Rethink Big

Comprehensive compensation redesign in a value-based world

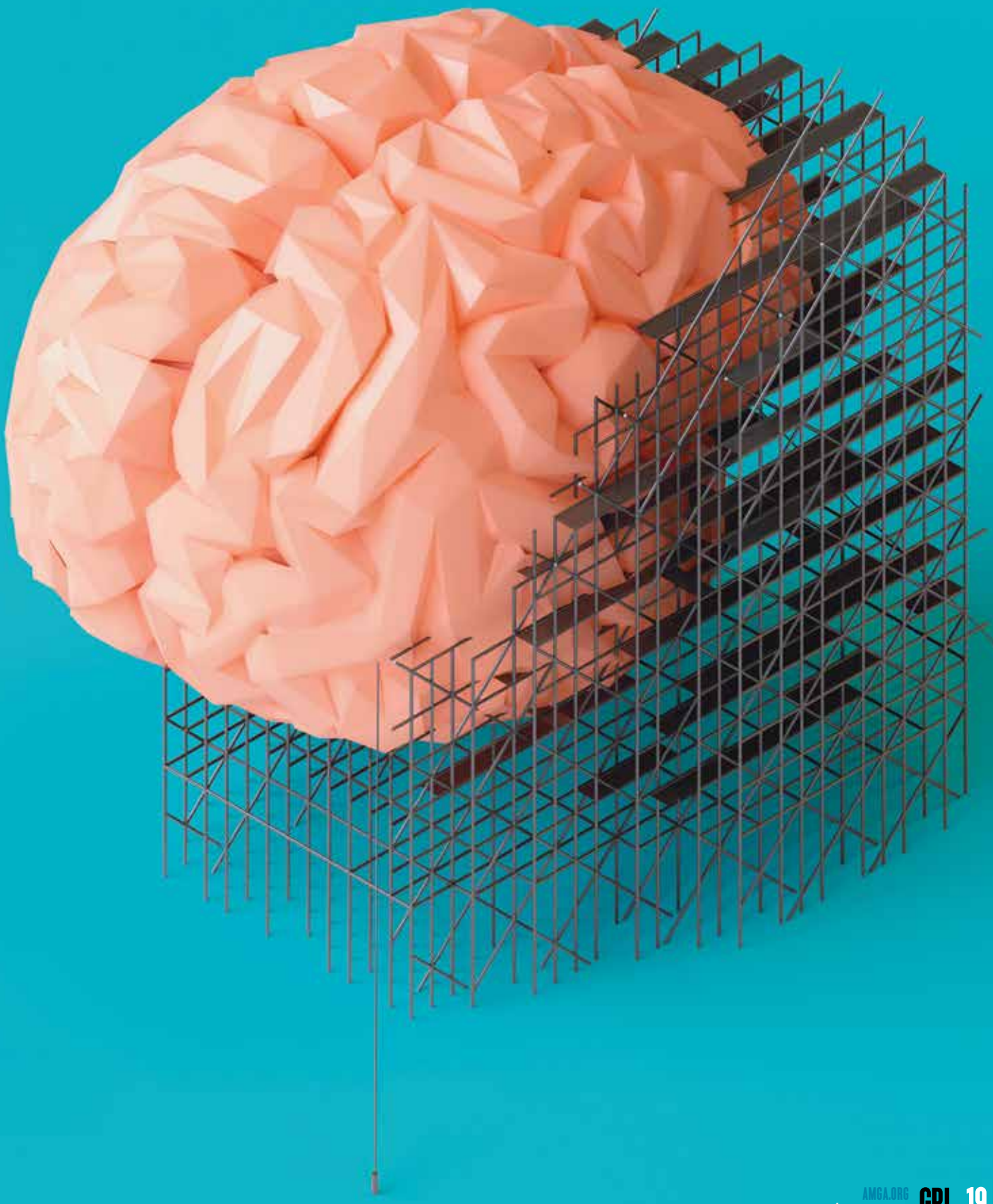
By Fred Horton, M.H.A.

We are at a unique place in physician compensation design, where the collision of aspects related to physician reward systems, practices, statistics, and metrics is demanding we take a different approach.

We have an inflection point created by the pandemic, coupled with recent changes in evaluation and management (E/M) values and the resulting survey and market data recalibration. At same time, there is significant dissatisfaction with compensation design programs that only capture productivity and keep physicians on the "hamster wheel." Many organizations are attempting to move to value and realize that the measurement systems that are most prevalent reward volume over quality. This inflection point provides ample opportunity to blow up your current compensation design and start fresh with new approaches and new metrics.

