HEALTH CARE REIMBURSEMENT IS RAPIDLY evolving from primarily fee-for-service to value-based, risk-sharing accountable care contracts. Health systems with employed physicians primarily paid on productivity-based compensation plans face the challenge of aligning their physicians’ financial incentives with the new market requirements for quality, outcomes and patient experience.

Health systems will need to migrate their employed physicians and owned practices as soon as possible to compensation plans that support the “Triple Aim” of improved population health, better patient engagement and lower per capita costs. Productivity will continue to be a factor in the near term since the transition to risk-sharing contracts will be gradual, but there is no question that value-based contracts are the preferred business models of the future.

It will prove difficult to impossible for health systems whose employed physicians are still compensated primarily on the old fee-for-service paradigm to successfully participate in these types of arrangements unless their employed physician compensation model is significantly realigned. In addition, a failure to align compensation incentives with the goals of reform may increase the risk of penalties for overutilization of acute care or diagnostic services that may be encouraged by the old volume-based practice mindset.

This is especially important for employed primary care physicians. These physicians will play the most critical role in the clinically integrated networks as primary team leaders to manage the transition to accountable care and population health management.

SALARIED EMPLOYMENT TO PRODUCTIVITY — The wave of physician employment in the early 1990s failed in large part due to guaranteed compensation models coupled with a lack of expertise in physician practice management. Direct hospital system employment of physicians all but disappeared a decade later as executives grew concerned about the poor productivity of their employed (and usually salaried) physicians and spun them back into private practice.

During the past decade, the pendulum has swung back to hospital-based employment with over 50 percent of physicians now employed directly or in practices owned by hospitals.
and health systems. This time, however, the vast majority of hospital-employed physicians have some type of productivity-based compensation model based on work relative value units (wRVUs), gross charges, net charges or net revenues. Very few have a salary-only model as demonstrated in Figure 1.

Employed-physician compensation models based primarily on productivity are now lagging payer reimbursement changes.

For example, the Affordable Care Act expands pay-for-performance (P4P) with hospitals through the Medicare Hospital Value-Based Purchasing Program that began last year, and it also expands the Physician Quality Reporting System (PQRS) program through 2014 (although it will move from a bonus to a reduction in payments in 2015). Commercial payers are following the example of Medicare with P4P and shared-savings trials.

Although there is a bit of exaggeration in Case Study #1 (see sidebar), if it rings true to you in any way, it is time to start the alignment of your health system strategy and your employed-physician compensation.

Compensation models that are primarily volume-based must transition to performance-based plans that reward patient outcomes and efficiencies. Let’s examine a six-step process to help your health system navigate the complex road to a new physician compensation plan. The journey should be deliberate and steady and before long, your group’s story will be similar to the progress and success of Case Study #2.

PHYSICIAN COMPENSATION STRATEGY — The key strategy for physician alignment for the past 10 to 15 years has been to acquire and employ physicians to ensure that services provided by these physicians or practices remain in the system and are not acquired by a competitor.

The primary concern has been keeping the physician productive, and that becomes the basis of the compensation plan. There has not been a need to organize these employed physicians with a formal governance structure, leadership team or consistent practice policies. Times have changed, and now the system needs a high-performing medical group — not a diverse collection of employed practices that are all “doing their own thing” under various compensation plans.

The employed medical group must exemplify a model of team collaboration not required previously. Compensation is a key driver of a culture of collaboration that will only happen with a fair and equitable physician compensation plan that has defined principles and a consistent methodology for the entire employed medical group.

Many systems use an ad hoc approach to contracting and compensation for their employed physicians. A common scenario is a member of the legal staff and an administrative leader of the employed physician group being accountable for negotiating and contracting with physician employees.

This often leads to a nonstandard approach as physicians generally “hear” about the contracts currently in place and try to “one-up” their colleagues with a slightly better deal leading to more inconsistency in physician contracts and compensation plans for the hospital system.

IN 2008, YOU EMPLOYED A CARDIOLOGY group that successfully negotiated for a five-year productivity-based contract with an RVU rate above market median. In 2009, you hired the busiest orthopedic surgeon on your staff with a productivity-based contract since you wanted him to be motivated to remain busy and provide operating room volume and improved patient access.

It is now 2013, and market reform is moving your payer contracts from volume- to value-based reimbursement more quickly than you had anticipated. The system has applied to be a CMS Shared Saving site, and discussions are in place with the largest payer to do a shared savings contract with a quality score as an entry gate.

Your cardiologists are consistently producing at the 90th percentile, which results in each of them taking home compensation that is 20 percent higher than their independent practice colleagues so there is tension at the division meetings and little interest in collaborating on quality initiatives.

