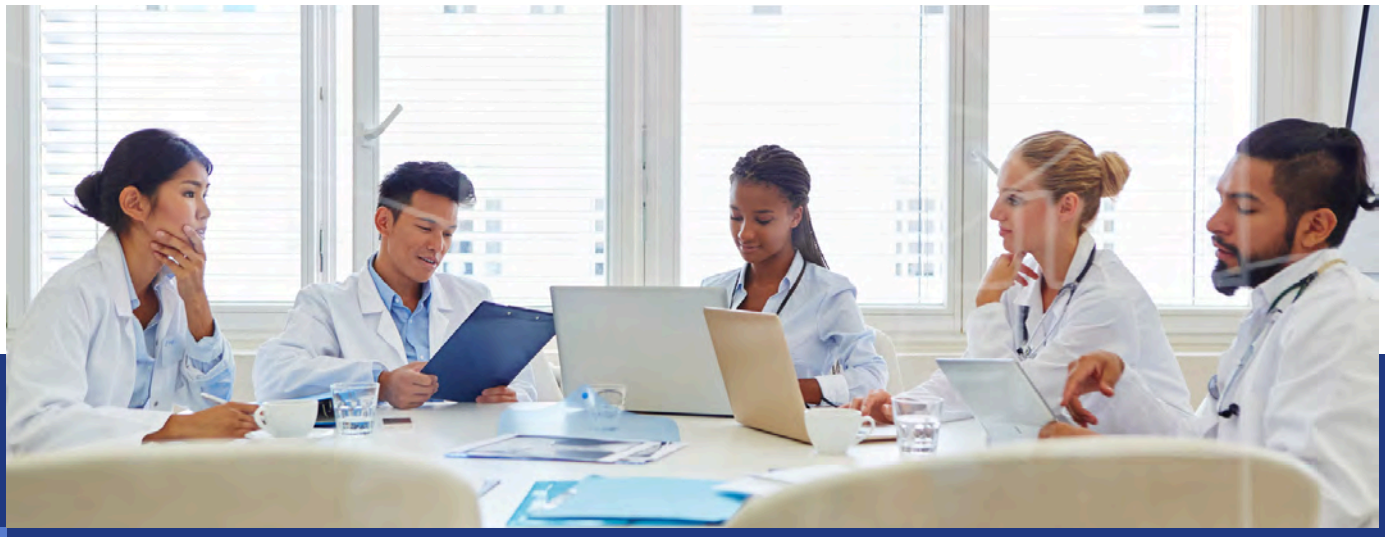
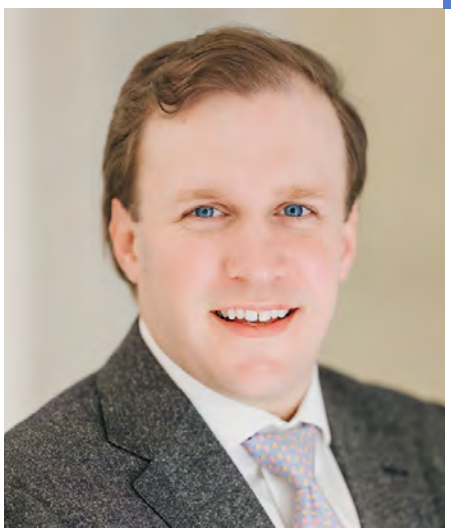
Coker

Provider Compensation Leading Practices for Physician Enterprises

By Alex Kirkland, MBA and Will Holets, MHA, MBA



About the **Authors**



Alex Kirkland

MBA
Senior Vice President

(615) 348-4037
akirkland@cokergroup.com

Alex Kirkland is a senior vice president at Coker. He has over 17 years of healthcare experience from a financial and operational background, focusing on physician compensation, reimbursement models, and population health. His primary focus with Coker is on physician alignment transactions, compensation trends, and payer reimbursement strategies.

