Physician Compensation in the Integrated World

-Transition to a Performance-Based Model-
  Tim Attebery, Wellmont CVA
  Suzette Jaskie, MedAxiom
The problem

- Value based reimbursement is coming, but it’s not here
- Belief that RVU’s are not the right productivity standard, but what is
- RVU productivity diminishes physician’s ability to create value in the system
- RVUs remain the primary currency the valuation process
Background Information

- Cardiovascular Associates integrated with Wellmont Health System (WHS) in May, 2010 forming the Wellmont CVA Heart Institute (CVA)
- CVA was in the 8th year of a CVSL Co-Management Agreement at the time of integration
- Group size at time of integration: 32 CV specialists (cardiologists and CV/CT surgeons) working out of 8 offices, 5 WHS-owned hospitals and 1 non-WHS hospital
- Group size now: 47 CV specialists (40 cardiologists, 6 CV/CT surgeons and 1 vascular surgeon) working out of 15 offices, 7 WHS-owned hospitals and 4 non-WHS owned hospitals
- CVSL Co-Management Agreement continued post-integration
Post-Integration Success

- GROWTH → new offices, new physicians, new services
- Integration of 9 existing CV physicians from other groups/organizations
- Recruitment of 6 new CV physicians to the area
- Consolidation of non-invasive imaging services
- Consolidation of all CVSL support functions into CVA
- CVSL reorganization and CVSL Financial Statement (roll-up)
- Level One Heart Attack Network; regional EMS network
- Cardiac PET, CMR, ASD/PFO, Radial Artery access, EVAR/TVAR, TAVR
- Significant expansion of heart failure program, vascular services & structural hear program
- Standardized clinical & technical workflows and protocols
- CVSL agreements with 2 non-WHS hospitals
- Managed care arrangements and CV carve-outs → exclusive CVSL provider
- Market Share → increased from 50% to 65%
Structure of Original Deal

- Asset acquisition
- 5-year employment agreement for existing CVA physicians
- Physician Compensation Pool – funded by a $$ amount per wRVU (with “Administrative” time converted to wRVU’s at 4.5 wRVU’s per hour)
- Additional $2 per wRVU annually if targeted wRVU/FTE physician is achieved
- 2% BONUS (at-risk $$); hospital-based CVSL performance metrics
- Distribution of $$ from the Pool – to “Associate Physicians” (non-partners) first; remainder is divided equally among the “Senior Physicians” (partners)
- 5-year Retention Bonus
- FMV review at the end of 3 years
- Protect WHS in the event of an SGR calamity or some other significant change in reimbursement
- If WHS reduces the Conversion Factor by more than 10%, CVA physicians have the right to unwind the deal
• Recommendation from CVA to WHS leadership to re-evaluate the entire plan as part of the 3-year review
• Recognition of defects/limitations with the current plan
• Prepare for “accountable care” and the continued shift toward “fee-for-value”
• Recognize the broader, “enterprise value” of CVA vs. the specific “production” value
• Partially driven by the successful development of a comprehensive CVSL Financial Statement (incorporating all CVSL revenue and expenses)
• Shift the 3-year review away from “wRVU conversion factor”
• Recommended that WHS & CVA bring in an outside consultant to facilitate the discussions and help design the future compensation plan
Process

• 14 member Steering Committee → 9 CVA physicians and 5 WHS representatives
• Engaged Suzette Jaskie in November, 2012
• Project consisted of 2 Phases
• Phase 1 – Assessment and General Recommendations
• Phase 2 – New Model Design
• Migrate the compensation toward more at-risk, performance-based $$
• Base salary (“floor”)
• Base determined by CVA’s relative productivity performance to MedAxiom annual survey
• “Productivity” – wRVU’s plus, eventually, patient panel size
“Begin with the end in mind….”
“Seek first to understand….”
Guiding principles:

The compensation plan must have *relevance* in the currently emerging Value Based Economy payment model.

The compensation plan must *facilitate goal alignment* of the physicians with each other, as well as the physicians with the health system.

The compensation plan will ultimately *incentivize physician performance required to execute the cardiovascular service line strategic plan*.

