly common)
- Incentives tied to quality are still an elusive goal
  - IT system requirements
  - Meaningful measures
  - Physician buy in
  - Most reimbursement still linked to fee for service

Trends (continued)

- Tolerance for financial losses attributed to physician practices is diminishing
  - Fiscally not sustainable
  - Raises compliance risks
- Physicians reluctant to accept imposed notions of quality or value
  - Provide them the evidence
- Changes in reimbursement/methods will happen regardless of ACA repeal and replacement
  - Time for change is now

Regulatory Constraints

- Medicare and IRS rules governing provider financial relationships
  - Stark Law
  - Anti-Kickback Statute
  - Civil monetary penalties
  - IRS rules governing tax-exempt organizations
  - State-specific laws

- Virtually all relationships must be:
  - Fair market value
  - Commercially reasonable

- Evolving enforcement environment
  - Financial losses
  - Individual accountability

Polling Question 1

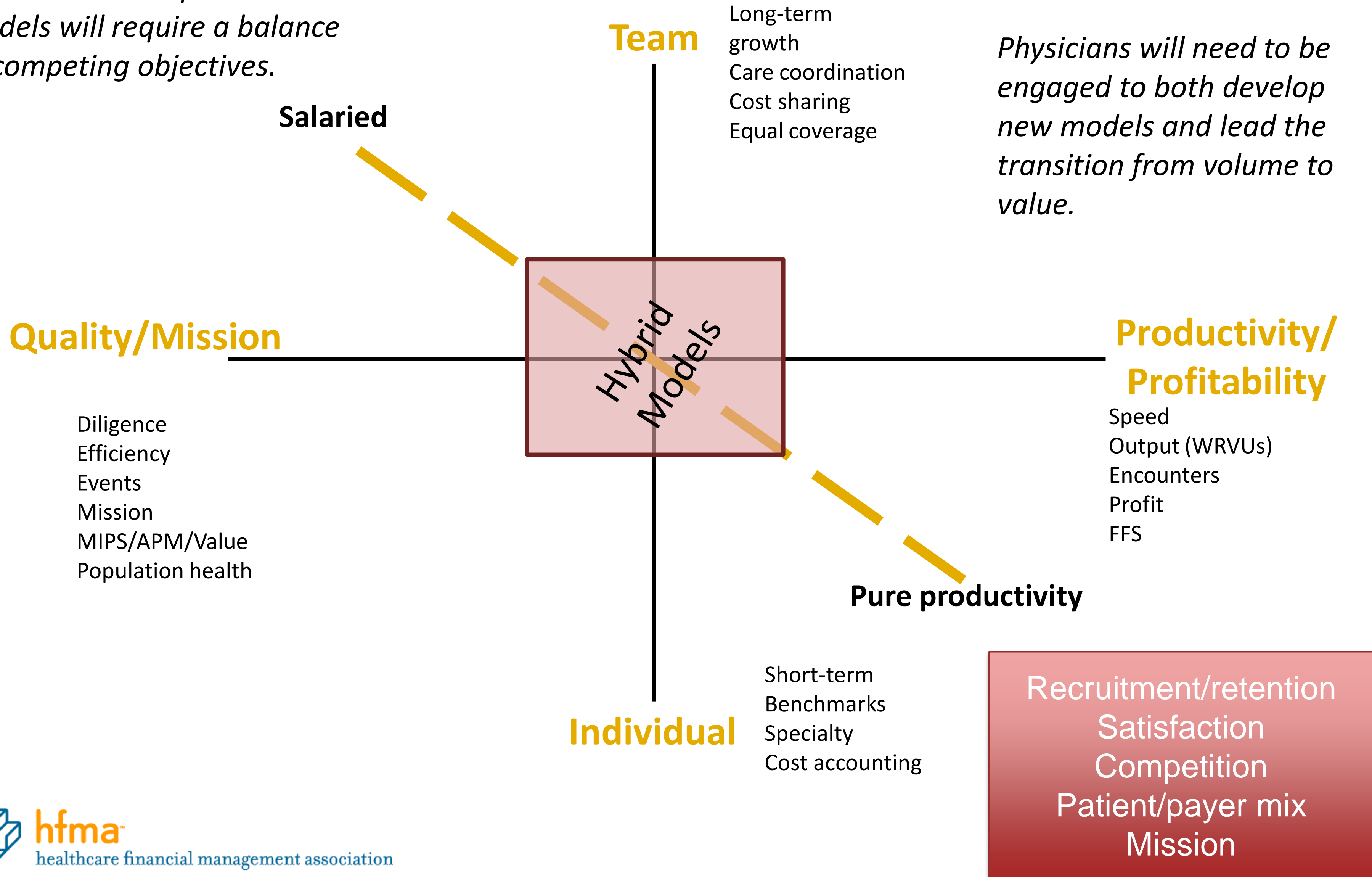
What is your greatest challenge with physician compensation?