Will Holets

MHA, MBA
Senior Manager

(470) 839-3647
wholets@cokergroup.com

Will Holets is a senior manager at Coker. He brings more than 10 years of healthcare industry experience working with prominent medical groups and physician enterprises across the country. Will is a seasoned healthcare consulting leader who specializes in developing tailored solutions through collaboration with key physicians and executives to achieve financial and operational improvement.

Contents

Introduction

In an ideal world, employed physician enterprises would have a clear compensation strategy with appropriate governance protocols so that their employed providers, physicians and Advanced Practice Providers (APPs) would be on a consistent, reliable compensation structure. Unfortunately, the realities of what brought together physician practices under an employment structure differ significantly from this utopian vision. Compensation design and redesign is a nuanced process that encompasses both scientific reasoning to support the economics of the physician enterprise as well as artful politicking to engage physicians properly throughout the process. There is no single finite answer to compensation. Rather, the execution of these two elements will determine the success of the compensation plan for the physician enterprise. In this paper, we evaluate the most common components of physician compensation plans and offer leading practices insights on them. Additionally, we provide commentary surrounding the core structures necessary for physician engagement throughout the compensation planning process.

Physician Alignment Trends

Over the past decade, health systems have increased their role within physician alignment arrangements, seeking new ways to affiliate with physicians. Present day reimbursement economics, paired with the evolution from volume to value will continue this trend as physicians look for alignment vehicles to shield themselves from incremental risk. A 2023 Physician Advocacy Institute (PAI) study showed that less than 25% of practicing physicians worked in a private practice environment. The shift from private practice to employment is expected to increase as regulatory and associated economic pressures mount. As a result, physician enterprises will grow or find themselves coordinating with physicians from different backgrounds through these affiliations. Either way, new forces are driving compensation decisions.

Physician enterprises have historically been reactive, making defensive acquisitions focused on market share growth to create critical mass. Accordingly, they are apt to make ad-hoc arrangements on a physician-by-physician basis resulting in various “one-off” compensation plans. This approach results in a collective of compensation plans which lack a unified philosophy or guiding principles to align providers toward a common strategic direction. This inconsistent approach creates the need for provider compensation redesign efforts within the physician enterprise.

Compensation Components

No universal compensation plan fits every physician enterprise. Market forces, payer dynamics and local economics drive unique nuances to an organization's compensation plan. Though there are many different models, the best compensation plans will consider many factors and have a principled approach. A philosophy on compensation that is physician-led, considerate of local economics, aligned with organizational goals and layered on top of an established vision should prevail throughout the organization.

An ideal compensation model for a physician enterprise should have common, standardized components with appropriate considerations for differences in primary care, specialty care, surgical care, and hospital-based physicians. The following are leading insights for the most conventional compensation components.

Base Compensation

Base compensation offers a level of stability often absent in private practice, providing an attractive sense of security for physicians considering employment. While base compensation ranges can vary, it is generally set at 80-90% of the prior year's or projected current year's compensation, assuming there are no significant changes in factors influencing compensation, such as clinical full-time equivalent (FTE), practice pattern, or regulatory updates. Base compensation can be structured in different ways, typically as a guarantee or a draw. Regardless of the method used, the long-term goal should be for the compensation plan's productivity or performance-based component to surpass the base compensation over time.

When offering base compensation through a guarantee, it is advisable not to provide long-term guarantees, particularly at higher levels based on market data.

It is reasonable to offer a higher guarantee during a physician's ramp-up period, typically within the first 12-24 months of employment. Guarantees are more common in rural areas, where patient demand for services may not be as high as in urban settings. When determining the guaranteed amount, use objective reasoning backed by credible data. The most common approach is to base it on market survey data, ideally setting it closer to the median and not exceeding the 75th percentile. A key principle to remember is that guarantees should never surpass the total cash compensation (TCC) paid to the physician, as this could undermine the effectiveness of the compensation model.

