Physician Compensation Structures:

Trends and Techniques

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Introductions

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Agenda

+ Overall compensation trends
+ Call pay structure and trends
+ Administrative pay structure and trends

Employment: Productivity-Based Compensation Structure

- Hospital employed - most often wRVU-based, inclusive of –
  - Base compensation
  - Productivity incentive “greater of”
  - Specialty-driven compensation per wRVU conversion factor
- Independent practice – most often net collections based
- Allows opportunity for “add-ons” –
  - Call pay
  - Administrative/medical directorship pay
  - Value-based incentives

Employment: Productivity-Based Compensation Structure Incentives and Disincentives

- Hospital employed
  - Incentivizes productivity
    - Productivity is aligned with compensation
  - Disincentivizes physicians from performing administrative duties
  - Disincentivizes physicians from facilitating recruitment
  - May lead to over coding/overusing
  - Physicians may not help control practice operational expenses

Employment: Productivity-Based Compensation Structure Incentives and Disincentives

- Independent
  - Incentivizes productivity
    - Productivity is aligned with compensation
  - Disincentivizes physicians from performing administrative duties
  - Disincentivizes physicians from facilitating recruitment
  - Physician may micromanage practice to “game” expense allocations
  - Physician penalized if payer mix is not ideal or revenue cycle is inefficient

Employment: Productivity-Based Compensation Structure Pitfalls to Avoid – Hospital Employed

- Stacked compensation – must be fair market value and commercially reasonable
- Determination of wRVUs
  - Modifier and MPPR adjusted
  - APP impact
  - 2021 MPFS Proposed Rule
- Base compensation high with no productivity floor
- Productivity-based not aligned with how physician works
- Quality incentives not measurable / meaningless
- No built-in call coverage requirement

Employment: Productivity-Based Compensation Structure Pitfalls to Avoid – Independent Practice

- Allocation of overhead
- Administrative compensation not considered
- DHS revenue distribution
  - Evenly
  - By wRVUs
  - By E/M
  - By ownership percentage
- Consideration of senior physicians
- Short-term disability, maternity, medical leave considerations
- Quality incentive/penalty consideration

Employment: Straight Salary Compensation Structure

- Gaining popularity because of its simplicity
- Opportunity for “add-ons” is more limited (adds complexity) -
  - Call pay often embedded with requirement established in advance
  - Administrative/medical directorship pay included and not separate
  - Value-based incentives
- Incentivizes role

Employment: Straight Salary Compensation Structure Pitfalls to Avoid

- Hospital employed – must be fair market value and commercially reasonable
- Components sum to the whole
- Annual documentation and analysis
  - Role fulfilled as designed?
- Physician “reward” is delayed
- Fewer opportunities for adjustment

Employment: Shift Based Compensation Structure

- Works best with hospital-based specialties
- Additional compensation -
  - Extra shifts
  - Add-on differentials
  - Administrative/medical directorship pay
  - Value-based incentives
- Incentivizes role/coverage

Employment: Shift Based Compensation Structure Pitfalls to Avoid

- Hospital based – must be fair market value and commercially reasonable
- Lack of standardization
- Poorly defined minimum work standards
- Differential “menus”/complexity
- Value-based incentive – group vs. individual

Employment: Hybrid Compensation Structure

- Works best with hospital-based specialties
  - Adapts to the way the physician works daily
- Elements of shift-based and productivity-based models
  - Base shift rate plus productivity incentive based on wRVUs (or ASA units)
- Additional compensation -
  - Add-on differentials
  - Administrative/medical directorship pay
  - Value-based incentives
- Incentivizes role/coverage/productivity

Employment: Hybrid Compensation Structure Pitfalls to Avoid

- Hospital based – must be fair market value and commercially reasonable
- Poorly defined minimum work standards
- Impact of APP on productivity
- Differential “menus”/complexity
- Value-based incentive – group vs. individual

Co-Management Structure

- Elements include -
  - Hospital/health system + independent physicians (one group or many groups)
  - May or may not necessitate the formation of a separate entity
  - Co-management of an entire service line (administrative pay) plus incentives for clinical quality metrics (quality pay)
  - Most often occurs when hospital/health system does not have solid integration in a particular service offering
  - Most likely service lines: cardiology, orthopedics, urology
  - Incentivizes integration without employment

Co-Management Structure - Pitfalls to Avoid

- Poorly defined administrative duties
  - Duties not necessary
  - Too many hours
  - Physician involvement not required
- Poorly defined quality metrics
  - Too many/too few
  - Complex or inability to measure
  - Payouts without improvement
- Overly complex allocation structures
- May be more difficult to assess fair market value and commercial reasonableness

PSA Structure

- Elements include -
  - Hospital/health system + independent physician or independent group
  - Types of PSAs vary widely
    - Most often: hospital-based coverage models
  - Occurs to fill a service need
    - Turn-key arrangements
  - Incentivizes integration without employment

PSA Structure - Pitfalls to Avoid

- Poorly defined structure
  - Administrative
  - Clinical
  - Quality incentives
- Lack of reconciliation or support for financial assistance
- Over or under assessment of benefits, malpractice insurance, and overhead expenses

Compensation Trends - Overall

- More consideration for quality incentives
  - Bonus only vs. at-risk
  - Bundles
  - Primary care/panel management
  - Well-designed metrics (real work vs. busy work)
- Simple, yet customized
  - Recognition of work-life balance
- Telemedicine
- External impacts
  - COVID-19
  - 2021 MPFS Proposed Rule – potential long-term market adjustments
- Recognition of APP impact on physician productivity

Call Pay – Structures and Trends

- Well-defined call panels and understanding of need
- Payment for excess call only
- Fewer agreements with indigent care add-on
- Concurrent panels/multiple locations
- At-risk component for engagement and quality milestones

Administrative Pay – Structure and Trends

- Understanding of need
  - Cannot use administrative pay to "make a physician whole"
- Documentation of hours worked and effort
- Annual performance reviews
- Physician executives
- At-risk component for engagement and quality milestones

Questions?