Your supply chain director is complaining because he can’t persuade the cardiology division to choose just one or two stent vendors, the door to balloon time is at the 25th percentile and the cath lab director is frustrated with the cardiologists not starting procedures on time 50 percent of the time.

The orthopedic surgeon is now making more than the CEO, as last year he produced 28,000 RVUs — almost twice the 90th percentile — which resulted in pre-tax compensation of $1.4 million. Patients complain about office wait times and him spending only a few minutes with them, which is true since he schedules 65 to 70 patients per day when he is in the office.

His practice’s poor patient satisfaction scores reflect this issue, but patients have few options and efforts to add another orthopedic surgeon have been rebuffed by the busy physician because he enjoys his high income level and there are no consequences related to his poor access.

Contracts are expiring this year for both cardiology and orthopedics. How can the compensation models be transformed to align to the health system’s strategy?
CHANGING COMPENSATION

1. CREATE A PHYSICIAN COMPENSATION COMMITTEE — The first step to creating a consistent compensation methodology is establishing a physician compensation committee.

Typically in a not-for-profit health system, this committee includes physician leaders whose compensation is not affected by the medical group’s compensation plan (such as the chief medical officer who is salaried as a system executive), an executive from human resources, a senior member of the legal department and the director of physician compensation (or if this is not a current position, the director or VP of compensation and benefits).

This group will evaluate the physician compensation market, review options and then approve the physician compensation plans and policies. To assure physician input in the design, a second committee is needed — the physician compensation advisory committee — consisting of physician leaders from the medical group.

This second group advises the physician compensation committee and not only provides valuable input into the design but members become the physician compensation “experts” in the medical group to help with communication and adoption of the new model.

Both committees should start with education sessions on physician compensation market data, regulatory issues related to achieving fair market value and the options in physician compensation models.

2. ESTABLISH A FLEXIBLE COMPENSATION PLAN — The first item of business for the compensation committees is to inventory the current plan models and the resulting compensation and then compare the results to the market. For regulatory reasons, it is prudent to use a blend of three or more national physician compensation surveys to determine the current market.

The physician compensation committee will then need to research compensation model options and decide how to best move the employed physician group to a more consistent plan that is fair, equitable (especially inside a specialty), aligned with system goals and easy to administer.

Although it sounds simple, trust will build with the physicians related to their compensation if they can easily understand the plan methodology, there is frequent communication and reporting of data and compensation is paid in a timely, consistent and accurate manner.

In view of current changes in provider payment reimbursement, the new compensation plan will need to be capable of evolving over time. As recently outlined in a report from the National Commission on Physician Payment Reform, fee-for-service reimbursement where physicians are reimbursed for each service they provide has added to the high cost of care and needs to move to reimbursement based on outcomes.

The physician compensation plan should also parallel this payer reimbursement change by having the physicians being paid increasingly on clinical outcomes and efficiencies in care. The “elephant in the room” is that the physician compensation

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### FIG 2

**Elements of Compensation**

<table>
<thead>
<tr>
<th></th>
<th>PCP Compensation in Current Volume-Based Reimbursement World</th>
<th>PCP Compensation in Future Value-Based Reimbursement World</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity</td>
<td>4864 RVUs*</td>
<td>Panel of 2500 patients</td>
</tr>
<tr>
<td>Compensation Rate</td>
<td>$41.00</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Productivity-Based Compensation</td>
<td>$199,424</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Guaranteed Salary</td>
<td>none</td>
<td>$136,924</td>
</tr>
<tr>
<td>Incentive-Based Compensation</td>
<td>$7,500</td>
<td>$60,000</td>
</tr>
<tr>
<td>For Service Quality</td>
<td>$2,500</td>
<td>$10,000</td>
</tr>
<tr>
<td>For Clinical Quality</td>
<td>$5,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Per-Patient Per-Month Management Fee</td>
<td>none</td>
<td>$4.00 (x 2500 patients)= $10,000</td>
</tr>
<tr>
<td>Total Compensation*</td>
<td>$206,924</td>
<td>$206,924</td>
</tr>
</tbody>
</table>

* Based on 2012 MGMA median for family medicine.

