benevera health

Physician Compensation in a Value-Based Care Environment

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The Changing Landscape of Physician Compensation

As organizational reimbursement structures migrate from traditional fee-for-service to risk-based models, physician compensation frameworks must follow suit. When overlooked, the misalignment between organizational reimbursement and physician compensation is likely to cause physician dissatisfaction while adding strain on the organization to successfully meet quality initiatives. This document provides an overview of different physician compensation models, why compensation needs to change as health systems transition to value-based payment models, the building blocks of compensation models, and a how-to guide for health systems to redesign compensation. The discussion and recommendations in this document are aimed at primary care practices and at PCP's with panels, in particular.

Compensation Models

Historically, four common payment models have been used to calculate physician compensation.[1] While each carries pros and cons, a new model must be realized in order to thrive in a value-based care environment.

Payment Model	Pros	Cons
Straight Salary	-Easy to administer -Predictable Income	-Limited individual performance accountability -Difficult to affect behavior change -Dissatisfying to hard working physicians
Equal Share	-Easy to administer -Discourages overutilization	-Assumes like-performance -Dissatisfying to physicians
Productivity (wRVUs)	-Encourages / rewards extra effort	-Not aligned with new payment models -More difficult to calculate -Creates competitive productivity
Capitation	-Rewards efficient care	-Dependent on market factors -Waxing and waning of annual income

Figure 1. Payment Models. AAP, 2018.

Value vs Volume

Organizations that successfully transition to value-based care must redesign physician compensation to shift focus from patient to population, fee-for-service to shared savings, treatment to prevention, and siloed to integrated care.[2]

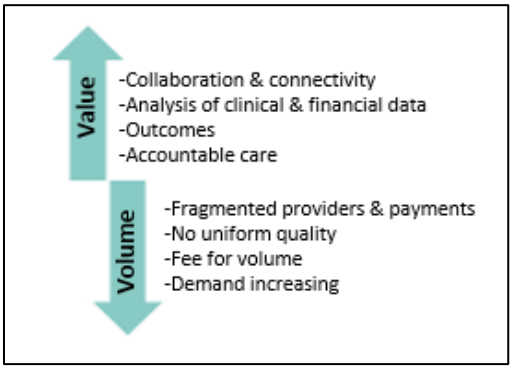


Figure 2. Value vs Volume.

As organizations and providers enter into risk agreements and migrate toward medical home and interdisciplinary care models, the divergence between old and new physician compensation models continues to expand.

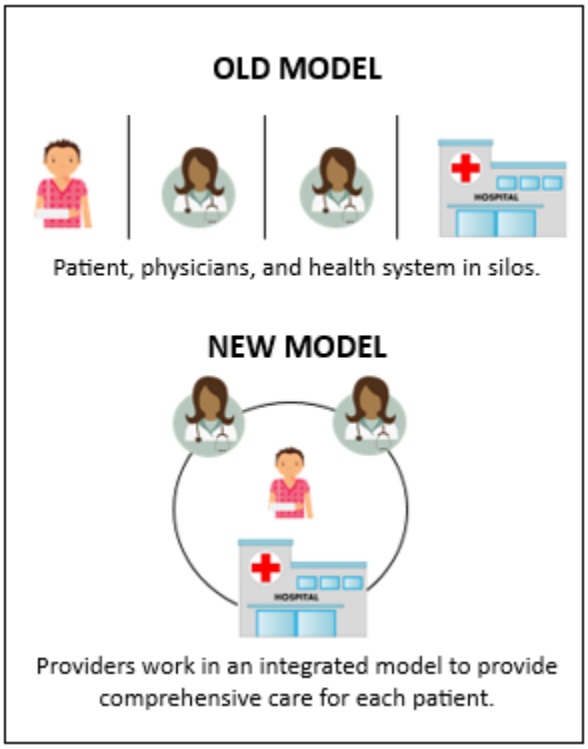


Figure 3. Model Comparison

Align Compensation with the Strategic Mission

The need to align physician compensation with the organizational strategic mission is threefold and aims to:

- Position the organization to achieve quality metrics used in determining reimbursement
- Incentivize and reward physicians to work toward quality over quantity and value over volume
- Avoid reimbursement penalties for overutilization of care and poor patient outcomes as a result of risk contracts

Compensation Redesign

Compensation should include the four major traditional domains of production, citizenship, access, and quality and may be tied to successful performance at either the domain or sub-domain level (see figure 4). In addition, compensation models in a value-based environment should include a fifth population health domain. It is important to note that there is no one-size-fits-all solution and compensation ratios should be tailored to specific organizational needs. Aligning compensation with initiatives that meet organizational priorities will yield the best gain for the organization, such as compensating for performance metrics tied to participation in risk-based contracts. Below are examples of elements within the domains.