I am not suggesting wholesale rejection of productivity-based systems (using work relative value units [wRVUs] or panel size, for instance). I think the goal should be "alignment" versus moving to any one model. The truth is if you are in a fee-for-service (FFS) environment, then making too drastic a shift away from wRVUs may invite failure. Your plan must be linked to the environment in which you operate, as well as to your strategic direction and, most importantly, to your culture. If your culture and your plan don't match, you must move your culture first and then put in the plan that reflects that new culture.

I also am not suggesting staying with a 100% productivity-based plan as you move into value and as your culture shifts. Again, the main point



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is to align rather than blindly implement a new plan without the considering culture, payer environment, provider engagement, and organizational goals.

You do not succeed in value-based contracts by changing your compensation formula. If it were that easy, we'd be much further into value across the country. You need to create the contracting strategy, environment, and culture.

Alignment is key to your success. I've worked in environments where they shifted too quickly away from wRVUs and nearly went out of business. I've also worked in an organization that was able to make the shift successfully because their payer environment, strategies, and culture were aligned to the new model.

Make no mistake: At end of day, these issues must be taken into account for your organization to remain viable. It's great to say we're moving to value, but if only 5%–10% of your payer mix has a value component, and you shift away from wRVUs, be prepared to feel the pain. It's great to philosophically want to get physicians off a volume-based system; however, it's dangerous to change the plan ahead of focusing on contracting alignment and successfully putting systems in place to allow physicians to practice in a value-based manner.

The Fundamentals of Compensation Systems

So, how do we shift to a value-based compensation model? I have four fundamental beliefs regarding what is possible, practical, and appropriate regarding physician compensation systems:

1. Physicians are consummate professionals, who are comfortable with competition and fundamentally want to excel at taking care of their patients, while contributing to their organization's success.
2. Any single metric that is utilized for provider compensation will have its faults, and any system can be gamed.
3. Design should be focused 90%–100% on providing a system that links performance to expectations. It should be viewed as how an organization sets its goals for its providers and how it rewards those providers.

   If anything, only up to 10% of a plan should focus on stopping negative behavior. In my experience, negative behavior is the exception, not the norm, so why dedicate a significant portion of your reward program to focus on curtailing rarely exhibited negative behavior? Also, if someone is exhibiting negative behavior, the consequences must be more than simply a negative impact to compensation. Don't distract your alignment methodology by funding a significant portion of your compensation design to serve as a policing function. Use the leadership tools of coaching, performance management, and reviews for those interventions. Creating a system for exception-based issues is counterintuitive to creating a design that works and applies to the vast majority of your physicians.
4. Your compensation plan is an entirely inadequate proxy for a performance review. Physicians deserve at least a twice-annual sit-down discussion related to their performance. We often state that the most expensive instrument in health care is the physician's pen. We work diligently to recruit physicians, so why are there such limited examples of organizations that conduct adequate performance reviews? Physicians are the highest compensated staff, yet we fail them when we have only limited conversations on expectations and when we don't conduct adequate performance reviews.

As an executive, I yearn to know how I stack up. Actually, I think as employees (regardless of title), we all have this yearning. My sense is that retention would greatly improve if we started having robust dialogue and investment in the physician performance review process. Additionally, performance would increase and more goals would be attained for the majority of organizations investing time and resources to implement and execute a performance management system for their providers.

Changing the Metrics

I recently had an opportunity to present data from our annual provider compensation and productivity survey at a program attended by healthcare leaders. Survey results are a reflection of inputs that come from the industry reporting "what happened," utilizing the metrics that currently exist in the industry. Typically, these results reflect how organizations perform on the same metrics that drive reimbursement.

