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Agenda

I. Introduction
II. Healthcare Reform
III. Midlevel Provider Trends
IV. Compensation Plan Development
V. Case Studies
VI. Conclusions

Attachment A – Metrics and Additional Considerations

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I. Introduction

I. Introduction
Our Speakers

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I. Introduction
Today's Objectives

Our discussion today focuses on incorporating midlevel providers into your primary care team and developing compensation models for these professionals. We encourage questions and your input.

- Understand how reform measures will impact access to primary care.
- Review the complexities associated with midlevel incentive compensation plans.
- Provide tools to align midlevel compensation plans with organizational objectives.

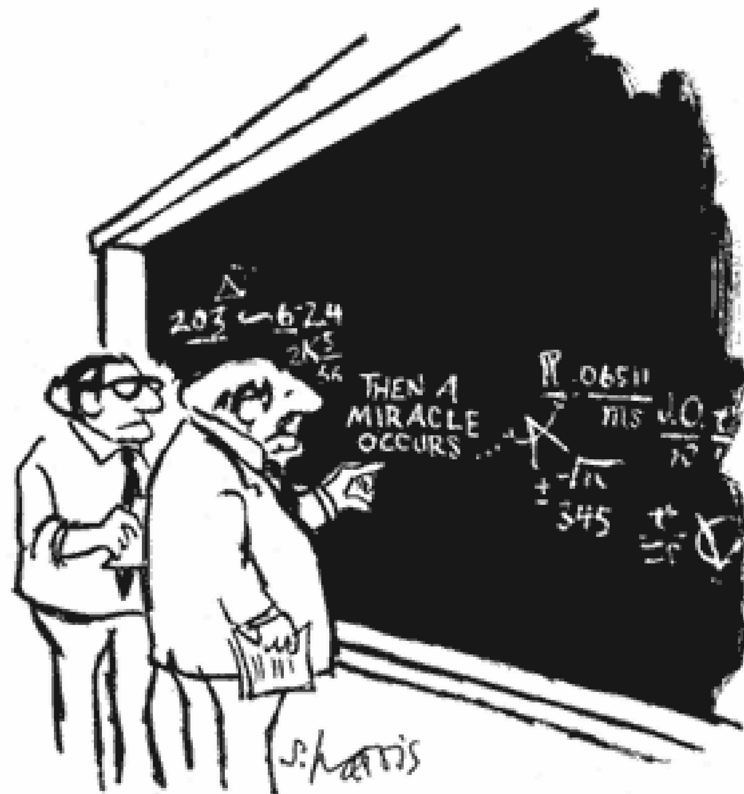
II. Healthcare Reform

II. Healthcare Reform
Step 1 – Healthcare Reform, Step 2 …?

Healthcare reform legislation initiated the process of change, but the path for successfully realizing the broader vision remains largely unclear.

- Healthcare reform legislation set things moving.
- Recent political leadership changes could delay some of the key components.
- The next steps are less clear …

"Then a miracle occurs."



"I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO."

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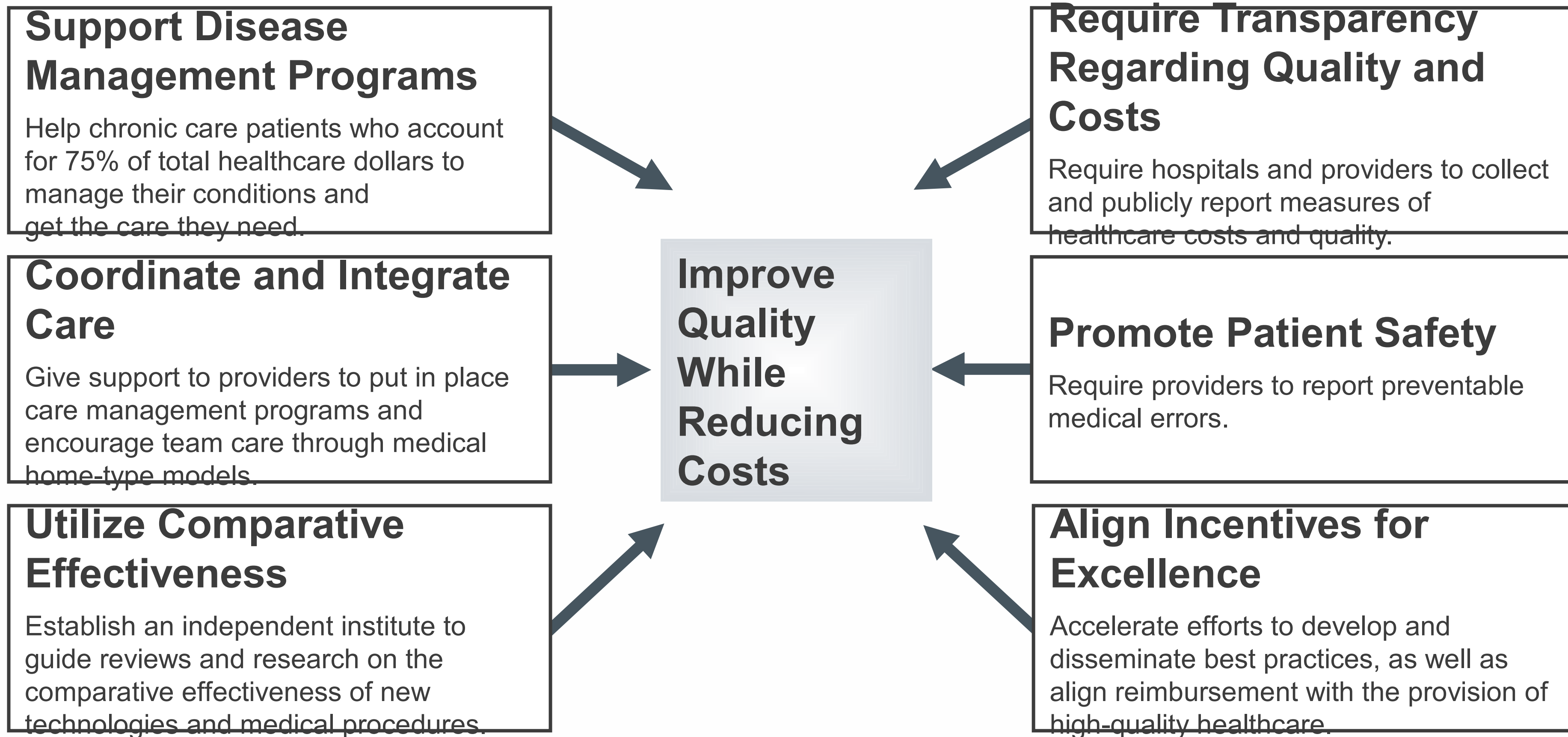
II. Healthcare Reform
Focus on Improving Value

Specific initiatives are expected to improve the value of healthcare services.



Change requires payment reform, hospital/physician alignment, and IT infrastructure.

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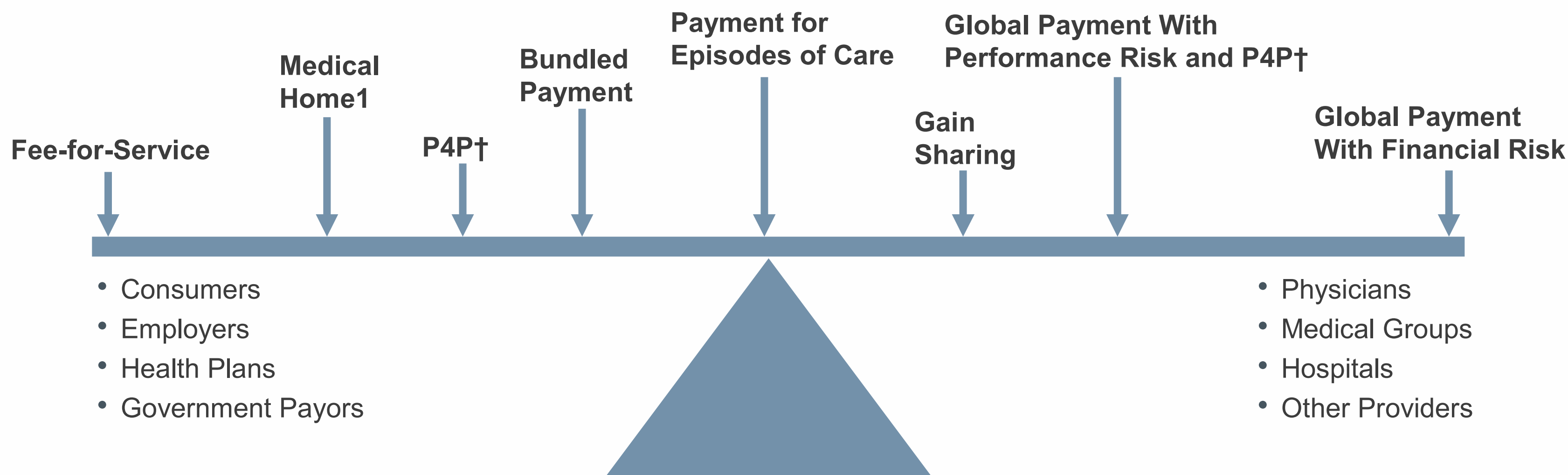
Shifting Payment System

As reimbursement shifts from payments based on FFS (volume) to a more value-based system, risk will shift from payors to providers.

he Risk Continuum Associated With Existing and Proposed Reimbursement Structur



1 Medical homes that receive extra dollars for patient management.
P4P† = pay for performance.

Source: Keith D. Moore and Dean C. Coddington, Healthcare Financial Management Association, "Accountable Care: The Journey Begins," August 2010.