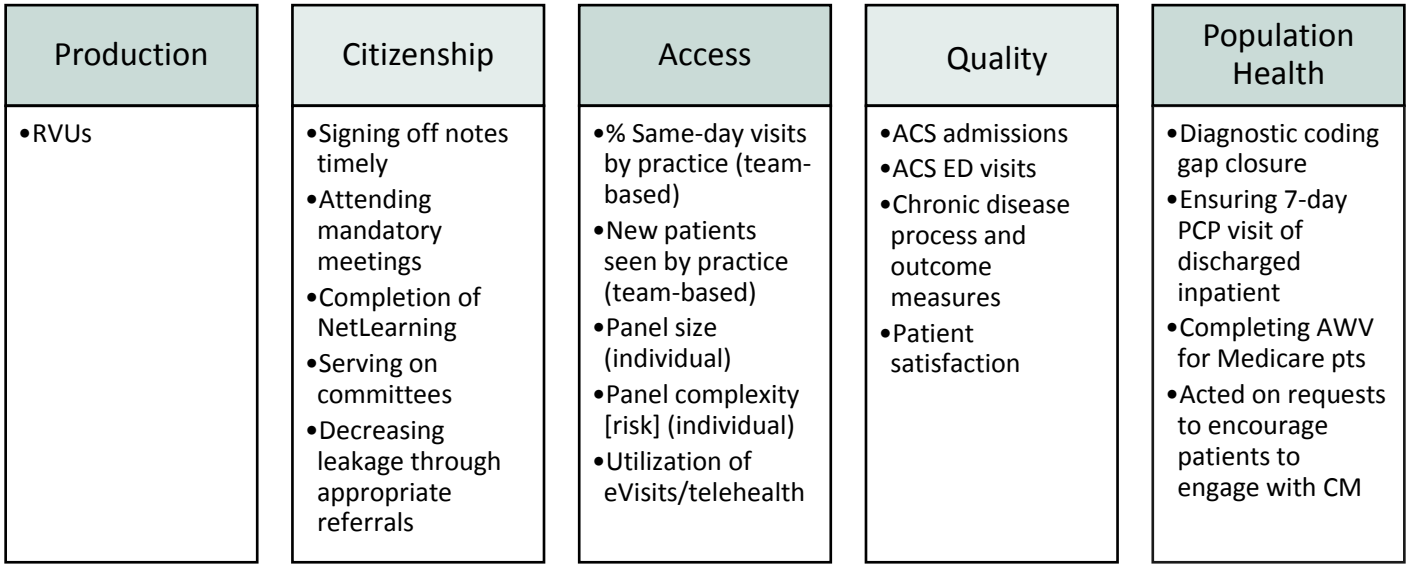


Figure 4. Compensation Domains.

Key points:

- In the early phases of compensation redesign, it is recommended to incrementally shift current payment ratios from primarily production (RVU-based) to quality and population health activities (outcomes-based).
- Choosing a small number (3 – 6) of measures that are mission-critical, easy to report on, and have readily-available data is preferred.
- Compensating providers for specific population health tasks is often an important initial element of the transition as it provides immediate reward linked to the new desired work and ways of thinking. In later stages, these activities become routine expectations, and no longer need specific compensation tied to them.
- For some elements, it is recommended to have a measurement-only period to fine-tune calculation methodologies and ensure the new approach is non-punitive for physicians.[5] During this period, some compensation can be linked to engagement on quality measures (reviewing reports, providing feedback, working on process changes) rather than on performance.

- Productivity-based compensation should take panel size and risk profile into account in order to encourage team based care of complex patients and management of populations rather than only rewarding office visits.
- The compensation model for the whole practice team (medical assistants, nurses, schedulers, coordinators, etc.) must be aligned with the model for the physicians in order for it to succeed.