### FIG 3

**HIERARCHY OF OUTCOMES MEASURES THAT MATTER TO PATIENTS**

<table>
<thead>
<tr>
<th>Tier</th>
<th>Description</th>
<th>Outcome Measurement Examples</th>
</tr>
</thead>
</table>
| Tier 1 | Health Status Achieved or Retained (survival, degree of health or recovery) | Mortality rate  
Functional level achieved  
Ability to return to work  |
| Tier 2 | Process of Recovery (time to recovery, disutility of care or treatment process) | Time to return to work  
Occurrence of deep vein thrombosis  
Occurrence of myocardial infarction  |
| Tier 3 | Sustainability of Health (recurrences, long-term consequences) | Maintained functional level  
Presence of regional pain syndrome  
Susceptibility to infection  |
The cultural emphasis in this country, based primarily on volume of productivity, has encouraged overuse of surgery, office visits and testing with no accountability for outcomes and efficiency.

Current models are primarily productivity based; in the near future, productivity needs to be only one component of a more complex plan of base salary and incentives that will improve outcomes as well as “bend the cost curve.”

In a recent article in Harvard Business Review, Michael Porter and Tom Lee discuss the movement to value-based payer reimbursement: “The transition will be neither linear nor swift, and we are entering a prolonged period during which providers will work under multiple payment models with varying exposure to risk.”

The move to a model of salary-plus performance-based compensation does not happen overnight.

3. Build your primary care plan — In an environment of new payer reimbursement models and new clinical models of care, the primary care physician’s world is changing the most. As primary care physicians move to a team-based, coordinated care model with patient-centered medical homes and medical neighborhoods, the need to eliminate productivity-based compensation models is most acute.

The compensation model for primary care physicians should promote “teaming” and outcomes, not independence and volume. To achieve good outcomes, primary care physicians will need to work proactively with the patient and specialists to coordinate care.

These required changes in the care model are compatible with the findings of a report from the National Commission on Physician Payment Reform that concluded that two of the reasons for the high level of expenditures in our health care system are:

1. Reliance on technology and expensive care.
2. A high proportion of specialty care.

Coordination and new models of care by primary care physicians will improve the value for patients, and the compensation plan for the primary care physician needs to support these changes.

To promote the focus on coordinated team care and chronic disease management, compensation plans for primary care physicians should include:

- A guaranteed salary based on years of experience.
- Incentives for access, clinical quality, service quality, efficiency, productivity and citizenship.
- A panel management fee.

Progressive Medical Group — (the employed physician group of a major health care system) developed a successful productivity-based physician compensation plan as the group grew from 50 members to several hundred in the late 1990s and early 2000s.

The group changed from using gross charges to modified RVUs as the measure of productivity as the data for RVUs became more robust in 2003 and added a small incentive for patient satisfaction.

The group introduced more robust incentives for primary care initially and then all of the specialties in the years 2005 through 2007. The initial metrics for primary care included diabetes care (measurement of a hemoglobin A1c twice per year), access (third next available of <7 days for well care), mammography rates and childhood immunization rates.

In 2010, in anticipation of becoming a CMS Shared Savings site, the group added a panel management fee for each patient in the primary care physician’s panel and increased the size of the incentive to 20 percent of the compensation while also increasing the number of clinical and efficiency incentives.

Both the panel management fee and the incentive payments are paid in addition to market-based compensation with the goal of total compensation being at the 65th percentile for primary care physicians whose productivity is at the 50th percentile of market data and who have excellent performance on the quality and efficiency incentives.

The group has achieved PCMH certification at all PCP sites and has hired nurse practitioners and RN care managers to form care teams in preparation for increased risk. Primary care physician satisfaction, as well as quality and efficiency performance, has improved in the past four years.

*Pseudonym
There is an opportunity to develop compensation incentives related to referral management of care for PCSP, there is an opportunity to develop compensation incentives related to referral management of care for PCSP certification.

Specialty divisions should work with the physician compensation committee to develop specialty-specific quality, cost and service metrics.

However, the new compensation plan needs to have enough overall consistency in methodology and philosophy that the physicians have confidence in the process and the data. The compensation plan should help to create a unified medical group culture, not a culture of constant disruption.

In 2012, Health Affairs published an article that described the Geisinger Health System’s compensation model for its employed physicians. The components of the plan are outlined in Figure 4.

Although there is still a significant percentage of the physician’s compensation determined by his/her productivity, “if physicians produce work RUVs that place them at even higher percentiles for their specialties, they can earn modest incremental increases that at a maximum are less than 1 percent of total compensation” so there is not unlimited income potential from productivity.

At 20 percent of the total compensation, the metrics for the incentive portion of the compensation plan change as needed to align the physician with the system goals. As a result of this compensation model, the system has experienced sustained reductions in costs, improved outcomes with patients served by PCMHs in the employed primary care practices as well as improved recruitment and retention rates of physicians — all done while being reimbursed primarily on a fee-for-service basis by payers but moving forward with a progressive physician compensation plan.