The models we will discuss are moving us toward the tipping point. The shifting risk will place greater emphasis on integrated care models, raising the importance of primary care.

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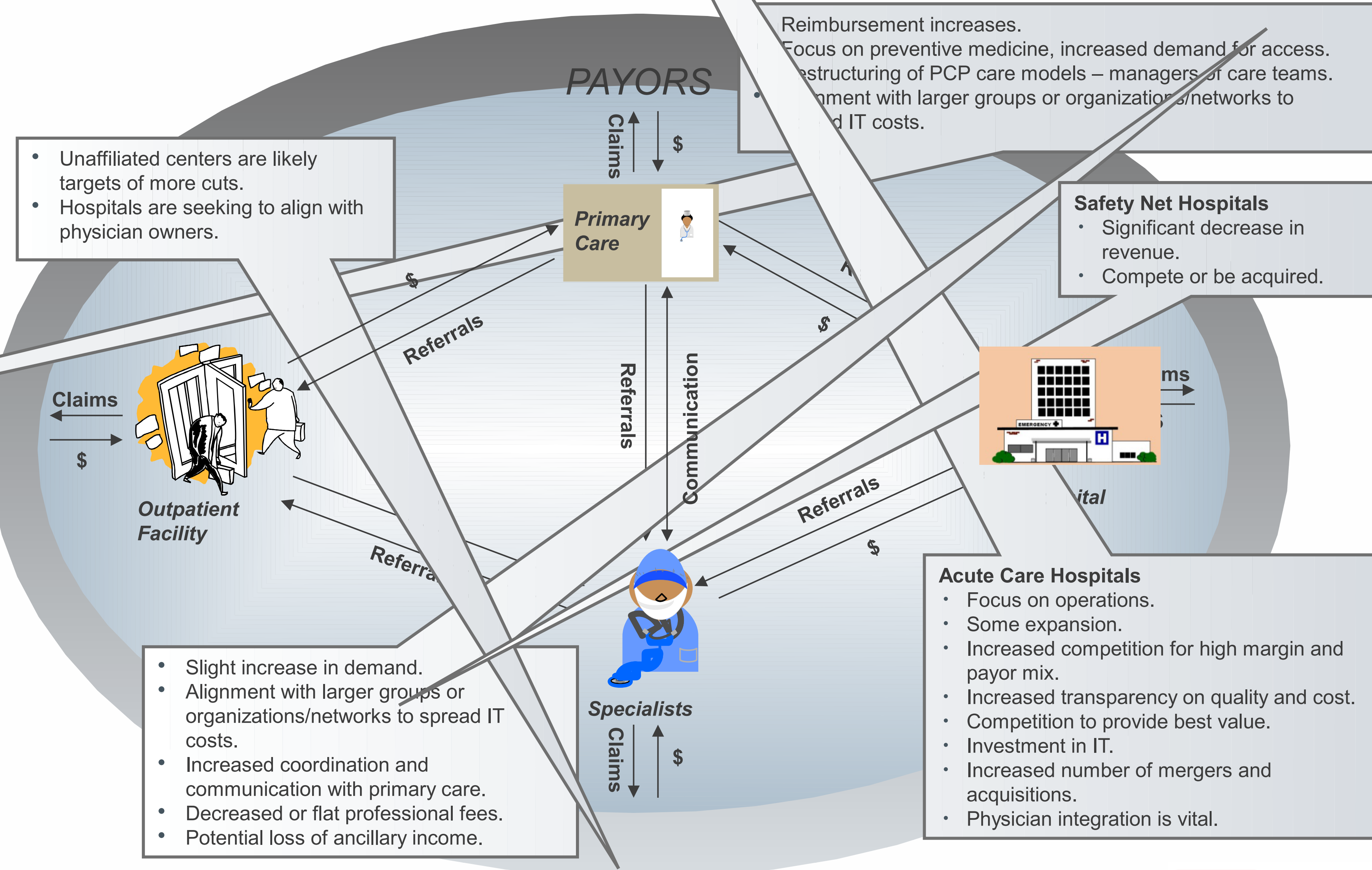
II. Healthcare Reform
Reimbursement Mechanisms

Value-based systems will include P4P/reporting, patient-centered medical homes, and ACOs. All of these systems emphasize monitoring and ensuring the right type of care over volume.

	P4P	PCMH	ACOs	Bundled Payments
Focus	• Quality/outcomes. • Cost savings. • Standardization.	• Chronic care. • Coordinated care. • Cost savings.	• Quality. • Cost savings. • Performance metrics.	• Inpatient episodes of care. • Implantable procedures. • Cost savings.
Payment	Incentive payment for meeting or exceeding quality benchmark standards.	• FFS. • PMPM or management fee. • Quality incentive. • Cost-savings incentive.	Based on calculated savings compared to established benchmarks.	• One payment. • Patient incentive. • Gain sharing.
Outcomes	• Ten physician groups awarded $16.7 million in incentive payments in 2008. • Sacred Heart received $400,000 in June 2008.	• Group Health: decreases of 29% in ED visits, 11% in hospital admissions, and 6% in office visits. • NC: $200 million in total cost savings over 3 years for diabetic and asthmatic patients.	Identification of demonstration project participants.	• Hillcrest: 4.4% savings for heart transplant and joint replacement surgeries. • Acute Care Episode (ACE) demonstration project.

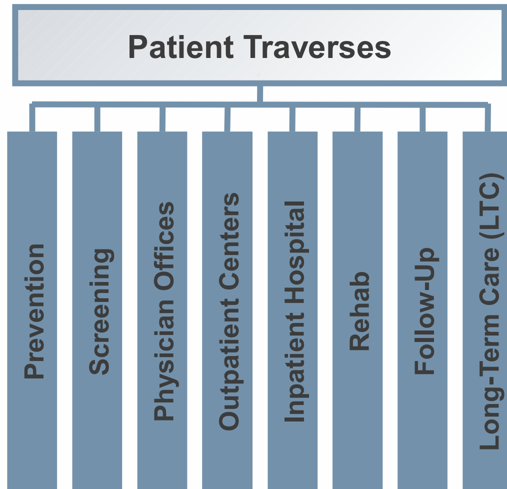
II. Healthcare Reform
Short-Term Impact of Reform



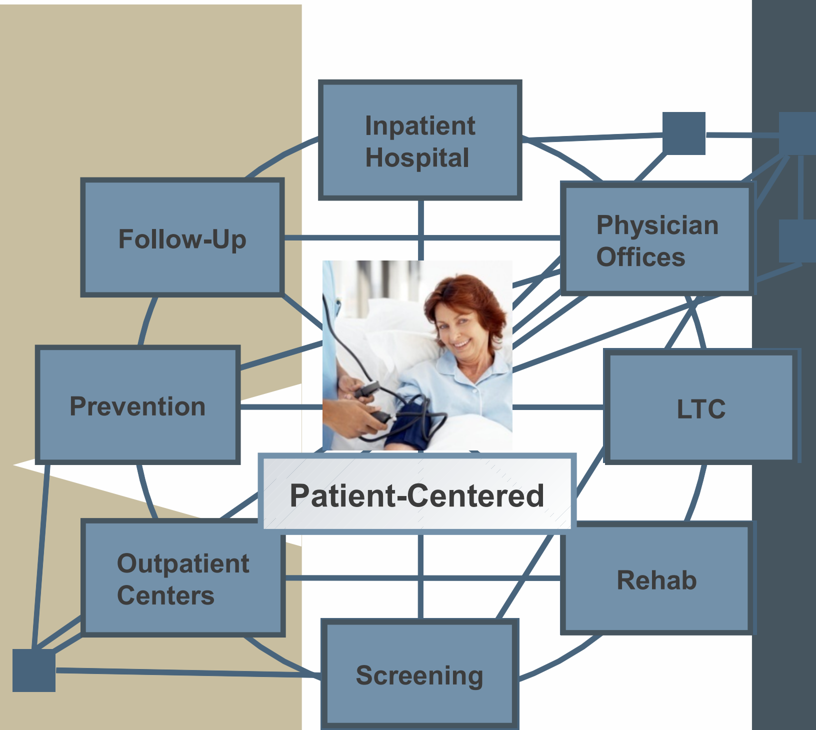
II. Healthcare Reform
Move From Episodic Care to Cycle of Care

However health reform unfolds, an increased focus on integration, quality, and data transparency is coming.

Move From *Episodic* Care



. . . to *Cycle* of Care



rdination Through Information, Patient Navigators, Partnerships

II. Healthcare Reform
Implications for Primary Care

The fundamental change will be to increase the insured population; however, the reimbursement levels may be lower than desired, necessitating the provision of cost-efficient care.

- Nearly all patients (95% to 97%) will have some type of insurance coverage.
- The newly insured population will demand access to care, including a significant number of primary care services.
- Approximately two-thirds of the newly insured are expected to be covered by some government program.1
- Unfortunately, the reimbursement levels will be at a relatively low level.
- Health systems, medical groups, and other ACOs will require creativity to not only provide care for those newly insured in their communities, but to do so cost-effectively.

1 Source: Lisa Dubay and Allison Cook, "How Will the Uninsured Be Affected by Health Reform? Non-Elderly Uninsured," *Timely Analysis of Immediate Health Policy Issues,* Robert Wood Johnson Foundation Urban Institute, August 2009.