If providing base compensation via a draw, it is important to recognize that it is not the same as a guarantee, despite common misconceptions. A draw provides a regular income stream, but it represents only a portion of the TCC paid to a physician. The draw amount is deducted from the TCC as incentives are calculated. Traditionally, physician enterprises set the draw percentage between 75-90% of the TCC. While the draw can be higher than a guarantee, it's advisable to adopt a conservative approach to avoid the potential challenge of needing to recoup compensation from the physician.

There are opportunities to provide a hybrid guarantee that assures the base compensation as long as the physician falls within an established structure of productivity. These options tend to work well in environments where guarantees have been a part of the standard compensation procedure, and, now, physicians are transitioning to an established compensation model, or the organization is moving to phase them out altogether.

Productivity Incentive

While value-based reimbursement is shifting the economics of physician enterprises, fee-for-service is still the most significant revenue stream and likely to remain that way in most markets. Physician incentives should proportionately correlate to their revenue streams to align behavior with funding sources.

Using worked relative value units (wRVUs) is the standardized way to assign productivity credit and are also payer mix agnostic. These serve as the primary reasons why wRVU-based models are the most commonly used incentives to promote patient volume and typically account for 80-90% of projected TCC. AMGA recently reported that 87% of groups utilize wRVUs as the main production component within their compensation plans. This range can vary based on specialty, where primary care may have more of its revenues tied to quality, or value-based reimbursement payments.

Some primary care models are beginning to augment wRVU-based incentives with panel size incentives but only as a small portion of compensation. Often, these start around 5% of projected TCC, but they are set up dynamically to enable adjustments for the impact as reimbursement types evolve.

Although there are many considerations within a wRVU-based model, we see one- or two-tier wRVU approaches as the most customary where different wRVU thresholds are set with higher conversion factor rates paid at the higher tiers. The second tier wRVU threshold will not always produce a material financial gain to the physician, so it can be an inexpensive investment to the organization that provides a psychological motivator aimed to incentivize physicians to achieve next-level performance.

It is critical to remember that market data is detached from your organization's economics. As opposed to automatically updating your conversion factors annually as surveys are released, we recommend considering updates to your conversion factors approximately every two to three years. Additionally, we recommend accounting for local economics whenever possible by incorporating consideration for budget targets and your collection rates. This approach is even more appropriate when considering the CMS evaluation and management (E/M) wRVU value changes that have occurred over the past four years. These changes, which in some cases have increased wRVU production by 20%, highlight the need for an organization to stay informed of all changes to the Medicare Physician Fee Schedule (MPFS).

Quality/Non-Productivity Incentives

These incentives are primarily tied to quality performance or some form of non-productivity metric and have gained greater prominence in the industry due to the shift in focus from "volume to value." However, for most organizations, due to reimbursement structure, volume is still the most important factor. Therefore, non-productivity incentives range from 5-15% of projected TCC in primary care and 5-10% for specialists. The key is to keep compensation incentives proportionate to revenue streams.

The MGMA survey definition of total compensation is the amount reported as direct compensation plus all voluntary salary reductions and should include salary, bonus and/or incentive payments, research stipends, honoraria, and distribution of profits.

Therefore, all forms of clinical compensation, including quality incentives, are already reflected in the compensation per wRVU market data and should be carved out of those market-based rates instead of being added on top of those rates.

Organizations should consider a top-down approach for non-productivity incentives that allocates the value of compensation based on wRVU market rates. In this model, the compensation per wRVU market rate is distributed across various incentive categories, with the allocation weighted according to the proportion of revenue generated by each stream. Figure 1, below, provides an example.

Figure 1: Example Allocation of Value

Targeted Compensation per wRVU rate (50th percentile of market data)		
wRVU Productivity (85%)	**Performance Incentive** (10%)	**Other Incentives** (5%)

If the median rate is $50.00, the wRVU incentive value is $42.50, with the performance incentive value, likely associated with quality, creating a $5.00 per wRVU opportunity. Other incentives in this example are valued up to $2.50 per wRVU. The terms "opportunity" and "up to" per wRVU value are used because the full amounts depicted may not always be paid. It is common to implement a tiered performance rate structure where varying levels of performance reward full and partial credit. Physicians will likely appreciate having such a structure, especially in scenarios where physicians are transitioning to these incentives.