The compensation plan will, to the extent possible given the current transformational nature of the healthcare industry, provide *physician’s economic stability*.
Guiding principles (continued):

The compensation plan must balance stability with risk understanding that the physicians are tolerant of risk to the extent required to elongate their compensation agreements.

The compensation plan will have a basic set of physician performance requirements that will minimally incorporate the physician compact created by the group.

The plan will facilitate physician’s engagement in the program, surrogate to their former ownership status.
The **presence or absence of compliance has an opportunity cost and thus value to the hospital system.** Potential measures of compliance might be adherence to meaningful use, adherence to clinical protocols, guidelines and policies and/or adherence to appropriate documentation.

**Clinical quality and reliability have tremendous value,** particularly in a value based economy contracting scenario. Potential measures of quality reliability would likely be population based measures like: percent of patient population meeting lipid or other goals, or percent of patients for which clinical registry metrics are met.
Other design considerations:

Non-rvu metrics that are valued in the compensation plan should be evaluated, retrospectively, to assure that the incentivized metrics resulted in performance that was of value for patients and specifically, the no unintended consequences occurred as a result of the incentive plan.

From a valuation perspective, it should be noted that the fair trade legislation views risk favorably.

From a business sustainability perspective, the degree to which risk and non-wRVU metrics are incorporated into the compensation plan will be dependent on evidence from the marketplace that such performance is compensable.

The plan seeks to build a platform based on a philosophy consistently shared with the system and its view of employed physicians that is ideally adaptable to other physician employees.
## Basic frameworks

<table>
<thead>
<tr>
<th>Framework</th>
<th>Job types</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity</td>
<td>Sales, hourly employees</td>
</tr>
<tr>
<td>Salary guarantee</td>
<td>Mid-level staff</td>
</tr>
<tr>
<td>Base plus incentives</td>
<td>Higher level staff and executives</td>
</tr>
</tbody>
</table>
Base salary plus incentive pay

- Predictability, stability for physicians
- Conducive to alignment
- Conducive to anticipated payment structure
- Risk for decreased physician productivity
- Risk to valuation
Calculating base pay

- Many alternatives
- This approach best matched the groups commitment to equal share
- Base salary is indexed from the mean group productivity level in the year proceeding the plan year. In other words, if the historical productivity of the group is 50%, the base salary index is established at the 50th percentile.
- Base salary is established annually.
Measures of productivity:

Time
Volume of work (units)
Effort adjusted volume (RVU)
Revenue
Patients

What’s the right measure?
Productivity measure migration
## Calculating base pay (2014 example)

### Productivity Measure Migration

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>wRVU wt</td>
<td>90%</td>
<td>80%</td>
<td>70%</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Pt. panel wt.</td>
<td>10%</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mean RVU Productivity</th>
<th>Benchmark</th>
<th>Benchmark</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>9281</td>
<td>60th %tile</td>
<td>$ 570,000.00</td>
<td>90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Panel</th>
<th>Benchmark</th>
<th>Benchmark</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1561</td>
<td>35th %tile</td>
<td>$ 425,000.00</td>
<td>10%</td>
</tr>
</tbody>
</table>

2014 Illustrated base compensation illustration: $555,500.00
## Compensation Benchmarking
(Extracted from actual valuation report blending 3 national surveys)

<table>
<thead>
<tr>
<th>Category</th>
<th>25 %tile</th>
<th>50 %tile</th>
<th>75 %tile</th>
<th>90 %tile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-invasive</td>
<td>$321</td>
<td>$420</td>
<td>$528</td>
<td>$693</td>
</tr>
<tr>
<td>Invasive</td>
<td>$358</td>
<td>$467</td>
<td>$608</td>
<td>$737</td>
</tr>
<tr>
<td>Interventional</td>
<td>$414</td>
<td>$501</td>
<td>$630</td>
<td>$776</td>
</tr>
<tr>
<td>EP</td>
<td>$371</td>
<td>$474</td>
<td>$611</td>
<td>$746</td>
</tr>
<tr>
<td>CT Surgery</td>
<td>$393</td>
<td>$522</td>
<td>$627</td>
<td>$759</td>
</tr>
</tbody>
</table>

Note: Compensation reported in thousands.
## wRVU Benchmarking
(Extracted from actual valuation report blending 3 national surveys)