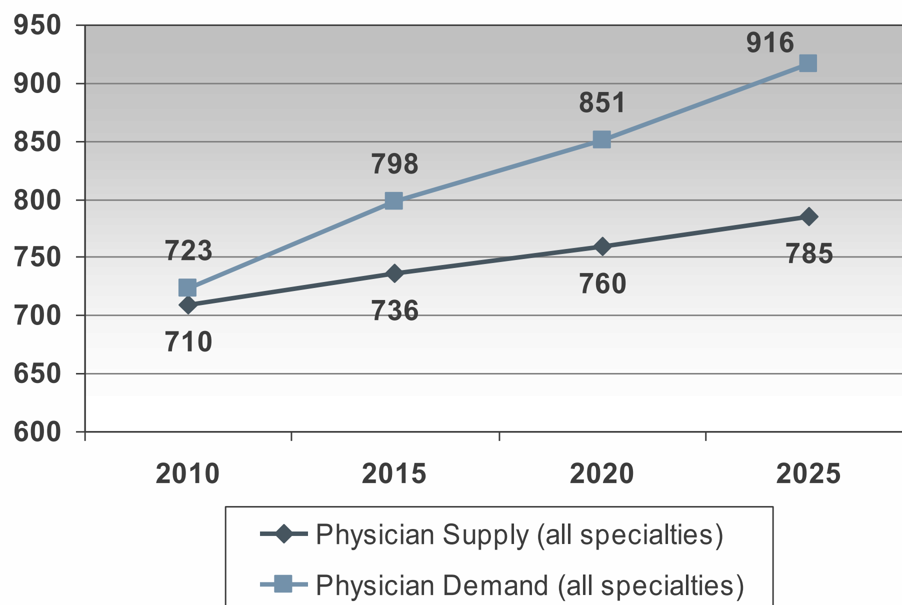
These implications are predicated on the health reform act remaining largely in its current state. We do not anticipate that any significant changes, from a provider's perspective, will occur in the next 2 years.

II. Healthcare Reform
Physician Supply Issues

The expected physician shortage will continue to stress our provider workforce.

- By the end of this decade, the supply of physicians is only expected to increase by 7% at current enrollment rates.
- This is starkly contrasted with an expected 36% increase in Americans over the age of 65.
- The physician shortage is projected to be over 91,000 physicians, including a shortage of 45,000 primary care physicians.

Projected Physician Supply and Demand Active Physician FTEs (thousands)[1]



1 Source: AAMC Center for Workforce Studies, June 2010 Analysis.

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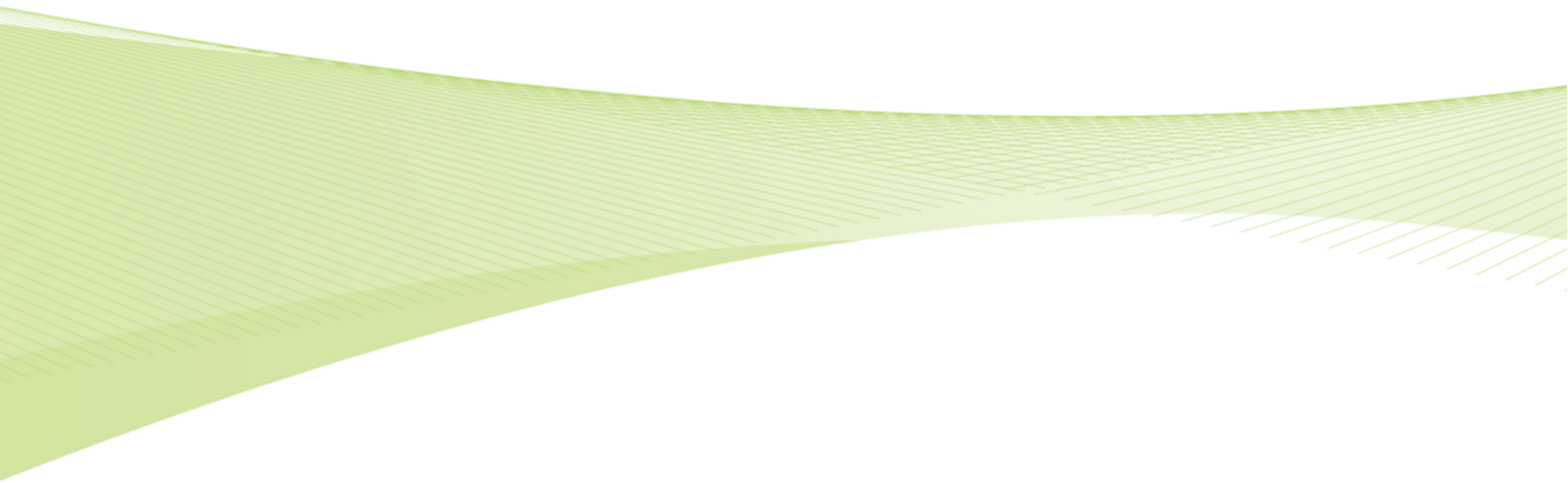
II. Healthcare Reform
Outlook Summary

The continued shortage of primary care physicians and increased demand for care will drive up the cost of physician compensation.

- ***Physician Shortage*** – The acute shortage of primary care physicians, exacerbated by expanded Medicaid coverage, will negatively impact access to timely care, resulting in an ever-more competitive recruiting environment and a continued upward trend in physician compensation, at least in the near term.
- ***Focus on Value-Based Compensation*** – Compensation methodologies will undergo a fundamental transition aimed at better aligning incentives toward value-based care, which will place a greater emphasis on resource management, outcomes, and quality of care. However, production will remain a primary incentive component as organizations limit their provider costs.
- ***Midlevel Provider Demand*** – Compensation and production for midlevel providers will likely increase as more organizations begin to employ these providers as a strategy to address the physician shortage and as a lower-cost option than using physicians. The renewed demand necessitates competitive compensation plans to support recruitment and retention of these providers.

III. Midlevel Provider Trends



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III. Midlevel Provider Trends
Growth of Midlevel Providers

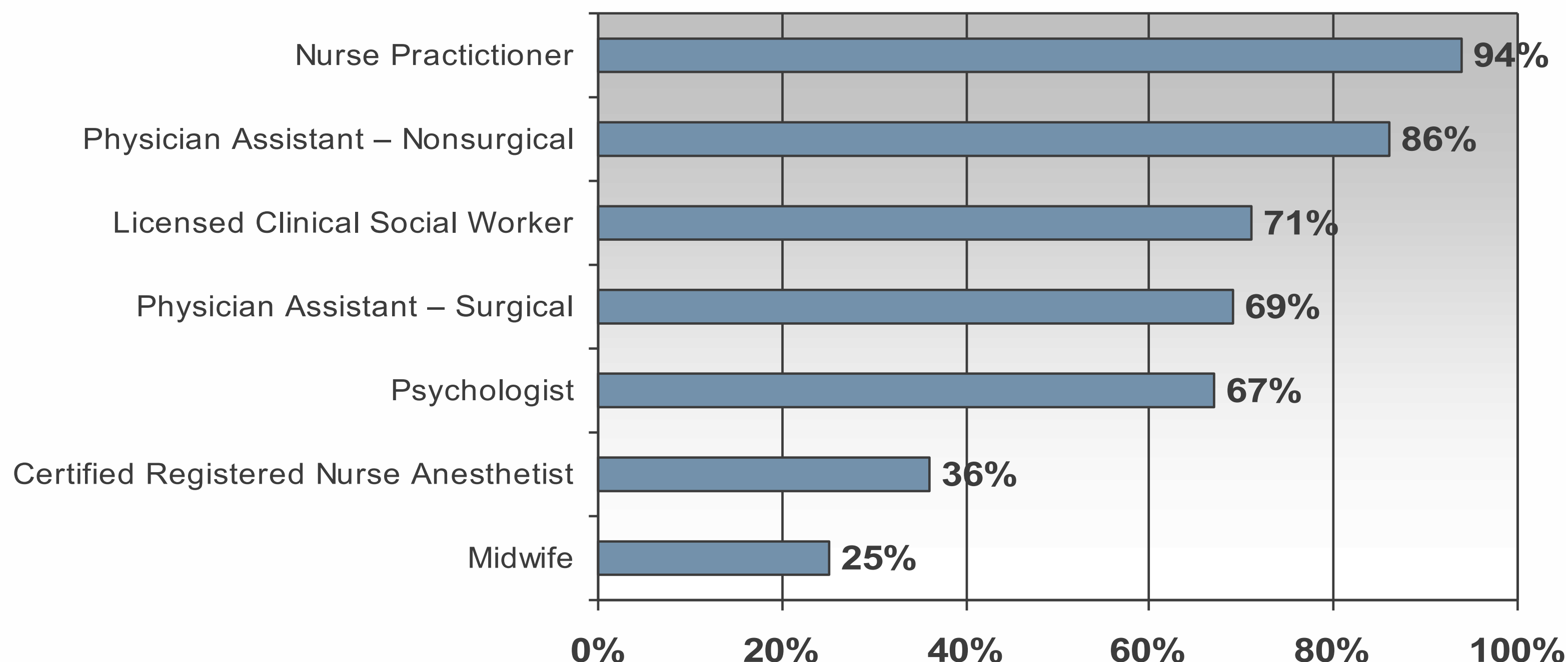
The number of midlevel providers is growing faster than the number of physicians due to the shorter length of training required.