When selecting quality metrics, it is important to consider several factors. Leading practices suggest aligning metrics that drive desired physician performance improvements with those that impact reimbursement. It is crucial to maintain a coordinated strategy for quality metric selection, ensuring overlap with payer requirements while focusing on a limited number of measures. This approach allows providers to concentrate their efforts on specific initiatives. Additionally, be mindful that having too many metrics can lead to diminishing returns.

Non-productivity incentives are typically tied to quality measures selected by a physician committee formed through collaboration. Other types of non-productivity incentives may stem from factors such as patient access, patient satisfaction, adherence to group processes, or ad-hoc objectives the organization aims to influence. Regardless of the specific metric, it's essential to establish an objective scoring mechanism and implement a tiered system to allocate partial and full credit.

Team-based Incentives

With the increasing emphasis on population health management and the shift toward value-based care, more physician enterprises are implementing team-based compensation incentives for both physicians and APPs. According to a 2021 report by SullivanCotter, around 25% of survey respondents incorporated team-based compensation elements into their physician compensation plan structures. Common examples of team-based incentives include shared length-of-stay goals for hospitalist teams and combined physician-APP panel size goals in primary care. As the physician shortage persists and organizations continue to expand the employment of APPs, the use of team-based incentives is expected to grow within physician enterprises.

Call Pay

Sometimes the compensation plan does not explicitly identify call pay mechanisms, resulting in multiple one-off arrangements leaving organizations without an established approach to call expectation and call compensation. Determine what constitutes typical coverage and expect to pay hourly or daily rates that exceed that expectation. Meaning, assuming a baseline level of call is expected when providing market-based TCC, and call pay should only be in place for excess call defining the burden of the call duties and correlating it to proper compensation. These details should be documented in the compensation plan to mitigate the unintended consequence associated with "stacking" different forms of compensation. (Note: As physician compensation arrangements are under increasing regulatory scrutiny, organizations must make systematic efforts to understand individual components of physician contracts, determine whether overlapping services or duties exist, and review the stacked compensation to avoid overpayment and ensure regulatory compliance.) Benchmarks help establish rates and keep pay within fair market value (FMV).

Administrative Compensation

The goal of any physician enterprise is to provide care for the community it supports. As such, a defined clinical FTE expectation should be in place, usually based on patient contact hours derived from a combination of office hours, hospital hours and surgical time. Naturally, completion of normal administrative functions is an expectation during these hours, but there may be a need for some providers to take on dedicated administrative responsibilities. When that is the case, it is appropriate to compensate for such effort, but designated health system priorities are the only administrative functions that should be compensated (i.e. medical directorships, leadership roles, and the like). These dedicated administrative responsibilities should be paid hourly and subject to an annual compensation cap. Benchmarks help establish rates and keep pay within FMV. Proper documentation is a requirement to substantiate payment, and at a minimum, the provider should have the dedicated responsibilities identified within their employment agreement and, preferably, memorialized in a separate transaction.

Advanced Practitioner Oversight

Some organizations elect to pay for APP oversight. This decision driver would be the mechanics of the care model based on the manner in which APPs are leveraged, so it may not be a common compensation component found in all compensation structures.

As with most compensation components, there are several ways to compensate, and organizations must be aware of unintended consequences that may occur from "wRVU gaming." For that reason, we prefer two methods of payment, depending on the scenario:

1. *The Supervisory Stipend Model* consists of a flat rate paid to supervisory physicians. This model is recommended for specialists if the APPs provide an overall positive economic impact, and for primary care when there is a desire to promote a team-based care model because it alleviates wRVU competition between physicians and APPs.
2. *The Modified wRVU Credit Model* contains a small dollar amount per wRVU that is paid for supervisory services to the supervising physician, subject to an annual cap, based on wRVUs generated by APPs. This recommendation is for primary care if APPs see their own patients.