<table>
<thead>
<tr>
<th></th>
<th>25 %tile</th>
<th>50 %tile</th>
<th>75 %tile</th>
<th>90 %tile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-invasive</td>
<td>4,986</td>
<td>6,831</td>
<td>9,195</td>
<td>12,256</td>
</tr>
<tr>
<td>Invasive</td>
<td>6,227</td>
<td>8,578</td>
<td>11,179</td>
<td>13,962</td>
</tr>
<tr>
<td>Interventional</td>
<td>7,141</td>
<td>9,068</td>
<td>11,472</td>
<td>14,945</td>
</tr>
<tr>
<td>EP</td>
<td>7,877</td>
<td>10,114</td>
<td>12,570</td>
<td>17,452</td>
</tr>
<tr>
<td>CT Surgery</td>
<td>6,680</td>
<td>9,104</td>
<td>11,639</td>
<td>14,597</td>
</tr>
</tbody>
</table>
In keeping with the guidance from the valuation consultant, it is recommended that the values of non-productivity incentives are compensated as a percentage enhancement from base salary. It is further recommended that a balanced score card is developed whereby the framework is established concretely, with flexibility to establish specific goals annually that align with the strategic plan.
Example - What it looks like:

**Base Salary + Incentives**

Incentive = between 0 – 30% in this example

<table>
<thead>
<tr>
<th></th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base salary</td>
<td>10%</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Plus</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Incentive plan example

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Current Status</th>
<th>Percent Total</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement CPOE templates</td>
<td>Based on physician developed patient protocols.</td>
<td>No templates</td>
<td>25%</td>
<td>4 templates</td>
<td>6 templates</td>
<td>8 templates</td>
</tr>
<tr>
<td>Appropriate documentation</td>
<td>Audited by ECG Consulting</td>
<td>82%</td>
<td>30%</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>ICD guideline consistent patient selection and documentation standard</td>
<td>Based on physician reconciled guideline application of major payers.</td>
<td>85%</td>
<td>25%</td>
<td>90%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Variance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$1.5 million aggregate cath lab supply cost reduction</td>
<td>Normalized by case volume</td>
<td>60%</td>
<td>80%</td>
<td>&gt; $1.2m</td>
<td>$1.2m - $1.5m</td>
<td>&gt; $1.5m</td>
</tr>
<tr>
<td>On-time cath lab start</td>
<td>Measured from scheduled block time</td>
<td>65%</td>
<td>20%</td>
<td>73%</td>
<td>85%</td>
<td>95%</td>
</tr>
<tr>
<td>On-time patient discharge</td>
<td>Appropriate patients before 9am</td>
<td>60%</td>
<td>20%</td>
<td>70%</td>
<td>80%</td>
<td>95%</td>
</tr>
<tr>
<td>Reduce HF Readmission Rate</td>
<td>CMS reported all cause</td>
<td>50%</td>
<td>&lt; 23%</td>
<td>&lt; 23.5%</td>
<td>&lt; 22%</td>
<td></td>
</tr>
<tr>
<td>Create structured reports for CV Imaging</td>
<td>Discrete data meeting guidelines and accreditation</td>
<td>50%</td>
<td></td>
<td>Echo</td>
<td>Echo/Nuc</td>
<td>Echo/Nuc/CVCT</td>
</tr>
<tr>
<td>Same day discharge program</td>
<td>Clinically appropriate cath lab</td>
<td>5%</td>
<td>75%</td>
<td>15%</td>
<td>25%</td>
<td>40%</td>
</tr>
<tr>
<td>New patient access within 3 days of initial request</td>
<td>Currently 11 day bottleneck</td>
<td>50%</td>
<td></td>
<td>7 days</td>
<td>5 days</td>
<td>3 days</td>
</tr>
<tr>
<td>Execute TAVR Initiation plan</td>
<td>Based on multi-discipline</td>
<td>25%</td>
<td></td>
<td>Initiate by 11/31</td>
<td>Initiate by 9/30</td>
<td>Initiate by 6/30</td>
</tr>
</tbody>
</table>
Value based plan adoption
<table>
<thead>
<tr>
<th></th>
<th><strong>Current</strong></th>
<th><strong>Future</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Framework</strong></td>
<td>Productivity based compensation pool, divided equally among qualified physician fte’s</td>
<td>Group productivity based base pay plus non-RVU metric determined incentives</td>
</tr>
<tr>
<td><strong>Base pay</strong></td>
<td>98% productivity</td>
<td>70% compensation</td>
</tr>
<tr>
<td><strong>Productivity</strong></td>
<td>100% work RVU</td>
<td>Blended definition: 50% work RVU and 50% patient panel size</td>
</tr>
<tr>
<td><strong>Requirements of employment</strong></td>
<td>License, Medical staff privileges, culture fit</td>
<td>Minimum standards in productivity, patient satisfaction, quality and culture/compact adherence</td>
</tr>
<tr>
<td><strong>Incentives</strong></td>
<td>Up to 2% of compensation</td>
<td>Up to 40% of base pay</td>
</tr>
<tr>
<td><strong>Determination of incentives</strong></td>
<td>In alignment with the strategic plan</td>
<td></td>
</tr>
</tbody>
</table>
Current Status