- Developing a standard compensation structure that is appropriate for various specialties
- Developing strong enough incentives that encourage fee for value
- Keeping track of an implementing regulatory requirements
- All of the above

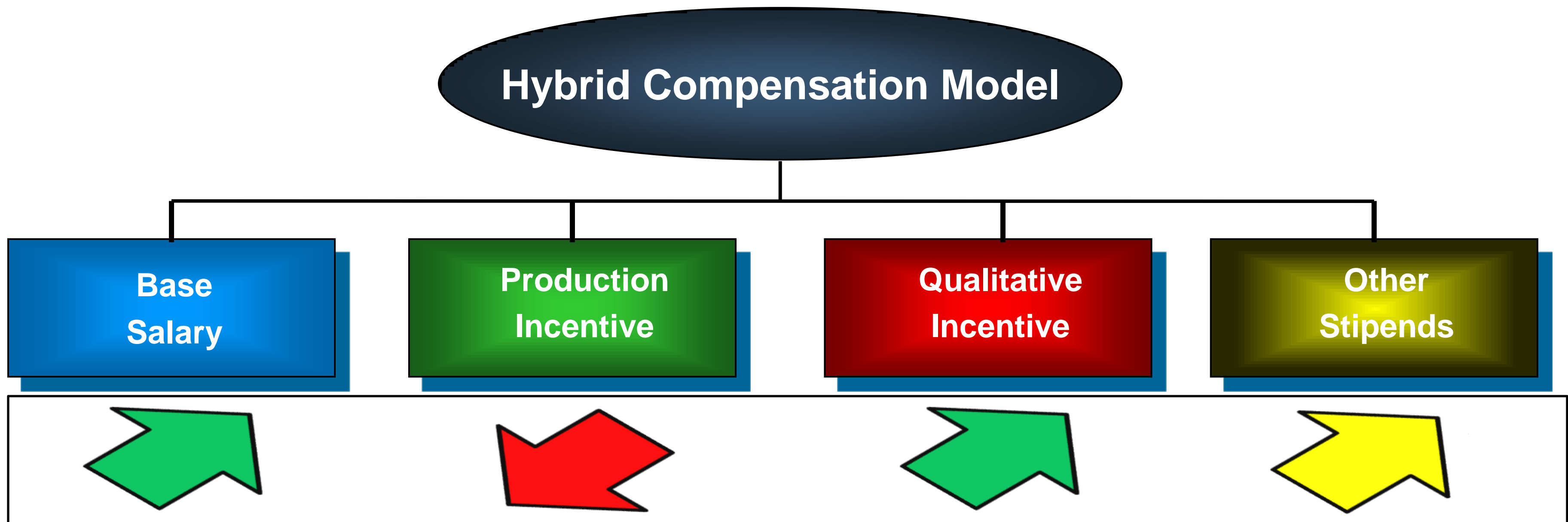
Traditional Compensation Structures

Model	Pros	Cons
Pure productivity (WRVUs, collections, etc.)	- Highly incentivizes physicians to work hard - Only pay for what you get - Common to independent physician practices	- Can create unintended consequences and unsupportive competition among physicians - Generally, not conscious of cost - Not aligned with new reimbursement models
Straight salary	- Easy to administer - Income predictability - May work better under new reimbursement models - Can promote teamwork	- Limited individual performance accountability - Can be dissatisfying to hard working physicians - Difficult to change physician mindset
Equal share	- Can be tied to financial performance - May work better under new reimbursement models - Can promote teamwork	- Limited to individual specialties - Requires like-performing physicians - Can be dissatisfying to physicians

Compensation Design and Competing Objectives



Compensation Structures (continued)



Notable key trends include:
(1) Increased pressures on base/floor levels of compensation, with expanded accountability for "minimum work standards;" (2) reduced reliance upon volume/productivity alone; (3) deliberate movement toward "capped" total incentives; and (4) enhanced reliance upon quality/service and efficiencies.

Pros: Adaptable to multiple specialties; can be adjusted over time; and accommodates multiple goals
Cons: More difficult to administer/more management; more complex to understand; and goals may need to be regularly adjusted

The Environment is Changing

Shift from Volume to Value-based Care?

Volume

- Fragmented providers and payments
- No uniform quality
- Fee for volume
- Demand increasing

Value

- Collaboration, connectivity
- Clinical, financial data, analysis
- Optimize outcomes
- Accountable care