5. MAINTAIN CONTINUOUS COMMUNICATION — It is important to communicate and involve your employed physicians in the changes required of their practices from health care reform and changes in payer reimbursement. You need their input and their willingness to change clinical care models to help you cross the “crevasse” from volume to value.

This topic is top of mind for most hospital administrators but many physicians have been so engrossed in the day-to-

<table>
<thead>
<tr>
<th>Elements of the Plan</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geisinger Primary Care Physicians</td>
<td>%</td>
</tr>
<tr>
<td>Base Salary*</td>
<td>78.5%</td>
</tr>
<tr>
<td>Participant in PCMH</td>
<td>8%</td>
</tr>
<tr>
<td>Incentive Bonus</td>
<td>13.5%</td>
</tr>
<tr>
<td>Quality—60%</td>
<td></td>
</tr>
<tr>
<td>Financial—34%</td>
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</tr>
<tr>
<td>Citizenship (teamwork)—6%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elements of the Plan</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geisinger Specialty Care Physicians</td>
<td>%</td>
</tr>
<tr>
<td>Base Salary*</td>
<td>80%</td>
</tr>
<tr>
<td>Incentive Bonus</td>
<td>20%</td>
</tr>
<tr>
<td>Quality—40%</td>
<td></td>
</tr>
<tr>
<td>Innovation—10%</td>
<td></td>
</tr>
<tr>
<td>Legacy (edu &amp; research)—10%</td>
<td></td>
</tr>
<tr>
<td>Growth—15%</td>
<td></td>
</tr>
<tr>
<td>Financial—25%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Salary is determined by experience, specialty market rate and whether past performance is consistently above or below expected productivity based on work RVUs.
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day aspect of their practice that they do not understand the implications of reform and the care model changes that will be required in the new world of coordinated care in which outcomes are the basis of reimbursement.

Communication can take the form of large “town hall” educational lectures by experts in the field or small practice meetings that allow more questions. Hospital administrators should be transparent with their employed physicians about the multiple pressures that are decreasing revenue streams, the new world of measurement that is driving the need to focus on improvements in quality outcomes and efficiencies of care that require a change in the compensation model.

6. MOVE TO MORE PERFORMANCE-BASED COMPENSATION
—The move to a model of salary-plus performance-based compensation does not happen overnight. As the medical group or health system begins to increase the percentage of value-based contracting, the game changes and there will be more emphasis on the cost savings and quality metrics that should be strategically linked to the payer contracts, as well as the health system quality and safety goals.

As the value-based reimbursement grows to 25 percent or 30 percent, the percentage of the physician’s compensation plan based on performance-based incentives also needs to increase proportionately. At this level of value-based incentive, most systems will still keep a significant portion of the physician compensation based on productivity to ensure that physicians have a desire to remain busy and that primary care physicians continue to grow panels (an important need for later capitation.)

When the group moves to a position where the majority of revenue (> 50 percent) is from value-based contracts or full capitation, the physician compensation is best managed with a base salary model determined by the physician’s experience and specialty and a performance-based incentive plan that is 30 percent to 40 percent of the overall compensation.

This incentive can include a portion based on productivity (to ensure the volume of patients in the group is adequate and growing) and the remainder should be based on numerous quality outcomes and efficiency metrics that are aligned with the system’s strategy.

By this time, the group will have the processes in place to report the quality, efficiency and productivity data to the physicians in a timely and accurate manner as well as the processes to administer the incentive payments on a quarterly or semiannual basis. With the improved communication plan, the employed physicians should be well-versed in the strategy and goals of the health system at this point and comfortable with the culture of measurement and transparency.

Figure 5 is a graphic representation of the changes in the compensation plan as the value-based reimbursement increases.

For systems that are not yet involved in value-based contracting, adding a pay-for-performance incentive plan is still a good way to start the transformation from productivity only to salary-plus incentives. Many physicians have not seen data on their own clinical or utilization performance or those of their peers with their current productivity-only model.

Starting an incentive plan, even if you are currently in a fee-for-service world, is a good opportunity to allow the physicians to become accustomed to measurement, data and transparency. It will also engage the physicians in process improvement efforts and system strategy goals.

The goal of the physician compensation plan is to encourage and support a transformation of care that leads to improved health of the patient population and outstanding organizational performance in a value-based environment.

The challenges of paying for outcomes instead of volume are many but a deliberate, steady and evolving approach will allow an employed medical group to transition to a compensation plan that is aligned with value-based reimbursement from payers and supports the strategic goals of the organization. This change in physician compensation culture must start now.

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REFERENCES