- Legal work in progress (2 amendments to the Senior Physician employment agreements)
- Finalize FMV analysis (separate consultant)
- Developing the performance categories and performance metrics
- Extend the current Comp Plan 90-days
- Amendment will establish a new 5-year term (July 1, 2013 through June 30, 2018); 2 years beyond original term
- Protects the Retention Bonus
- Removes the unwind provision
- Developing a new “Physician Performance Evaluation Program”
Performance-Based Compensation

- Need a “funding source” for each incentive $$
- Behavior (process, initiatives)
- Outcomes (impact, results)
- All the ways the CVA physicians can favorably impact WHS (direct and indirect financial benefit)
- Defines “CVA physician work/contribution” beyond wRVU’s
5 PERFORMANCE CATEGORIES

1. QUALITY PERFORMANCE (Payer & External Ratings)

2. FINANCIAL (Revenue and Cost Management)

3. SERVICE PERFORMANCE (Patient Satisfaction)

4. RISK MANAGEMENT PERFORMANCE

5. CLINICAL PROCESS PERFORMANCE
Quality Performance

- Payer payments and/or designations tied to Quality Performance (CMS, BCBS, Anthem, UHC, Cigna, etc.)
- CareChex performance
- Mortality
- Core Measures; Value-Based Purchasing
- Door-to-Balloon and “R to R”
- ACC and STS measures
- Leapfrog
- Pinnacle Registry performance
- Other
Financial Performance

- OPTIMIZE NET REVENUE
  - quality of coding & documentation
  - readmission rates
  - quality of managed care and other contracting
  - Productivity (wRVU’s will continue to be incentivized)
  - Market development & growth → new services, new markets
  - not writing off accounts
Financial Performance

- EXPENSE MANAGEMENT
  - CVSL salaries/benefits as a % of Net Revenue
  - Supplies as a % of Net Revenue
  - Other expenses as a % of Net Revenue (including depreciation, outsourced professional fees, maintenance & service)
Financial Performance

• Obs LOS and variable costs (cardiac fast-track program)
• Inpatient LOS and variable costs
• Special initiatives
Service Performance

- Patient Satisfaction → office
- Patient Satisfaction → hospital CVSL ambulatory & outpatient
- Press-Ganey
- Percentile Performance
Risk Management

- Payer Denials (post payment)
- CMS RAC audits
- Documentation
- Coding Accuracy
- Malpractice claims and settlements
Clinical Process Improvement

- Meaningful Use (office and hospital), PQRS, E-Rx (avoid penalty)
- Epic implementation
- Door-to-balloon, R to R
- Cardiac Fast Track operation
- Pre-Cert/Pre-Auth process
- Pre-admission process
- Transfer process
- Post discharge coordination of care; readmission reduction; HeartSUCCESS (heart failure program)
- Timeliness of interpretations
- New office patients seen within 5 business days
- Patient Education
- Office cycle time (OV’s & New Patients throughput in the office)
- HeartSHAPE process (coronary calcium scoring service)
- OTHER
Success in the face of seismic change

It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change.

Charles Darwin