- Currently, there are about 80,000 physician assistants (PAs) and 140,000 nurse practitioners (NPs) in the United States.1
- Further projections indicate that 30,000 additional PAs and over 110,000 additional NPs will be active by 2025, partially helping to fill a shortage of approximately 45,000 physicians for a similar time frame.2
- Only 12,000 physicians are expected to be entering primary care specialties between 2010 and 2025.
- Midlevel providers improve efficiency in healthcare by providing routine or less complicated care, while allowing physicians to address more complex issues.
- Midlevel providers can also provide care in a number of medical and surgical subspecialties.
- The savings from employing a midlevel provider, relative to a physician, is causing most health systems to strongly consider them as an alternative.

1 Statistics source: American Academy of Physician Assistants *(www.aapa.org)* and American Academy of Nurse Practitioners *(www.aanp.org)*.
2 *www.ncpa.org/pub/ba706*.

III. Midlevel Provider Trends
Midlevel Provider Employment

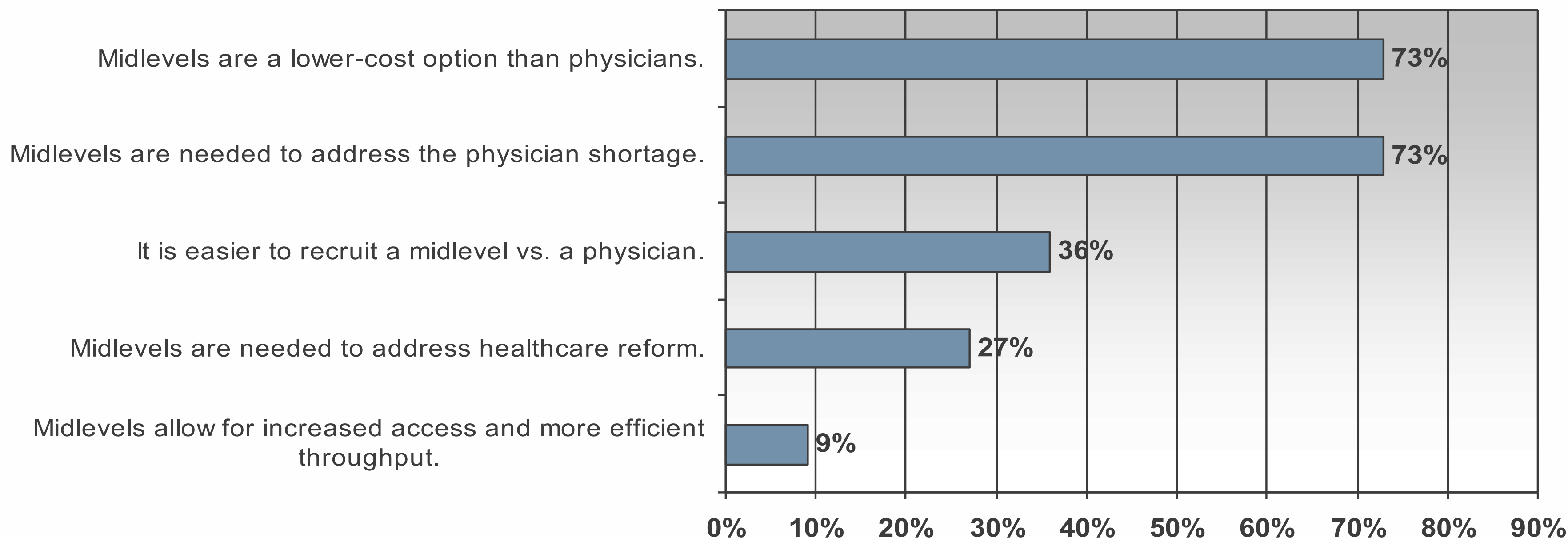
Percentage of Healthcare Organizations Employing Midlevel Providers by Type – 2010



Source: ECG Northwest *Provider Compensation, Production, and Benefits Surveys*, year 2010 based on 2009 data.

All survey organizations indicated that they expect their midlevel provider recruitment efforts to increase or stay the same over the next 12 months.

III. Midlevel Provider Trends
Midlevel Provider Employment Rationale



Source: ECG Northwest *Provider Compensation, Production, and Benefits Surveys*, year 2010 based on 2009 data.

III. Midlevel Provider Trends
Reimbursement Implications

The utilization of midlevel services has significant implications on reimbursement; incentive compensation plans should align with the organization's billing practices.

Direct Billing

- New problems and consults.
- Not part of a physician-initiated plan of care.
- Physician not in the office.
- Reimbursed at 85% of the physician fee schedule.
- Bill under the midlevel's own provider number.

Incident-to Billing

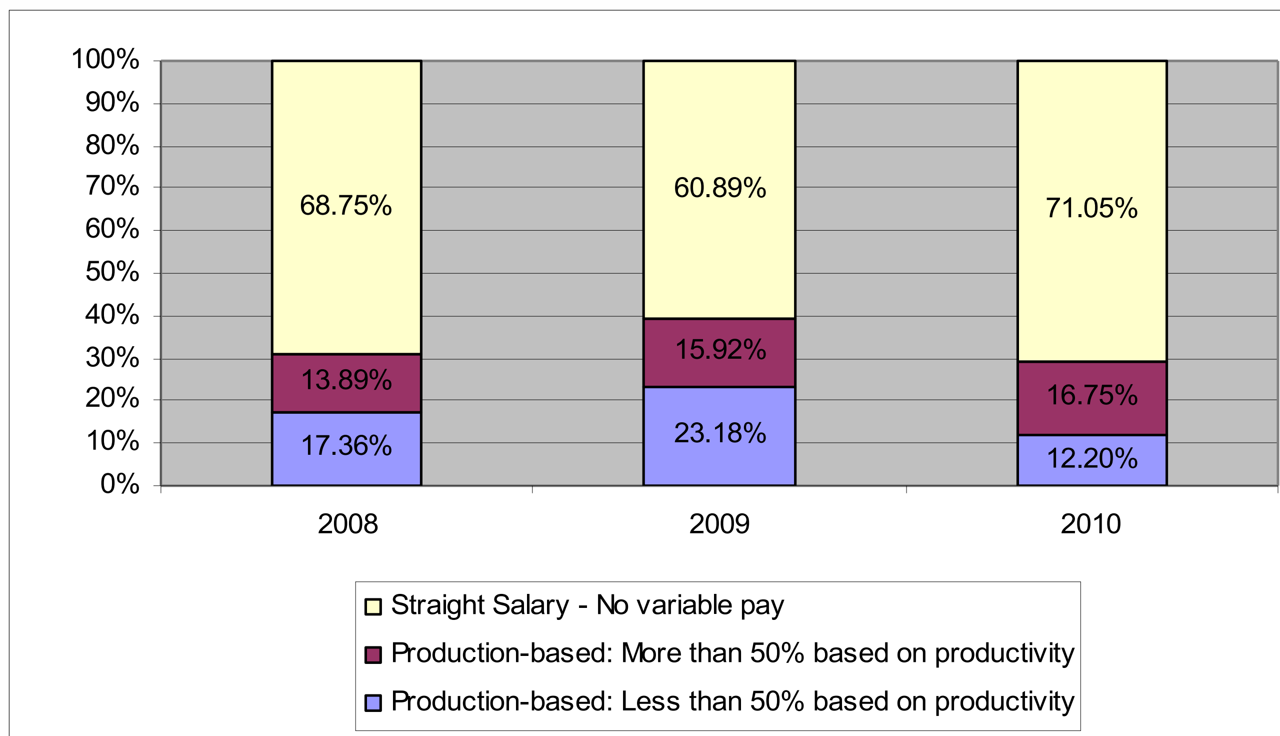
- Established patient services.
- Part of a plan of care previously established by the physician.
- No new problems or consults.
- Physician in the office.
- Reimbursed at 100% of the physician fee schedule.
- Bill under the physician's provider number.

Determining which providers receive WRVU credit for specific visits is an important step in developing an appropriate compensation plan for midlevels.

III. Midlevel Provider Trends
Compensation Plan Types and Metrics

We expect a continuing shift in compensation models to better align incentives with value-based care that will reward a combination of provider production, resource management, and ultimately, health outcomes.

Percentage of Midlevels by Compensation Plan Type



Source: ECG Northwest *Provider Compensation, Production, and Benefits Surveys*, year 2010 based on 2009 data. Nurse Practitioners and Physician Assistant – Nonsurgical only.

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III. Midlevel Provider Trends
Incorporating the New Elements

With payment changes looming that may fundamentally alter the way provider organizations obtain reimbursement, it is important that your compensation plans can adjust to these new incentives/revenue streams.

- Patients expect quality and service.
- Measure and provide incentives for clinical outcomes.
- Use technology to mitigate cost drivers and manage utilization.
- Prepare for the reimbursement pendulum to swing back toward risk assumption.

In this new reality, compensation models must focus on more than just productivity.

IV. Compensation Plan Development

IV. Compensation Plan Development
Initiating the Process

The first step along the way to creating a plan is to define the parameters for development.

Determine goals and objectives for the organization and then create principles for plan development.

- What are the organization's provider group goals and objectives?
- Can your existing infrastructure support the number and type of providers you are seeking to employ?
- What type of recruiting environment is your market, and what are your competitors offering?
- What types of services/specialty areas will your providers be offering?
- Are there certain types of behavior you want to incentivize?
- Do you have defined work rules for employed providers?
- What reliable data elements are available to measure elements of a plan?
- What market benchmarks will be used to establish appropriate compensation levels?

There are likely many additional questions specific to your market situation.

IV. Compensation Plan Development
Plan Development Keys

Any provider compensation planning process should involve several key steps.