A consideration that could be applicable to either approach is to reward the overseeing physician more in the first year of the oversight relationship than in the years that follow. This can be through a higher stipend in year one or through a higher rate per wRVU amount in year one. The concept here is that physicians may be reluctant to take on additional APPs due to the "getting to know you" period, and as such a higher monetary value is aligned with the relationship ramp up period. The higher value is intended to be temporary as in later years the relationship between the physician and the APP will become more efficient.

APPs practice authority or scope of practice differ significantly by state and state regulations often differ between Nurse Practitioners (NPs) and Physician Assistants (PAs). In addition, there is a growing trend to increase the scope of practice for APPs, reducing the need for physician oversight/supervision. Organizations must be mindful of this trend and the differences in state regulations as they compensate physicians for APP oversight.

Treatment of Paid Time Off

Benchmark data for wRVUs are calculated based on 46-48 weeks of work per year. As a result, double payments can occur if paid time off (PTO) is not taken, and any accrued PTO is paid out in addition to the wRVU-based compensation. To avoid this, a defined number of days off—covering vacation and sick days (but excluding holidays)—is typically allocated, known as Allowed Time Off (ATO). Unused ATO days are generally not paid out but may be "banked" for future use if necessary.

Hospital-Based Physicians

Hospital-based physicians are dependent on hospital volumes and likely cannot influence their level of patient demand, so their compensation components should differ from primary care and specialist physicians. The core focus of hospital-based physician compensation models should be time-based, which limits the amount of total compensation that can be tied to performance.

Professional reimbursements are increasingly incorporating value or quality components across the board. As a result, it may still be appropriate to align a portion of hospital-based physician compensation with performance based on quality metrics, typically in the 5-15% range. While some shift-based specialties do include wRVU productivity in their compensation plans, wRVUs can serve as a valuable tool for hospital-based physicians primarily to help determine when to add an additional shift or physician.

Core Compensation Structures

Identifying the proper compensation components ensures the appropriate economics are in place, but that is only part of the equation. The other half lies in developing an effective implementation plan that helps physicians embrace the new compensation components and integrate them into the desired structure. Engaging physicians in the compensation strategy process is the best way to foster buy-in, as it gives them an opportunity to voice their thoughts.