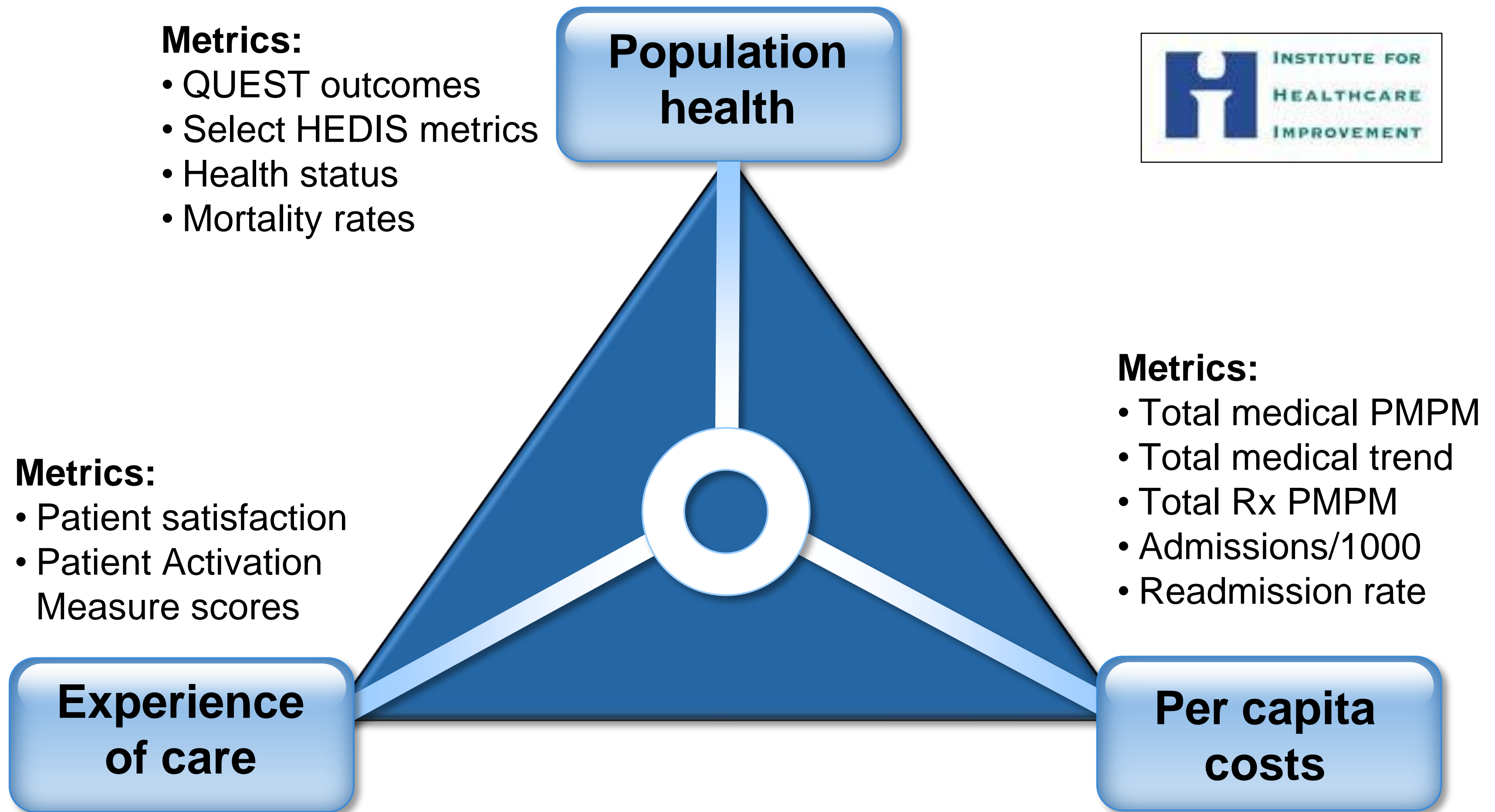
Polling Question 2

What option below matches the types of physician compensation models your organization is currently involved in or is planning to implement?

- Pure productivity
- Straight salary
- Equal share
- Hybrid

“Triple Aim” Philosophy Provides a New Paradigm: Value-Based

“The Best Care, for the Whole Population, at the Lowest Cost”

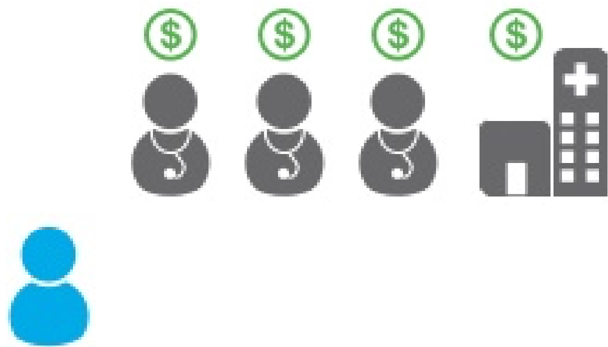


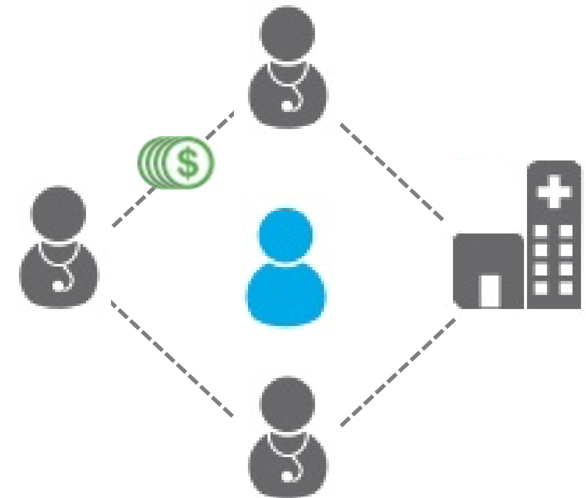
The term “Triple Aim” is a trademark of the Institute for Healthcare Improvement

Shift from Volume to Value

Fragmented, Volume-Based System
(Old Model)

Integrated, Value-Based System
(New Model)





Old Model		New Model
Fee-for-service	PAYMENT	Bundled, shared savings, capitated
Patient	FOCUS	Population
Treat; high-margin specialty care	INCENTIVE	Prevent
Siloed; specialty/disease-specific	INOVATION	Integrated; cross-functional

Medicare on the Move

Jan. 26, 2015, U.S. Department of Health and Human Services announcement:

- "…set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018."