- Tailor the plan to the provider's practice; this will help to define what type of plan is required.
  - Independent provider.
  - Physician extender.
  - Mixed practice.
- Determine the participants required for development to ensure proper representation.
  - Establish a committee to design plan parameters and review and approve modification/special cases.
  - Consider physician and midlevel representation in addition to administrative leadership and analysts.
- Outline the required approvals so that the timeline can be tailored to fit the schedule.
  - Determine who needs to approve the compensation plan (e.g., hospital administration, physician group administration, hospital/regional system board).
  - Identify resources for determining fair market value of the plan.

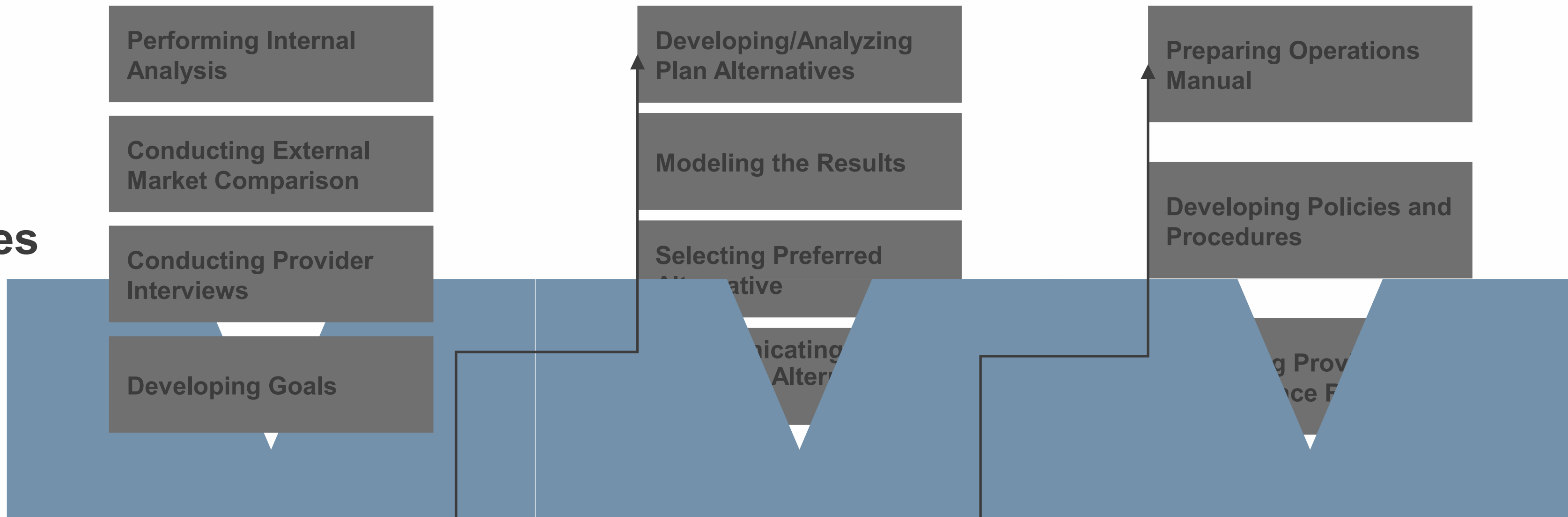
IV. Compensation Plan Development

Typical ECG Compensation Planning Process

The objective of compensation planning is to develop and implement a provider compensation formula that mirrors the values, goals, and culture of the organization.

Internal and External Assessment | **Compensation Redesign** | **Implementation**

Major Activities



Results and Deliverables

Situational Assessment

- Description of current formula.
- Analysis of formula results.
- Comparison to market/industry benchmarks.
- Goals for redesigned model.

Revised Compensation Formula

- Description of goals, methodologies, and implications.
- Calculation of compensation, by provider.
- Summary of results, by specialty.
- Transition plan.

Implementation Plan

- Operations manual.
- Financial model.
- Physician reporting package.

Timeline

	Internal and External Assessment	Compensation Redesign	Implementation
Timeline	**2 Months**	**2 to 3 Months**	**3 to 6 Months**

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IV. Compensation Plan Development
Range of Compensation Models

The following pages describe common compensation models that span the range of typical provider employment arrangements.

Guaranteed Compensation

Variable Compensation

Base Salary

Base Salary With Incentive

Straight Incentiv e

Tiered Incentive

Tiered Incentive Plus Bonus

Guaranteed Compensation	Incentive Compensation
• Limited downside risk for providers. • Less upside potential for providers. • Weaker incentives to alter provider behavior. • Reflects a typical employer/ employee arrangement.	practice.

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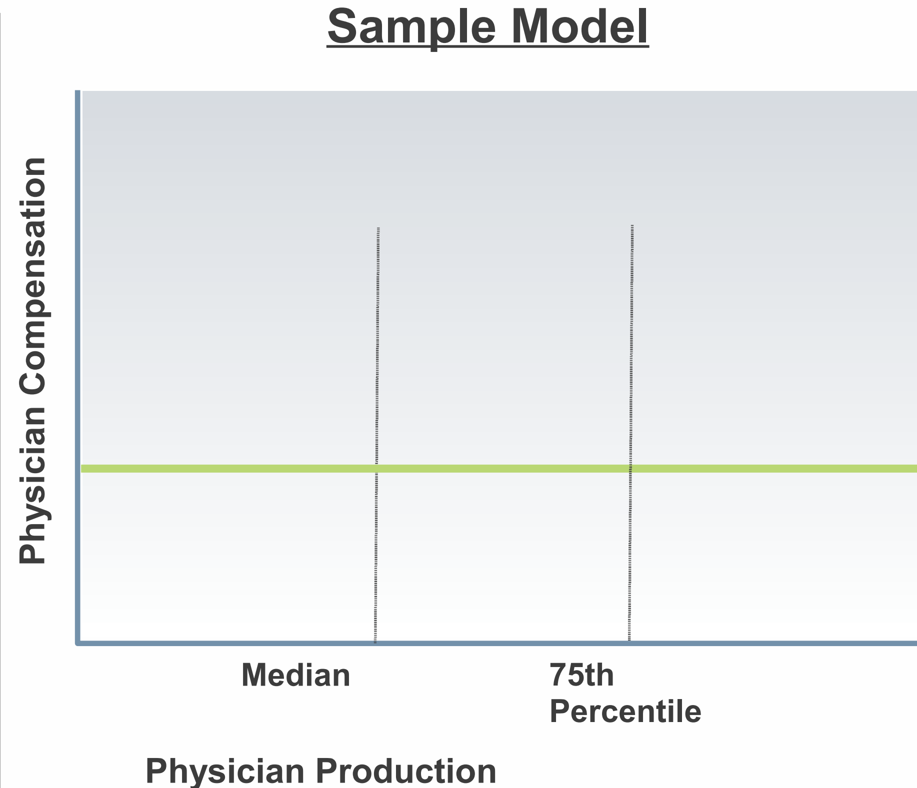
IV. Compensation Plan Development
Base Salary Model

The base salary compensation model is comfortable to many providers but provides little incentive to maintain or increase productivity.

- Limits the providers' downside risk by placing a floor on compensation levels.
- Provides the same income regardless of provider productivity levels.
- Accordingly, provides little incentive for providers to maintain or increase productivity.
- Is most appropriate for midlevels practicing as physician extenders who are not actively engaged/included in nonproductivity programs, as well as newly hired providers.

Sample Model



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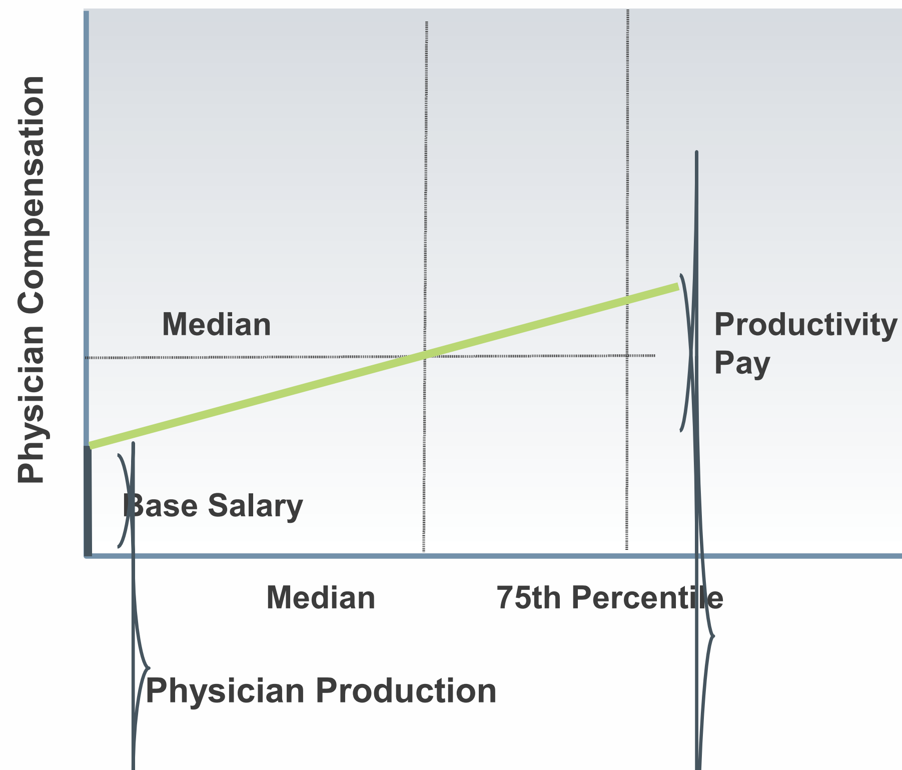
IV. Compensation Plan Development
Base Salary With Incentive Model

The base salary with incentive model gives providers moderate incentives to increase productivity if they are producing near or above the threshold level.

