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Physician Compensation Models – Compensate Doctors Based on Metrics THEY Can Control

Want to really frustrate your employed Physicians? Tell them that they will be compensated based on factors that are completely out of their control. By doing so, no one wins.

For various strategic and economic reasons, Hospitals are increasingly employing Physicians and other providers in an effort to further develop primary and specialty care services, gain increased market share and broaden referral bases in order to provide quality care for their communities and maximize revenue streams and alignment opportunities to the Healthcare Systems. As Hospitals employ Physicians, there are many factors for organizations to consider when designing or redesigning a Physician Compensation Model. Here are those factors that are a "must" when developing a Physician Compensation Model that is sustainable for the future. Remember: Compensation Models must align incentives and compensate based on what Physicians can control.

Flexibility for the Organization

Designing a Compensation Model that is both uniform in its structure yet is flexible enough to adapt to various specialties and circumstances is important. Compensation Models must provide a means of compensating Physicians fairly for their services, align incentives and maintain economic viability for the organization and yet remain within Fair Market Value in order to be compliant. National Compensation Survey data (e.g. MGMA, AMGA, etc.) can be basic and helpful tool to evaluate appropriate compensation levels. However, survey percentiles only tell part of the story. Organizations must gain a clear understanding of such local/regional issues as: makeup of their provider network / service mix, ability to recruit and retain across multiple specialties and impact of local market forces (i.e. competition, market presences, etc.). Additionally, the framework of any Compensation Model must take into account the inherent differences in clinical practice between Primary and Specialty Care particularly when adapting to include both surgical and medical specialties.

Revenue Factors that Drive Physician Practice Financial Performance

While there are many factors that contribute toward bottom-line profit or loss in a Physician Practice, in a Fee-For-Service (FFS) environment there are several basic drivers of Physician Practice Revenue:

1. **Patient Volume** – Patients' access to Providers results in volume. Volume = Revenue. Increased volume yields increased wRVU Production and hence increased Revenue to the practice (and depending on Compensation Model) increased income to the Provider. Revenue generation is directly influenced by such factors as Provider Access, Patient Access and Patient Flow and is in large part under the direct control of the physician.
2. **Service Mix** – The types of services offered by Physicians to their patients results in Service Mix. Service Mix directly impacts wRVU Production and therefore Revenue generation. Getting "credit" for the maximum number of wRVUs appropriate for the service(s) rendered is critical to both Physician Compensation as well as Revenue generation for the organization. In both private and employed settings Service Mix is influenced by such factors as E&M vs non-E&M services, levels of E&M coding, etc.

3. **Revenue Cycle** – The organization's ability to bill for and collect payment for the services rendered by its Physicians is dependent upon the Physician, the Office Support Staff as well as the Central Billing Office. Factors such as timeliness and accuracy of coding and documentation, POS collections, insurance authorizations are all influenced by the Physician and are under the direct control of the Practice. However, in an employed setting claims submission, collection of reimbursements, etc. are generally under the direct control of the Central Business Office (CBO) and is out of the hands of the Physician.
4. **Payer Mix** – Payer Mix is the roster of third party Payers accepted by the organization. Organizations make strategic and often mission driven decisions to contract and participate with certain Payers. The level of reimbursement that is contractually agreed upon with each Payer ultimately determines the revenue associated with each service rendered by the Physician. In a private practice setting, the Physician owners have the power to choose what Payers they may or may not wish to participate with. However, in the employed setting, these are strategic decisions made by the organization. The employed Physician has no control over Payer Mix.

Non-Revenue Factors that Drive Physician Practice Financial Performance

1. **Patient Experience** – The overall Patient Experience drives Patient Satisfaction. Patient Satisfaction influences referral patterns. Referrals (including self-referral) are the life blood of any Physician Practice. Oddly, the Physician can often have their best efforts to offer a great Patient Experience dashed by other influences such as the behavior of the support staff, the condition of the office environment, CBO errors, appointment scheduling issues, etc. Therefore, although great Patient Experience should be Physician driven and lead by example, it can be very difficult to develop an equitable methodology that will fairly compensate the Physician based on Patient Experience. Having said this, great Patient Experience can indirectly lead to increased Revenue by way of increased referral volume resulting from satisfied patients and Referring Physicians.
2. **Quality** – The quality of services rendered is increasingly contributing to the success of Physician Practices. Quality Outcomes in the form of Outcomes Data (real) and impressions of Quality in the form of the Patient's Experience and Referring Physician opinion (perceived) can have a direct and significant impact on Practice Performance.
3. **Cost Saving Initiatives (ACO)** – With continuing growth of Value Based Care and "pay for value" reimbursement methodologies, comes increasing pressure to reduce the costs of care. Reimbursement Models that are centered around shared savings places particular emphasis on organizations to optimize quality outcomes, improve wellness while reducing costs and utilization of high dollar services. Physicians have historically earned volume based income. New incentives to drive up quality and drive down costs must be considered as an important component of compensation.
4. **Practice Expense** – The operating expense of the practice and overhead directly influences the financial performance of the Practice. This includes employing optimal support staffing levels, supply chain and supply utilization, rent, etc. Often in employed practices settings, a portion of hospital overhead is allocated back to the individual practice(s). In practice practices, such expense allocations do not exist. Further, the employed physician has no control over whether or how much expense may be artificially allocated back to the practice.