- "…set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs."

- "This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments."

  - http://www.hhs.gov/news/press/2015pres/01/20150126a.html
  - https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-29-2.html

MACRA

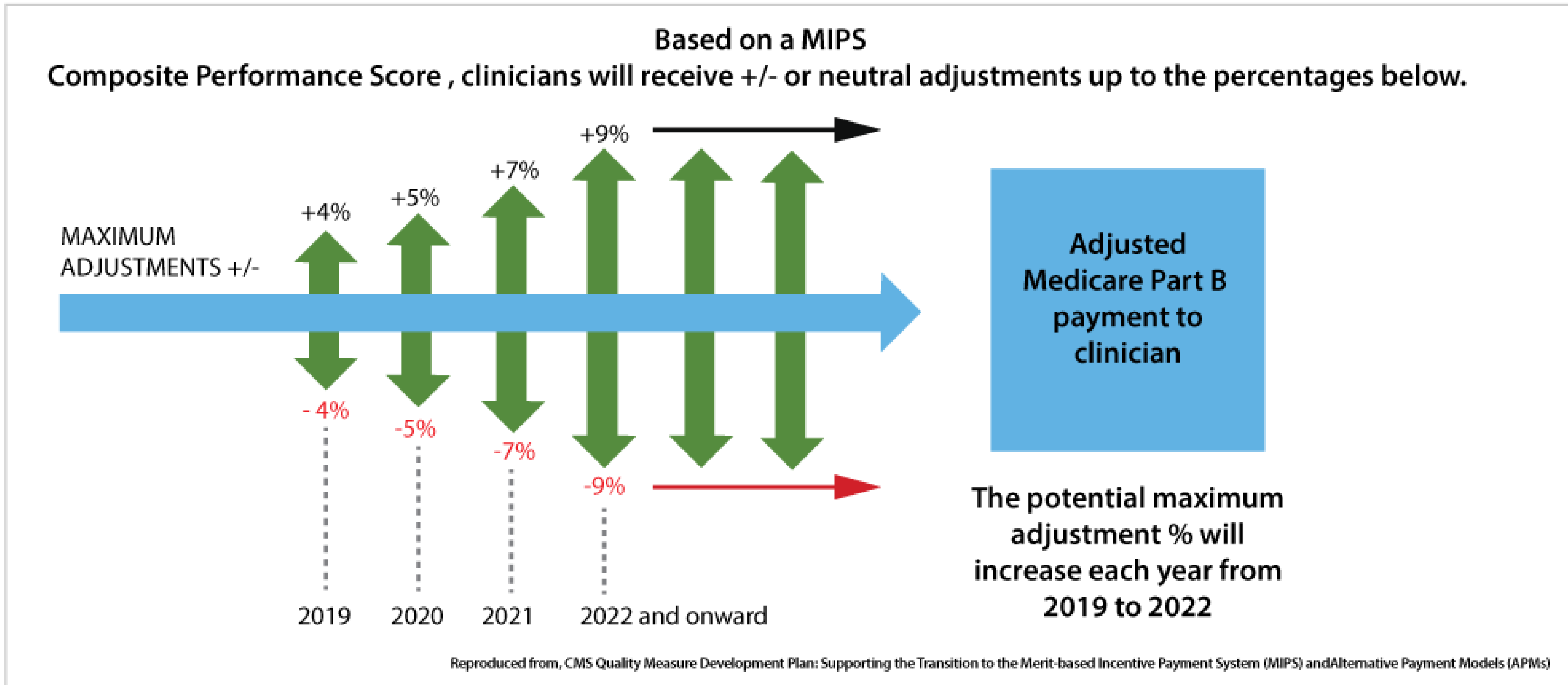
- MACRA went into effect on Jan. 1, 2017
  - Repeals the sustainable growth rate (SGR)
  - Replaces Meaningful use (MU), Physician Quality Reporting System (PQRS), and value-based payment modifier reporting with Merit-Based Incentive Payment System (MIPS) reporting
  - Rewards participation in advanced Alternative Payment Models (APMs) and attainment of quality and performance metrics.