- Limits the providers' downside risk by placing a floor on compensation levels.
- Provides additional income for any productivity that providers generate above a given threshold.
- May not provide a meaningful incentive if the base salary is set too high.
- Is most appropriate for midlevels who operate as physician extenders or have a mixed independent/extender practice.

Sample Model



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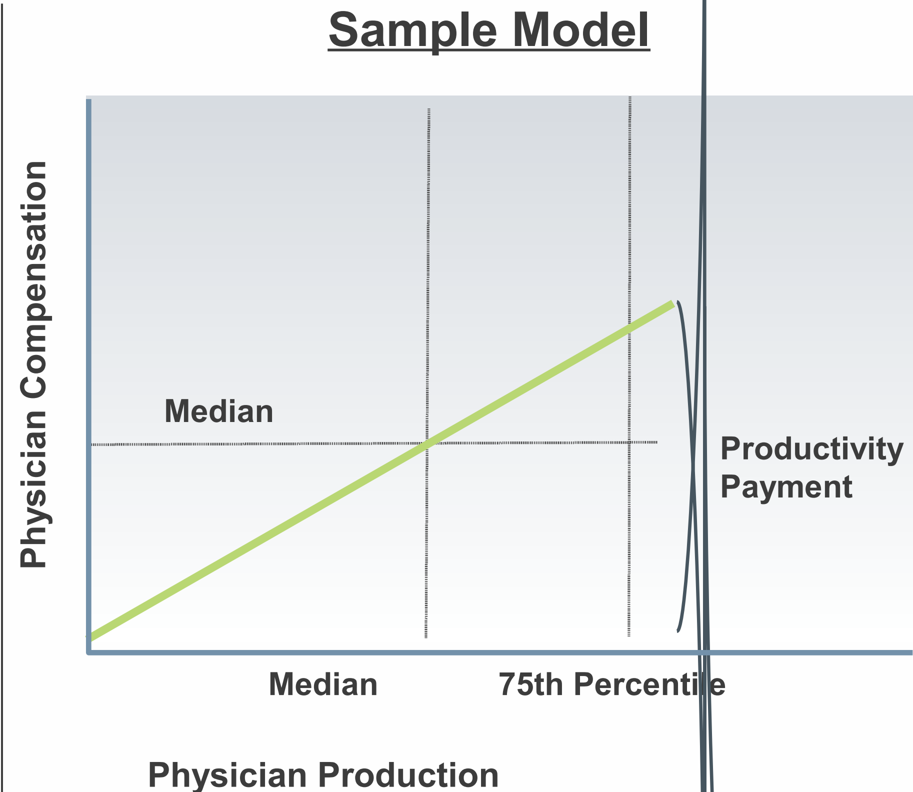
IV. Compensation Plan Development
Straight Incentive Model

The straight incentive model is often a starting point for hospitals that do not have significant experience with employed provider models.

- Includes no base compensation; under this type of model, providers' earnings are entirely dependent on productivity.
- Provides strong productivity incentives, regardless of the providers' current productivity levels.
- Is most appropriate for midlevels with independent practices who have dedicated patient panels.

Sample Model

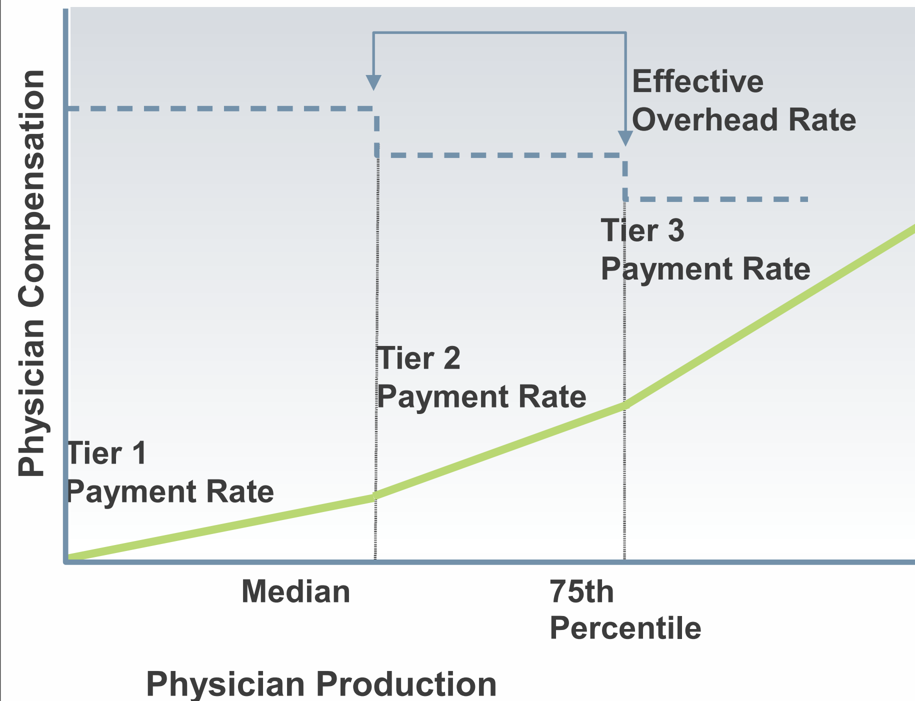


IV. Compensation Plan Development
Tiered Incentive Model

Under this model, tiered overhead rates increase the provider's incentive as his/her production moves beyond established thresholds.

- Provides stronger incentives at every level of productivity.
- More closely approximates market-level compensation because production levels impact individual effective overhead rates.
- Allows for additional tiers to be added so as to increase incentives (a curve is also sometimes utilized rather than multiple tiers).
- Incentive pools can be incorporated for various nonproductivity metrics.
- Is most appropriate for midlevel providers who have their own dedicated patient panels.

Sample Model



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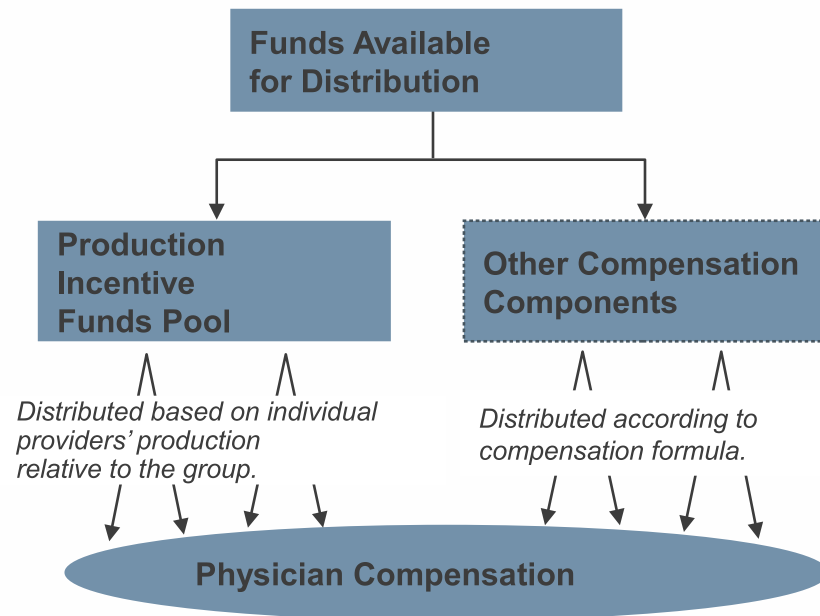
IV. Compensation Plan Development
Relative Incentive Pools

A plan can establish a pool of funds that is divided among participating providers based on their relative production or other metric.

- Pools can be set at:
  - An established dollar amount.
  - A percentage of funds available.
- Pools can be set at the group, clinic, or care team level.
- Advantages:
  - Provides a quantity of funds that is guaranteed to be paid out.
  - Limits the organization's financial risk.
- Disadvantages:
  - Holding other providers' productivity constant, an increase in individual productivity will not yield a same-sized increase in incentive payment.
  - If other providers increase their productivity, high producers must also increase their productivity to maintain their share of the pool.
  - May not provide a meaningful incentive if funding is inadequate.



Sample Incentive Calculation

Funds in Pool:	$100,000
Production Metric:	RVUs
Total RVUs Earned:	25,000
Provider RVUs Earned:	500
Payment Amount:	(500 ÷ 25,000) × $100,000 = **$2,000**

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IV. Compensation Plan Development
Overview of Plan Components

The basic structure of a compensation plan must match the organization's goals; clear principles should be established at the outset of the planning process to ensure cohesion between the plan and the organization's objectives.

Incentive	Typical Plan Goals	Performance Metrics	Typical Plan Percentage
Work Effort	Reward a high level of clinical activity that will result in increased revenues and/or improved patient access.	Charges, net revenues, RVUs, panel size, visits/encounters, and office hours/availability.	80% to 90%
Medical Management/ Quality	Encourage cost-effective and clinically appropriate care.	HEDIS indicators, inpatient days per thousand population, ambulatory visits per thousand population, and selective utilization rates (e.g., ER visits, MRIs).	5% to 10%
Patient Service/ Access	Acknowledge a patient-oriented focus and the importance of patient satisfaction to enrollment growth.	Patient satisfaction surveys, patient complaints and compliments, panel retention, time to third available appointment.	0% to 5%
Citizenship	Reward the performance of nonclinical activities that benefit the organization.	Committee participation, peer review, specific work group outcomes, teaching, and staff surveys.	5% to 10%

Various productivity and nonproductivity incentive metrics are included in ATTACHMENT A.