In recent years, I've become ever more anxious in anticipation of delivering similar presentations. There is growing dissatisfaction with the

Table 1

Fee-for-Service Environment: Scorecard Compensation Modeling – Internal Medicine

Specialty	Internal Medicine
Specialty Number	1210

Target Compensation	Percentile		45	55	60	65	70
	Amount		$279,312	$298,446	$302,925	$311,888	$321,902

Goal Domain	Goal Weighting	Performance Levels:	1	2	3	4	5
wRVU Production	80.0%	Threshold	P25	P40	P50	P60	P70
		Threshold Amt.	4,095	4,670	4,986	5,313	5,750
		Comp.	$223,450	$238,757	$242,340	$249,510	$257,522
Patient Satisfaction	5.0%	Threshold	P30	P40	P50	P60	P70
		Threshold Amt.	90.7%	91.6%	92.3%	92.9%	93.5%
		Comp.	$13,966	$14,922	$15,146	$15,594	$16,095
Access	5.0%	Threshold			P50		
		Threshold Amt.	0%	82.6%	85%	90.0%	92.5%
		Comp.	$13,966	$14,922	$15,146	$15,594	$16,095
Cost	5.0%	Threshold			P50		
		Threshold Amt.	110.0%	105.0%	100.0%	95.0%	90.0%
		Comp.	$13,966	$14,922	$15,146	$15,594	$16,095
Citizenship	5.0%						
		Comp.	$13,966	$14,922	$15,146	$15,594	$16,095
Citizenship	100.0%		$279,312	$298,446	$302,925	$311,888	$321,902
		Comp.	$27,931	$29,845	$30,293	$31,189	$32,190
Total	100.0%		$279,312	$298,446	$302,925	$311,888	$321,902

standard metrics in the market, and the audience tends to share their points on this with the messenger—me. Their belief, with which I wholeheartedly agree, is that metrics reported on do not tell the whole story, and we need additional metrics to fully evaluate "performance."

While I'm sympathetic to the dissatisfaction, I'm a realist and understand the complexities of any single metric or a couple of metrics driving what should, in essence, be a "provider's total rewards" program.

While wRVUs or panel size or salary percentiles may be inadequate, the answer is not abandoning these metrics, but rather ensuring that they are only parts of a comprehensive evaluation program. That program should take into account, in some manner, provider output related to the provision of care. If two providers have the same outcomes, the same access, the same satisfaction, but physician A sees half the number of patients or has half the panel size or produces half the wRVUs as physician B, I'd argue that physician B should, in fact, be paid more. If that is not the way the compensation plan is aligned, then over time, there will be significant concerns around internal equity and likely an erosion of focus on productivity in any form.

Let me be clear: I am not a fan of having any one indicator serve as *the* metric to determine compensation and, by proxy, be the sole factor to rate performance. I believe performance and expectations must reflect a more comprehensive view.

A Process for Compensation Redesign

Let's break down the aspects and a process to determine a more informed and effective approach to develop a comprehensive and aligned compensation plan, which includes a thorough performance evaluation.

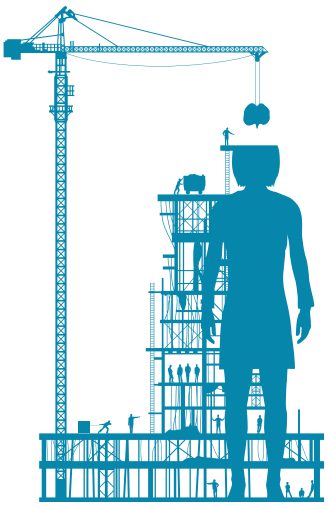
1 Determine what metrics are important, such as wRVUs, panel size, quality (and how it is measured), cost, patient satisfaction, and others. Also, consider academic work and research, depending on your setting.

2 For each area, consider how big a role the factor should play in determining performance and how much it is aligned to expectations. Also, determine how much a component can vary in total. For instance, does the wRVU component apply on a per wRVU basis or do you create several tiers that only result in a 25% difference from top to bottom production? Similarly, the percent that this component drives overall compensation should be determined. If you simply apply it at a 75%–90% level and, therefore, minimize all other components' impact, know that you will not have achieved a plan much different from the average FFS plan today.

3 From there, determine, by specialty, what constitutes a 25%, 50%, 75%, 90% (and so on) level of performance on each metric.

4 Now, determine the level of overall compensation that will form the compensation pool.

5 Once the above calculations occur, the math can be completed, and the accompanying documentation can be put together.



6 From this point, you must conduct a comprehensive annual performance review. Metrics utilized should not be a surprise. Rather, data and reporting systems should ensure the level of performance on an indicator are known by each physician in advance. The review is the opportunity to revisit performance, provide support, counsel, and coach. Reviews should be two-way conversations and among the most important you have throughout the year.

Table 2 is a fairly straightforward plan that is focused on volume and would be utilized in a more traditional FFS environment. As you can see, Dr. MacKenzie is a high producer, with his wRVU production hitting the 68th percentile. He does well in patient satisfaction, but struggles in access, cost, and citizenship. Since productivity drives 80% of the plan, with an additional four incentives with only 5% contribution each to the compensation formula, his ending pay is very close to his production, at the 63rd percentile.