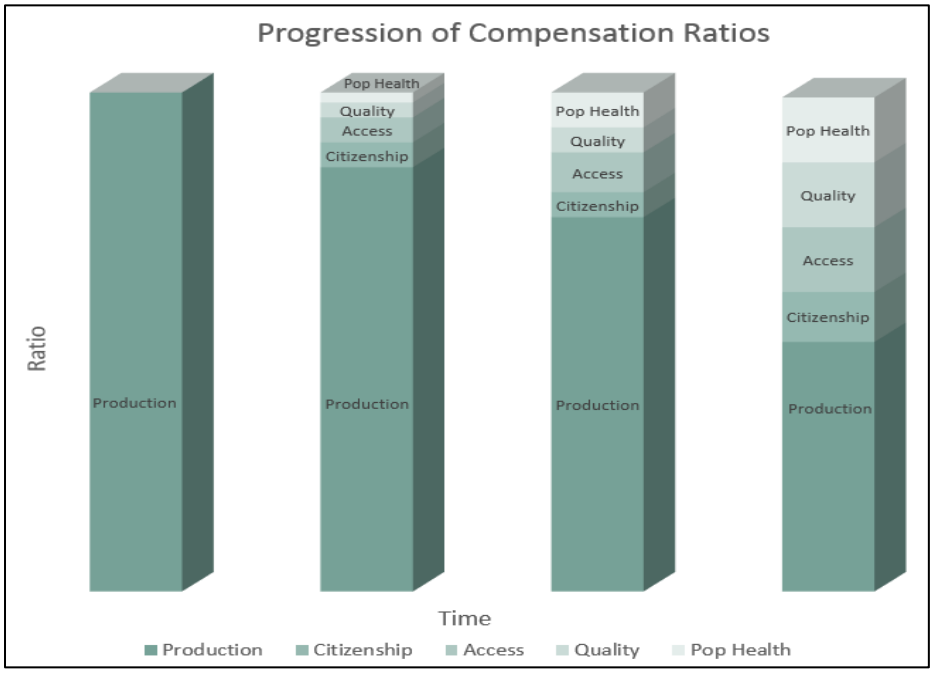


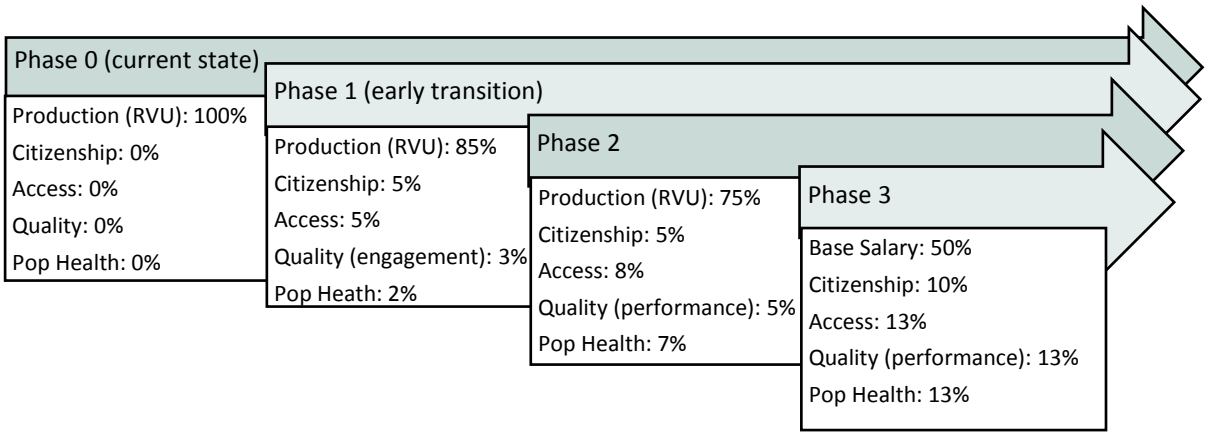
Figure 5. Compensation Progression.

Note that as an organization's reimbursement through risk agreements reaches or exceeds 50%, it is recommended that the production (RVU) portion of compensation be converted to a base salary, adjusted for risk-adjusted panel size, while continuing to compensate for quality, citizenship, and access.[6]

As with any organizational process, it is critical to implement a strong control plan to ensure ongoing success. As risk agreements evolve and change, compensation ratios and metrics must be re-aligned to position physicians and the organization for long-term success.

Compensation Model in Practice

Memorial Hospital embarked on a physician compensation redesign process as they began to take on more risk-based contracts and participate in a Medicare ACO. The goal of the redesign was to encourage primary care providers to focus



on management of their population of patients. Prior to the compensation redesign, Memorial Hospital primary care physicians were paid on an RVU basis, encouraging them to see as many patients as possible. The new compensation model was rolled out as follows:

Figure 6. Compensation Structure Rollout.

The migration away from production-based reimbursement should occur in phases which are set based on organizational priorities. Specific timelines will vary.

Getting Started

There is no single approach that can be prescribed for all health systems. Organizational leaders must engage in an in-depth exercise to evaluate the strategic mission, current and future potential risk agreements, and resources available to align, guide and develop the compensation redesign roadmap.