IV. ...ensation Plan Development
Pl... Supervision

Determining how the utilization of midlevel providers impacts physicians must also be considered.

Least Comple x

...ption	Description
... no ...sation.	• Physicians would not receive any additional income for supervising midlevels. • The general assumption is that physicians are ultimately able to optimize their practice through the use of midlevel providers.
...h a midlevel ...sion stipend.	• Physicians responsible for the supervision of assigned midlevels would receive a defined payment amount for this activity. • The supervision of midlevels would then be considered part of the physician's overall responsibilities.
... midlevel ...ance to ...sing ...ns.	• Supervising physicians would receive credit for midlevel productivity, typically revenue or a discounted rate per WRVU. • Specifically, a predefined percentage of the WRVUs generated is allocated to the physician or the department. • Typically, in these models midlevel salaries and potentially other direct expenses are subtracted from physician income after credit is given for midlevel production.

Most Comple x

If physicians are credited with the majority of practice production, alternate incentive metrics, such as visits, may be more appropriate for midlevels.

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IV. Compensation Plan Development

Benefits and Concerns – Physician Supervision Options

Option	Benefits	Concerns
Provide no compensation.	• Typically, no modifications to the current plan are needed. • Midlevels would only be hired to meet demand or practice style (i.e., could prevent unnecessary hiring practices).	Physicians may not identify opportunities for increased efficiency with the use of midlevels.
Establish a midlevel supervision stipend.	• Provides some reward/recognition for the management of midlevels. • This model is simple to administer and easy to understand.	• This option does not directly encourage optimization of the practice through midlevel use. • Typically, the midlevel is supervised by more than one physician, which complicates and limits the actual incentive. • A policy is needed that defines when providers can hire midlevels (e.g., market demand).
Allocate midlevel performance to supervising physicians.	• Physicians experience a direct compensation impact from midlevel work effort. • Specifically, physicians would be directly incentivized to ensure that midlevels are optimized in their practice.	• It is necessary to establish consensus with regard to what proportion of midlevel WRVUs is allocated to physicians and the rate at which the RVUs are paid. • A policy is needed that defines when providers can hire midlevels (e.g., market demand).

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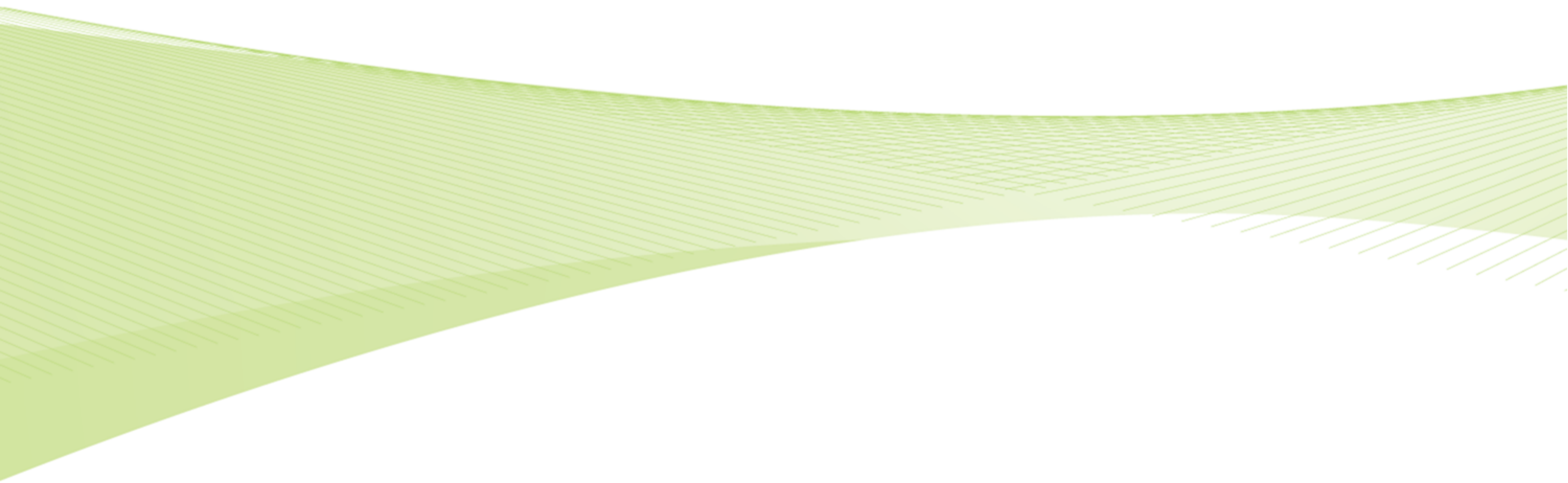
V. Case Studies



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V. Case Studies
Incorporating Quality and Volume

Situation: A 300-physician primary care group wanted to implement a quality incentive component to its compensation plan, as well as reward clinicians who successfully manage a large panel of patients.

- The group initially focused on 14 high-priority HEDIS metrics:
  - Colorectal cancer screening.
  - Breast cancer screening.
  - Cervical cancer screening.
  - Control of hypertension.
  - Comprehensive diabetes care (HbA1c screening, HbA1c control, LDL screening, LDL control, nephropathy, retinopathy).
  - Cholesterol management.
  - Well-child visits, 0 to 15 months and 3 to 6 years.
  - Immunizations.
- We worked with the group to develop a points system that rewards achieving target quality scores on each of these metrics, as well as on the volume of patients seen.

Incorporating Quality and Volume *(continued)*

Providers earn points for every patient for whom they apply the proper care protocol, as well as bonus points if they hit organizational quality targets.

	Patients Not Receiving Proper Care Protocol	Patients Receiving Proper Care Protocol
Target Was Met	0.00 Points	1.25 Points + 30.00 Bonus Points for Meeting Target
Target Was Not Met	0.00 Points	1.00 Point

Example Calculation

Colorectal Cancer Screening

- Target – 65%.
- Provider performance – 62% for 100 patients.
- Points – (100 × 62% × 1.00) = **62.0**.

Breast Cancer Screening

- Target – 80%.
- Provider performance – 82% for 300 patients.
- Points – (300 × 82% × 1.25) + 30 = **337.5**.

Control of Hypertension

- Target – 75%.
- Provider performance – 87% for 150 patients.
- Points – (150 × 87% × 1.25) + 30 = **193.1**.

Total points = **592.6**.

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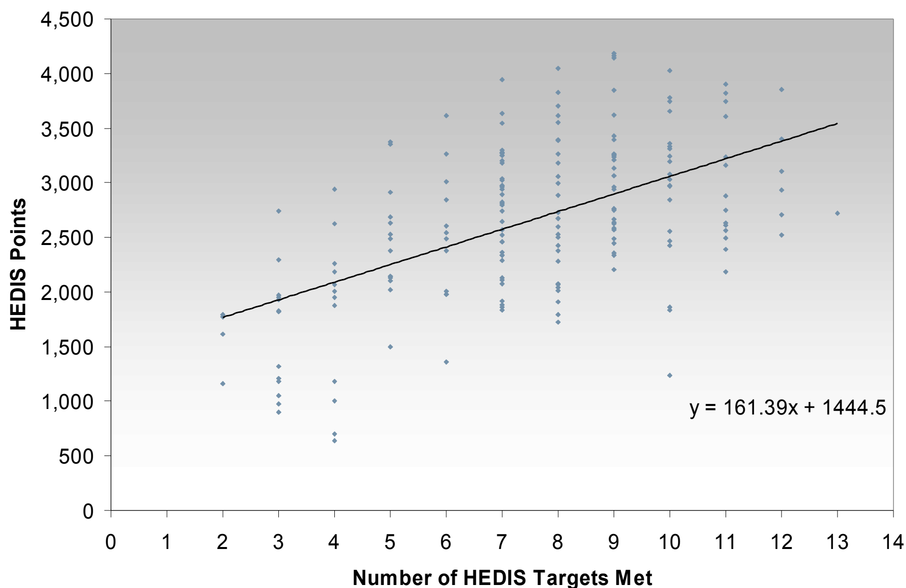
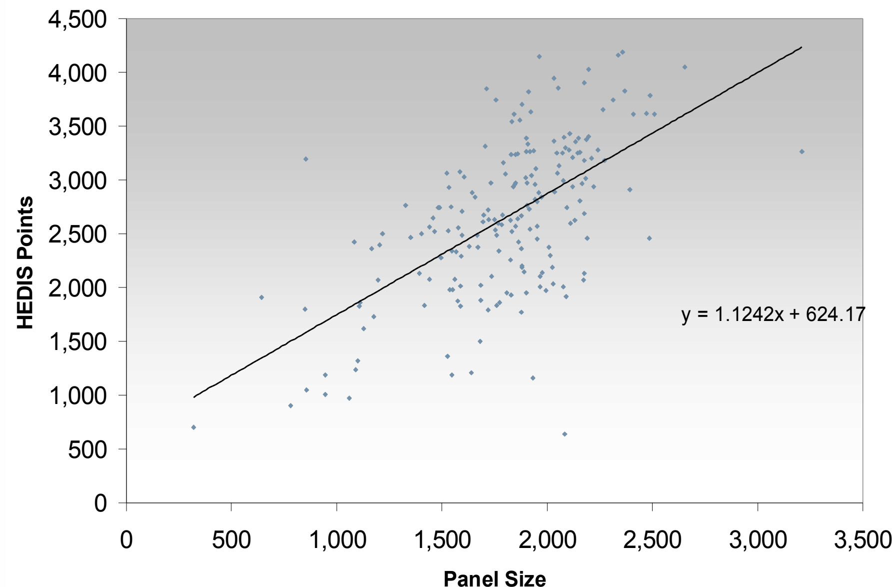
V. Case Studies
Incorporating Quality and Volume (continued)

Analysis showed that both meeting quality targets and the size of the provider's panel were well correlated with the outcome measure of total HEDIS points.