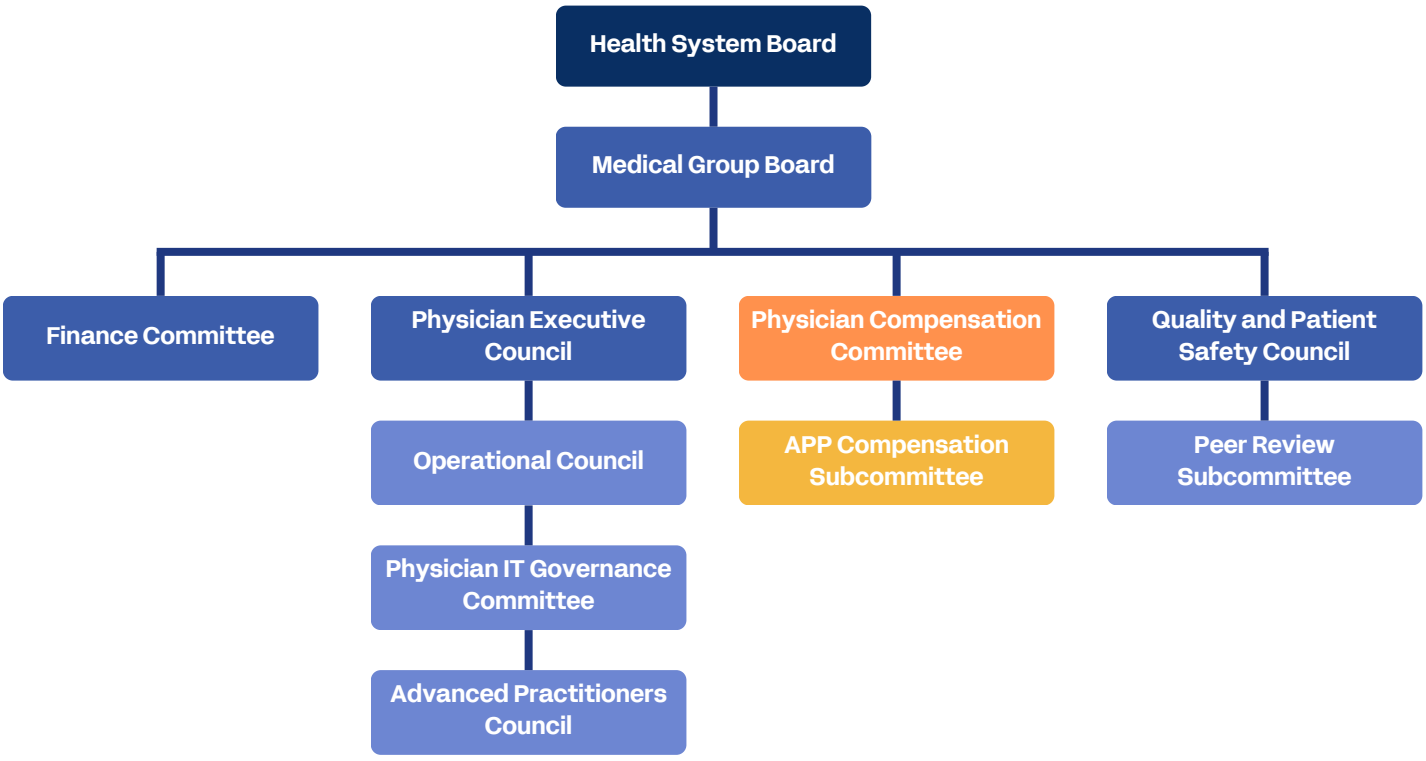
As part of a compensation strategy initiative, it is essential to consider the appropriate structures that must be in place to govern future compensation decisions and think through the details that arise in day-to-day life within the compensation plan. The core compensation structures that should be in place to navigate compensation change effectively are addressed in the following pages.

Compensation Committee

Compensation plan governance is a critical issue within the physician enterprise compliance framework, with potential far-reaching implications. A common concern is whether the hospital's board of directors should govern physician compensation or delegate oversight to the physician enterprise board. In smaller organizations, it is often typical for a member of the C-suite or legal counsel to oversee physician compensation in collaboration with the hospital's board. Governance structures can vary widely, but from a leading practice perspective, it is essential for organizations to establish a strong governance framework and ensure that fiduciary responsibilities related to physician compensation are proactively managed.

The size of the physician enterprise is a matter to consider before establishing a governance structure. From a functionality standpoint, it probably does not make sense for physician enterprises that have ten employed physicians to have a multilayered governance structure, including a formal compensation committee. In a physician enterprise that has 50 or more employed physicians, a compensation committee becomes a necessity. Figure 2 charts a governance structure for a health system and affiliated medical group as the physician enterprise, where the health system has delegated physician compensation oversight to the medical group, via the medical group's physician compensation committee, with ultimate supervision retained by the health system's board of directors.

Figure 2: Example of Health System and Physician Enterprise Governance Structure



The compensation committee should be created based on a charter that defines the roles and responsibilities of the committee, including the committee's duty to provide oversight and reporting and not merely as a body that makes recommendations. A physician compensation committee should oversee compensation model development and the maintenance and ongoing oversight thereof, updates to compensation policies and procedures, advocating for updates to approved compensation models, and compensation-related issue resolution.

As care models evolve, and APPs become a larger component of the physician enterprise, many groups have developed an APP compensation subcommittee. This subcommittee is charged with providing oversight, strategic maintenance, and guidance to the organization's APP compensation plan. As Figure 3 illustrates, the compensation committee should have established roles as determined by the compensation committee's charter.