Dr. Dye, on the other hand, has much lower production, but scores very well on patient satisfaction, access, cost, and citizenship. Given his excellent scores on the non-productivity incentives, his ending compensation is at the 49th percentile, which is a bit above his level of production.

Table 3 provides a contrasting scenario. The plan is structured to be much more focused on value. As you can see, production only forms 20% of the plan. Panel size has been added as a component, also at 20%. Patient satisfaction now forms an increased component of the plan at 20%, along with access at 20%. Finally, cost and citizenship components have also been increased from 5% to 10% with the new plan. When the performance of the two physicians is applied to the new formula (Table 4), one can see the impact upon their compensation and that the plan aligns much better with the performance of Dr. Dye.

When you examine his performance on the compensation parameters, Dr. MacKenzie does not derive the same level of compensation, given the misalignment of his performance to the components of the plan. While he has high wRVU productivity, he fares worse in the other metrics in the plan. His panel size is much lower than the percentile of his wRVU production, suggesting possibly a churning approach where he is seeing his patients too often. This is carried over to his low performance on the cost component, as well as on access. Given that productivity is only 20% of the overall compensation design, his overall performance, and therefore compensation, decreases to the 59th percentile, which is 9 percentile points lower than his production.

Dr. Dye, on the other hand, practices in a manner that is much more aligned to value-based care. We see that his panel size is at the 61st percentile, which when coupled with his strong performance on cost, would suggest he treats patients efficaciously, while not overutilizing. His access and citizenship performance is exemplary as well, and

Table 2

Fee-for-Service Environment: Example Organization Annual Professional Review

Physician #1				
Name	Alister MacKenzie, M.D.			
FTE Status:	1.0			
Goal Domain	**Performance**	**Percentile**	**Scoring**	**Comp**
wRVU Production	5,636	68	4	$249,510
Patient Satisfaction	93.0%	-	4	$15,594
Access	80.0%	-	1	$13,966
Cost	113.7%	-	1	$13,966
Citizenship	3	-	3	$15,146
		Average Score:	2.60	
Performance Comments/ Goals:		Total Compensation:		$308,182
		Compensation Percentile:		63
Comments on Performance		**Goals for the Future**		
Dr. Mackenzie is in the top quartile of wRVU production in his department		Continued improvement in Dr. Mackenzie's patient access and cost of care scores meet/ exceed departmental goals		
Dr. McKenzie continues to be a high performer in patient satisfaction		Dr. Mackenzie could increase his patient satisfaction scores by partnering with his colleagues to implement best practices		
Dr. McKenzie continues to improve his service to the group by serving on the patient access and informatics committees				

Physician #2				
Name	Pete Dye, M.D.			
FTE Status:	1.0			
Goal Domain	**Performance**	**Percentile**	**Scoring**	**Comp**
wRVU Production	4,562	38	1	$223,450
Patient Satisfaction	93.0%	-	4	$15,594
Access	95.0%	-	5	$16,095
Cost	92.1%	-	4	$15,594
Citizenship	5	-	5	$16,095
		Average Score:	3.80	
Performance Comments/ Goals:		Total Compensation:		$286,829
		Compensation Percentile:		49
Comments on Performance		**Goals for the Future**		
Dr. Dye continues to have top quartile patient satisfaction scores for his department		Continued growth in Dr. Dye's production to meet/exceed departmental goals		
Dr. Dye is popular with his colleagues; he sets a good example for others in treating all members of the department with respect				
Dr. Dye continues to excel in the areas of patient access and overall cost of care				

his patient satisfaction, while not a 5, ranks above average and leads to a score of 4. Overall, given his strong performance on the non-productivity metrics, which make up 80% of the plan, he performs well enough to have his compensation rise to the 63rd percentile, 25 percentile points above his wRVU production, which is at the 38th percentile. He is rewarded for practicing in a manner that is aligned with a value-based model.