The following steps are intended to assist organizations navigate through the development and implementation process:

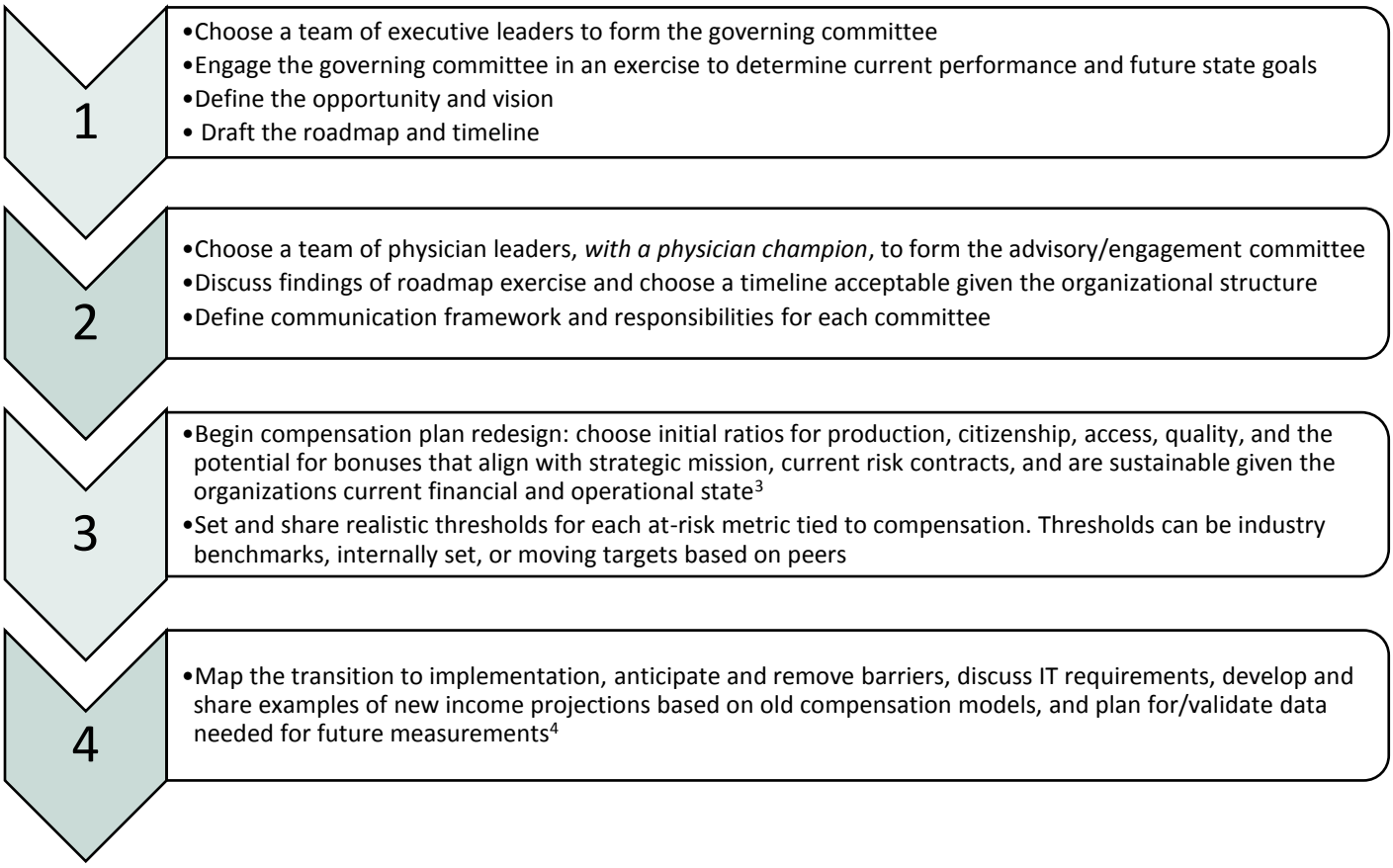


Figure 7. Implementation Roadmap.

The average timeline for steps 1 – 4 is 12 months and can be tailored to meet individual health system needs. To ensure success, it is critical to assign a physician champion to the advisory committee as early in the process as possible. The physician champion will be responsible for leading the group as well as communicating, advocating, and engaging fellow physician colleagues throughout the organization. Transparent communication regarding finances, operations, reporting, and future state goals are crucial to a successful implementation.

References

1. American Academy of Pediatrics. Physician Compensation Models. 2018.
2. Stech, D. & Gilfillan, K. Developing Effective Physician Compensation Plans. November, 2016.
3. AGMA Consulting. Physician Compensation Plan Design at Roper-St. Francis Physician Partners. March, 2017.
4. The Advisory Board. Get the Solution for Physician Compensation. September, 2017.
5. Deloitte. Connecting the Doc's: Compensating Physicians for Value, not Volume. August, 2016.
6. Floyd, P. Roadmap for Physician Compensation in a Value-Based World. September/October 2014.