Quality Payment Program - Two Pathways

- Merit-based Incentive Payment System (MIPS)
  - Composite Scorecard
    - Quality
    - Improvement activities
    - Advancing care information
    - Cost (2018)
- Advanced Alternative Payment Model (APM)
  - An APM is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

Dollars Available for Compensation



- Value-Based Compensation Models

Positioning for Change

Key Challenges

Physician engagement and adaptability

Compliance

Effective incentives

Alignment with reimbursement

Transition from volume to value

hfma
healthcare financial management association

Polling Question 3

What is the most effective way to increase physician engagement in quality measures?

- Sharing data
- Compensation models
- A physician champion
- All of the above

Compensation Models

- Model 1 – Hybrid
- Model 2 – Population health
- Model 3 - Others

Practical Compensation Solutions

Model 1 - Phased Hybrid	

Overview	• Incrementally shift compensation from volume to value
	  • Phase 1 – Limited incentives for quality/citizenship (up to 15%)
	  • Phase 2 – Individual and group quality performance measures (up to 25%)
	  • Phase 3 – Combination of PMPM and other incentives (50% plus)

Advantages	• Allows physicians time to adjust • More time to develop management and information system capacity • Permits flexibility to accommodate both fee for service and value reimbursement • Doesn't require new funding to support quality goals
Disadvantages	• May be too slow • May reduce productivity and fee-for-service revenue • Greater administrative demands • Setting meaningful quality metrics
Legal/Regulatory	• Fair market value/commercial reasonableness

Model 1 - Hybrid

Total Compensation	Component	Details
	Base (up or down)	May be tied to benchmark or percent of prior year compensation
		Base may increase or decrease as a percent of total compensation in advanced phases
	Production incentive (down)	WRVUs or portion of Professional Collections
		Reliance on production incentives decreases in advanced phases
	Quality incentive (up)	Initially may be based on non-clinical measures such as patient satisfaction
		Advanced phases require the performance of specific quality outcomes and care coordination

Actual Hybrid Model – Adaptable

ABC Physician Group -- 2017 Physician Compensation Worksheet

Physician Information

Lever 1

Physician Name		NEW
Specialty		INT
FTE		1.00
Call		Full
Call Adjust		$ -
Salaried		No
SALARY (Delete value if not salaried)		
APP Supervision		0.00
Prior Compensation Less Add-Ons		$ 400,000
Base Salary	0.75	$ 300,000
BASE SALARY		**$ 300,000**

Production

Lever 2

WRVU Rate		$ 51.75
WRVU Threshold		5,797
WRVUs		
Personal		9,211
Outreach		-
Total WRVUs		9,211
Bonus WRVUs (Variance)		
Personal		3,413.90
Outreach		-
WRVU Bonus		
Personal		$ 176,669
Outreach	$ 7.50	$ -
SUBTOTAL		**$ 176,669**

Performance and Quality

Lever 3

Lever 4

Performance Threshold		
Eligible		$ 15,000
Performance Metrics Achieved		2
Performance Earned		$ 10,000
Quality Bonus		
Eligible Amount	15%	$ 45,000
Less Performance		$ 30,000
Percent Earned		75%
Amount Earned		$ 22,500
SUBTOTAL		**$ 32,500**

Administration, Research and Supervision

Administration	
Stipend Amount	$ -
Research	
Earned Amount	$ -
Supervision	
MLP Cost	$ -
MLP Revenue	$ -
Coverage Percent	0%
MLP Supervision Payment	$ -
SUBTOTAL	**$ -**
SUBTOTAL COMPENSATION	***$ 509,169***
Other Adjustments	
TOTAL COMPENSATION	**$ 509,169**