Performance Management Is Key

As can be seen above, a physician practicing in one model versus another model can have vastly different levels of compensation. While that in and of itself is significant, we should not simply stop at the point of paying compensation. In order to address the unaligned behavior in either model, the physician leader to whom these physicians report must take time to

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Goal Domain	Goal Weighting	Performance Levels:	1	2	3	4	5
wRVU Production	20.0%	Threshold	P25	P40	P50	P60	P70
		Threshold Amt.	4,095	4,670	4,986	5,313	5,750
		Comp.	$55,862	$59,689	$60,585	$62,378	$64,380
Panel Size	20.0%	Threshold	P25	P40	P50	P60	P70
		Threshold Amt.	1,339	1,630	1,814	1,998	2,202
		Comp.	$55,862	$59,689	$60,585	$62,378	$64,380
Patient Satisfaction	20.0%	Threshold	P30	P40	P50	P60	P70
		Threshold Amt.	90.7%	91.6%	92.3%	92.9%	93.5%
		Comp.	$55,862	$59,689	$60,585	$62,378	$64,380
Access	20.0%	Threshold			P50		
		Threshold Amt.	0%	82.6%	85%	90.0%	92.5%
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		Threshold Amt.	110.0%	105.0%	100.0%	95.0%	90.0%
		Comp.	$27,931	$29,845	$30,293	$31,189	$32,190
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Total	100.0%		$279,312	$298,446	$302,925	$311,888	$321,902

discuss their performance under each component of the respective compensation plans. Without adequate performance management, while physicians will be rewarded or negatively impacted in terms of compensation, they will not be given the support necessary to discuss and possibly alter their behavior so that the organization, and the individual physician, can be better aligned.

This requires completing appropriate mid-year and annual reviews, where each component of the plan and the individual's performance are discussed in an open and transparent manner. Additionally, when necessary, an improvement plan should be put in place. Only by utilizing a rigorous, transparent, fair, and regularly occurring performance management review process will the organization and the physician have the best opportunity to refocus and work toward aligning with the goals that are formalized via the compensation plan. Assuming the compensation plan is aligned to the payer environment and direction of the organization, this is the way the organization can expect to achieve its desired goals, which are carried out by their physicians.

The scenarios above provide stark examples of how compensation plans can reward or negatively impact physicians who practice in divergent manners. There is not a one-size-fits-all compensation plan that can be applied to all settings. A plan that is successful in one organization may be totally inappropriate in

Table 4

Value-Based Environment: Example Organization Annual Professional Review

Physician #1	
Name	Alister MacKenzie, M.D.
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Goal Domain	Performance	Percentile	Scoring	Comp
wRVU Production	5,636	68	4	$62,378
Panel Size	1,823	51	3	$60,585
Patient Satisfaction	93.0%	-	4	$62,378
Access	80.0%	-	1	$55,862
Cost	113.7%	-	1	$27,931
Citizenship	3	-	3	$30,293
		Average Score:	2.67	

Performance Comments/ Goals:	Total Compensation:	$299,426
	Compensation Percentile:	59

Comments on Performance	Goals for the Future
Dr. MacKenzie is in the top quartile of wRVU production in his department	Continued improvement in Dr. Mackenzie's patient access and cost of care scores meet/ exceed departmental goals
Dr. McKenzie continues to be a high performer in patient satisfaction	Dr. Mackenzie could increase his patient satisfaction scores by partnering with his colleagues to implement best practices
Dr. McKenzie continues to improve his service to the group by serving on the patient access and informatics committees	

Physician #2	
Name	Pete Dye, M.D.
FTE Status:	1.0

Goal Domain	Performance	Percentile	Scoring	Comp
wRVU Production	4,562	38	1	$55,862
Panel Size	2,013	61	4	$62,378
Patient Satisfaction	93.0%	-	4	$62,378
Access	95.0%	-	5	$64,380
Cost	92.1%	-	4	$31,189
Citizenship	5	-	5	$32,190
		Average Score:	3.83	

Performance Comments/ Goals:	Total Compensation:	$308,377
	Compensation Percentile:	63

Comments on Performance	Goals for the Future
Dr. Dye continues to have top quartile patient satisfaction scores for his department	Continued growth in Dr. Dye's production to meet/exceed departmental goals
Dr. Dye is popular with his colleagues; he sets a good example for others in treating all members of the department with respect	
Dr. Dye continues to excel in the areas of patient access and overall cost of care	

another. Plans must be customized and focused on the alignment of culture, organizational focus and direction, payer environment and how much an organization participates in value contracts, and the manner in which physicians practice. Additionally, the performance review process must be comprehensive and support physicians to practice effectively in the environment of the organization (value vs. volume). When all is synchronized, the organization has the ability to perform in a manner that is aligned and to be successful within its unique environment. GPJ

***Fred Horton, M.H.A.**, is president of AMGA Consulting.*