Compensate Based Upon ONLY What the Physician Can Control

Developing a Compensation Model that depends upon performance in areas that the Physician has little or no control over will only serve to negatively impact Patient Access, Practice Profitability and Provider Productivity/Compensation and Professional Recruitment & Retention to name a few. Here are the main compensation related factors that the Physician has direct involvement and control over in their practice:

1. **Patient Volume** – The Physician has the ability choose to be busy (perhaps really busy) or not. In a private practice setting, the Physician is *only* paid after all of the other expenses associated with his practice are covered (i.e. support staff, rent, utilities, supplies). In order to optimize practice performance, this private practice "eat what you kill" mentality must be replicated in the employed Physician Compensation Model. Physician Compensation can and should be directly influenced by how hard each provider works. Work harder should mean earn more.
2. **Service Mix & Clinical Documentation** – The Physician controls the Service Mix that they render to their patients. Simple things like scheduling (and being available to see) appropriate follow-ups, offering in-office and in-hospital procedures as is appropriate, generating a specialty appropriate ratio of E&M to non-E&M services, offering wellness exams, and other services, etc. influences wRVUs generated per encounter. Further, documentation that is not accurate and complete to maximize the wRVUs earned for each encounter, leaves money on the table and reduces cash collections. More wRVUs should mean more Compensation.
3. **Revenue Cycle** – Only certain aspects of the Revenue Cycle can be controlled by the Physician/Practice. These Physician/Practice controlled areas are: Timely and accurate provider documentation and coding, insurance authorizations & POS collections. Once again, in a private practice setting, the Physician does not get paid until the service is authorized, the chart is closed and the cash has been collected. All other aspects of the Revenue Cycle in the employed setting fall under the responsibility of the CBO and are out of the doctor's control.
4. **Quality** – Meeting or exceeding key organizational quality metrics and reporting requirements can indirectly impact organizational financial performance in the form of Payer Incentives or Penalties. While this in not a productivity related impact, the Physician should and does have great influence over performance related to Quality metrics.

Basic Compensation Model Components

Busier private practice Physicians earn more money. This is true in both solo provider practices as well as in group settings. Further, Compensating based on an "eat what you kill" philosophy can instill a competitive dynamic as well as remove any perceived unfairness in compensation levels among providers. Busier employed providers earn more money too. Replicate this private practice model in the employed practice setting.

In a dynamic environment, private practices can sometimes be viewed as unstable. Many Physicians often become employed seeking the stability of a "regular pay check". Steps should be taken when designing a compensation model that help to mitigate large fluctuations in income (i.e. offer sought after stability) yet incent and compensate Physicians for increased productivity. It is recommended that as a general rule no more than 50% of total income should be "guaranteed" in the form of a base salary or other guaranteed income. As a result, in the absence of other non-production performance incentives (quality, etc.) up to 50% of total compensation can be attributable to productivity. Further, in order to maximize

the incentive to work harder, productivity related compensation must be paid frequently. Even waiting to the end of a quarter to pay a quality related bonus to the doctor is too late. Effective production incentives requires near instant real-time gratification.

Note: If the organization is in the early stages of transitioning from straight salary (guaranteed income) Compensation Arrangements, it is recommended that a new Compensation Model be introduced that addressed productivity only. Quantum leaps from straight salary to production plus quality and other incentives makes for a very difficult transition for existing employed providers.

Good Compensation Models must align Organizational incentives with that of the Physician. More wRVUs => More Revenue => More Physician Compensation. wRVUS are generated from both incremental volume as well as the number wRVUs per encounter. Services Mix and coding levels drives wRVU generation per encounter. Work together with Physicians to maximize coding levels to the highest level of specificity appropriate for the services rendered. Compensation Models should include a means of tying Physician income to meeting / exceeding organizational quality metrics and performance standards. Generally 5% to 10% of total compensation can be tied to non-production related metrics (i.e. quality incentives). Compensation for such metrics should take into account the organization's ability to measure and track such metrics on a timely basis. Steps must be taken to integrate compensation for Production and Non-Production Incentives into a uniform Model. One such method is to create a Non-production Incentive in the form of an addition per wRVU Conversion Factor enhancement that is applied once key thresholds have been met by the Physician.

Compensation for Other than Clinical Production Related Activity

In a private practice setting, physicians undertake non-clinical activity on their own time. That is, the business of operating their practice takes place in addition to the necessary clinic work required to cover their practice overhead and generate the Physician's desired market wage. No protected time for Committees, Meetings, Directorships, etc. In both private practice and in employed settings, non-clinically productive activities negatively impacts provider productivity. Therefore, if we expect toe employed provider to perform like a private practicing provider, it will be necessary to offer other streams of compensation to offset any other obligations that the organization might place upon its employed Physicians. These other activities may include: Leadership Stipends, Directorships, Call Compensation, etc. The duties, responsibilities and time commitment(s) and any associated compensation should be clearly memorialized in either the Physician Employment Agreement or in a separately executed Agreement. Note: Compensation such as this is subject to conforming to FMV.

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