Summary		
Specialty Median WRVUs		9,167
MD Percent of wRVU Median		100%
Specialty Median Compensation	$	509,000
MD Percent of Total Compensation Median		100%
Effective $/WRVU	$	55.28
Increase / Decrease - Proj 2016 compared to 2017	$	109,169

Solutions (continued)

Model 2 – Population Health	
Overview	• Combination of base compensation, fee-for-service production and PMPM • Similar to a hybrid model
Advantages	• Physicians incentivized to manage a specific population's care or overall individual panel size • Permits flexibility to accommodate both fee for service and value reimbursement
Disadvantages	• May be difficult to apply to some specialties • May reduce productivity and fee-for-service revenue • Greater administrative demands • Ideally aligned with specific payer contracts–may require additional funding
Legal/regulatory	• Fair market value/commercial reasonableness • Civil monetary penalties – stinting on care concerns • Can new bonus programs be stacked on existing compensation without fair market value concerns?

Model 2 – Population Health

Total Compensation	Base	May be tied to benchmark or percent of prior year compensation
	Production incentive	WRVUs or portion of professional collections
		Low rate per WRVU tied to all WRVUs or higher amount above threshold
	PMPM – withhold incentive	Tied to specific patient population(s) or overall panel size
		Require the performance of specific quality outcomes and care coordination

Other Approaches

- Employed Cardiology Group
  - Structure: High base plus limited bonus
    - All physicians, regardless of subspecialty, paid equally with fixed-bonus opportunity (@12% of total compensation)
  - Highly scheduled and managed work standards
    - Minimum encounter standards
  - Bonus requires demonstrated achievement in:
    - Quality
    - Patient experience
    - Individual productivity (meeting the minimum)
    - Professional advancement
    - Community contribution
  - FMV challenge for some individual physicians
    - Demonstrate genuine higher quality outcomes individually and/or as a group
  - **Requirements**: Unique culture, strong physician and managerial leadership, and hospital-physician partnership

Other (continued)

- Employed Primary Care Practices (Minnesota)
  - Structure: Quality-oriented hybrid
    - 40% clinic oriented incentives tied to state quality reporting system
      - Diabetes, vascular disease, depression, cancer screening, and asthma
    - 20% individual physician panel size
    - 10% clinic panel size
    - 20% patient encounters
    - 10% patient experience

- Source:
  - Platt, J. and Brandt G.; Fredrickson and Byron, PA

Types of Quality Incentives

- Types
  - Process
  - Structure
  - Efficiency
  - Outcomes/immediate outcomes
- Unit of observation/reporting
  - Individual
  - Group
  - Specialty
- Others categories
  - Behavioral health
  - Patient engagement
  - Electronic access
  - E-prescribing
  - Public health and reporting
  - Care coordination
  - Patient safety
  - Others
- Source
  - https://qpp.cms.gov/learn/qpp

hfma
healthcare financial management association

Success Factors

- Model design/process
  - Define your objectives
  - Involve physicians
- Quality Incentives
  - Must be meaningful
  - Make a difference in terms of the Triple Aim and fiscal outcomes
  - Educate physicians
- IT/analytics
  - Produce reliable results
  - Must be timely
- Exceed 10% of total compensation
  - To change behavior
  - Can take a carrot (pure bonus) or stick (withhold) approach
  - Example: Co-management
- Achievement/incentive should not be "automatic"
  - Set the bar high enough to make a difference
  - Calibrated to support financial sustainability
- Regularly evaluate, report findings, and update
  - Reset the bar

Dashboard Elements

- Physician and group/clinic perspectives
- Objective/quantifiable
- Performance metrics
- Specialty-specific
- Panel size
- Progress toward goals
- Peer comparison
- Regular and timely

Questions

Daniel P. Stech
Principal
Pinnacle Healthcare Consulting
dstech@askphc.com

Katie Gilfillan
Director, Healthcare Finance Policy, Physician and Clinical Practice
HFMA
kgilfillan@hfma.org