Figure 3: Example of Health System and Physician Enterprise Compensation Committee Roles

	Medical Group President	Physician Compensation Committee	Medical Group Board of Trustees	Health System Compensation Committee
Committee Charter		Follows	Adopts	
Philosophy	Follows	Adopts	Approves	Approves
Goal and Budgets	Recommends and Follows	Adopts	Approves	Reviews (as needed)
Recruiting		Recommends	Approves	Reviews (as needed)
Agreements	Approves	Reviews		
Policy Exceptions	Recommends	Approves	Reviews	
Evaluations		Reviews		

Compensation Policy

A compensation policy documents the organization's overall compensation philosophy. It focuses the attention of all stakeholders on key tenets of the compensation structure and should provide a lens through which to ensure compensation structures adhere to the mission, vision, and values of the organization.

The policies and procedures concerning FMV and commercial reasonableness testing should be outlined within the compensation policy. It should document what triggers an internal review and what determines an external review.

Although individual employment agreements will detail specific terms on a provider-by-provider basis, it is important to have a consistent philosophy that embeds certain agreement terms into each contract. For example, it is standard to see two- to five-year term contracts with automatic one-year renewals and 90-180-day notice periods for termination. Non-compete agreements are subject to negotiation, but be aware that market dynamics will play a factor.

Another consideration is each physician's contract year. There is a separation risk in moving all physicians to the same contract year, but reference should be made to the same calculation period. One-time stub periods may be used to bridge a contract year to a standardized calculation period.

Compensation Plan

The goal of the compensation plan is to provide consistency for incentives across all physicians and specialties. Many organizations detail compensation mechanics within each physician's employment agreement. This situation is not ideal because it dramatically increases the chances for separate arrangements even among like specialties. Those distinct arrangements incentivize different behaviors resulting in uncoordinated outcomes. A centralized compensation plan document is preferable that aligns physician incentives toward strategic organizational objectives. The compensation plan can be flexible to consider incentives specific to primary care versus that of specialty care, surgical care, or hospital-based physicians. It should be written outside of the employment agreement with each employment agreement referencing the compensation plan. That way updates can be made to a single document versus numerous updates to multiple physician employment agreements.

Contract language is vital within the compensation plan document. It should accurately reflect the spirit of the development of the compensation structure and should include appropriate exhibits that illustrate the critical compensation components. The compensation plan should be detailed in nature so that it can address how different issues will be adjudicated and note operational factors such as the timing of payments. It is essential to attain legal and consulting expertise to ensure a compliant and well-developed compensation plan.

Compensation Playbook

Provider compensation is a complex equation with significant financial implications for the organization and individual providers. To increase transparency into the provider compensation administration, a leading practice is to develop and publish a compensation playbook. The playbook is a dynamic physical and/or electronic document that outlines how the physician enterprise structures and manages physician and APP compensation. The playbook is modified or updated as changes are made to the plan structure or to the processes and policies of the compensation plan.

The compensation playbook will provide a comprehensive overview of all aspects of the compensation plan, from the use of survey data to the development of department-specific quality goals. It will include details on various compensation models, payment structures for activities such as call pay, and benefit information for physicians and APPs. The primary goal of the compensation playbook is to ensure that provider compensation practices are transparent, equitable, competitive, and aligned with organizational goals, while also adhering to all relevant regulatory guidelines.

Summary

Leading practice in making any compensation change involves engaging providers, early and often, to agree collectively on the direction they want to structure compensation with administrative leaders. Addressing compensation is a delicate subject, and if mismanaged, it can be detrimental to a physician enterprise. It is critical to go through the appropriate steps of the process to include the proper compensation components, lay the necessary compensation structures, and ensure physician voices are heard.

Coker

For further information about Coker,
and how we could be of assistance, please contact:

(800) 345-5829
askcoker@cokergroup.com
visit cokergroup.com