HEDIS Points Versus Number of HEDIS Targets Met



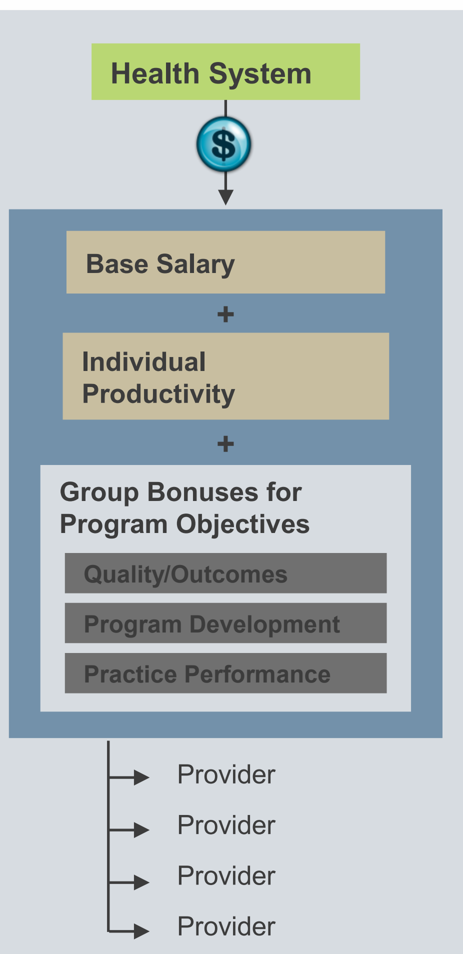
HEDIS Points Versus Panel Size



HEDIS bands were set, based on the initial distribution of total points, and physicians were paid correspondingly more for reaching higher bands.

V. Case Studies
Base Salary Plus Multiple Bonus Model

Implementing a model that provides various service line bonuses could reward providers for nonclinical services that contribute to overall program development.



Description

- Providers will receive a base salary based on a predetermined industry percentile (e.g., 70% of the 50th percentile of benchmarks for the cardiology specialty).
- Providers will receive a productivity bonus based on WRVUs above a threshold level.
  - The threshold is typically based on the level tied to base salary (e.g., 70% of median RVUs).
  - The payment rate per WRVU is based on survey benchmarks.
  - Optionally, the payment rate can be tiered.
- Additionally, providers will be eligible to receive bonuses related to the service line's key objectives.
  - Bonuses could reflect service line objectives related to (among others) cost control, citizenship, program development, and research.
  - Service line bonuses would likely be provided to the physician group at a fixed rate (i.e., compensation for achieving each discrete set of service-related objectives).
- Payments for nonclinical activities (such as medical directorships) could be pooled or paid to the affected individuals.

Considerations

- By providing a base salary guarantee, this model would help ensure financial stability for the providers.
- Including service-related incentives could compensate providers for nonclinical services that contribute to overall program development (e.g., outreach).
- Developing consensus on the key service line metrics could prove difficult; however, it will be important for hospital administration and the providers to agree on a discrete set of service line targets.

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V. Case Studies
Physician Supervision and Credit for Physician Extenders

The committee decided that compensating physicians for their role in supervising physician extenders is largely dependent on how the midlevel is used in the practice.

Key Issues

- Primary care physicians often utilize physician extenders to triage patients, which generally makes the practice more efficient, thereby netting overall gains in productivity.
- Other physicians encourage physician extenders to develop their own primary care patient practices, which can decrease productivity for the physician due to responsibilities such as chart over-reading and order signing. Typically, this occurs in the primary care physician specialties (in some cases, these responsibilities can be minimal).
- In other specialties, however, physicians actually enhance their productivity by working with physician extenders; this often occurs in the surgical subspecialties.
- Due to these differences, the foundation structure may encompass developing several different supervisory payment models and employing the models on a case-by-case basis. In some cases, the physicians would receive no payment for midlevel supervision.

Potential Supervisory Payment Models

- Adjusted net revenue model.
- Productivity credit model.

The potential supervisory payment models are outlined on the following pages.

V. Case Studies

Physician Supervision and Credit for Physician Extenders: Adjusted Net Revenue Model

Under the adjusted net revenue model, the supervising physician would benefit from any profit generated by a supervised physician extender.

Description

- The foundation collects all revenue generated by the physician extender.
- An overhead rate is applied to the revenue collected (e.g., 30%).
- Physician extender salary and benefits are also applied to the revenue (e.g., $100,000).
- Remaining income is credited to the supervising physician(s) as additional compensation.

Adjusted Net Revenue Model – Example Calculation

Description	Element	Value
Revenue Generated by Physician Extender	A	$170,000
Overhead Rate (30%)	B	51,000
Physician Extender Salary and Benefits	C	100,000
Remaining Income Credited to Supervising Physician	D = A - B - C	$ 19,000

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V. Case Studies

Physician Supervision and Credit for Physician Extenders: Productivity Credit Model

Under the productivity credit model, the physician supervisor would receive credit for a percentage of the physician extender's productivity.

Description

- WRVU production, by physician extender, is tabulated.
- A percentage of the WRVUs produced is credited to the supervising physician(s) (e.g., 25%).
- A conversion rate, based on the physician compensation plan, is applied to the credited WRVUs.
- The supervising physician(s) is credited with the compensation amount.

Productivity Credit Model – Example Calculation

Description	Element	Value
WRVUs Produced by Physician Extender	A	2,000
Percentage of the WRVUs	B	25%
WRVUs Credited to Supervising Physician	C = A × B	500
Compensation Rate Per WRVU	D	$40
Compensation Credited to Supervising Physician	E = C × D	$20,000

VI. Conclusions

VI. Conclusions
Optimizing Midlevel Provider Programs

The use of midlevels should be optimized for operational efficiency and revenue generation.

Coding Considerations

- Assess CPT coding profiles and volumes to identify opportunities to utilize midlevels (i.e., low-acuity E&M code volume and limited procedure volumes).
- NP or PA services incident to a physician service receive maximum reimbursement.

Operations Considerations

- Eliminate administrative responsibilities for nonphysician providers, such as scheduling and obtaining insurance verification and authorization to optimize scheduling.
- Ensure that nonphysician providers adhere to state and Medicare licensure requirements.
- Train all providers on the use of electronic health record systems to optimize objective clinical reporting, outcomes tracking, and ultimately, quality of care.

VI. Conclusions
Optimizing Midlevel Provider Programs (continued)

Billing Considerations

- Billing directly by nonphysician providers, when appropriate, can help to maximize operational efficiency, though reimbursement usually drops 15% per visit.
- It is important to know the regulations and reimbursement levels for each payor based on provider type and service delivery details.
- For those NPs and PAs who are initiating the billing process, an extensive training program is recommended in order to maximize effectiveness and ensure compliance with all regulatory requirements.
- Ensure that existing superbills are updated regularly and include all of the typical services performed by the nonphysician practitioners to support proper charge capture.

VI. Conclusions
Keys to Success

Several key factors will help organizations to be successful in their compensation planning efforts.

- ***Provider Input and Direction*** – Recruit opinion leaders to assist in the design of the compensation plan.
- ***Market Relevance*** – Pay competitive income for competitive work effort.
- ***Flexibility*** – Adopt a plan that flexes with the market annually.
- ***Transition*** – Include analysis of the impact and transition to the new structure. Plans typically includes some temporary income protection.
- ***Communication*** – Communicate fully and frequently to all providers.
- ***Simplicity and Objectivity*** – Establish understandable, objective, and measurable incentives.
- ***Alignment of Incentives*** – Align provider and organization incentives.
- ***Respect for Culture*** – Respect the differences in the decision-making process and organizational style within the medical group.
- ***Resistance to Making Special Deals*** – Once the planning process is complete, stay true to the decisions that were made by the committee.

VI. Conclusions
The Future

Amid industry changes and recruiting challenges, provider organizations should reaffirm their 2011 strategies in order to ensure success.

- Review and update compensation plans and utilize appropriate benchmarks.
- Engage providers in short- and long-term organizational planning efforts.
- Develop recruiting and retention programs that incorporate the realities of the economic environment and the changing provider workforce.
- Understand the factors that influence your business, but do not let them paralyze you.

Winning provider organizations are those that have a clear strategy, commit to efficient operations, and align incentives of the organization and its providers.

Questions & Answers

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Attachment A
Metrics and Additional Considerations

Productivity Metrics

A variety of productivity metrics can be utilized; each has advantages and disadvantages that should be evaluated in terms of plan goals.

Variable	Advantages	Disadvantages
RVUs	• Most accurate available measure of provider work effort. • Most consistent comparison of physician productivity across regions. • Payor-blind. • Can be customized to the meet the organization's needs.	• Divorced from the economics of the practice. • Some providers do not understand recent changes to the RVU system. • Often incite philosophical conversations about the "value" of any one service compared to others.
Collections	• Direct measure of cash inflow. • Aligned with financial strategy.	Affected by payor mix, payor contract rates, and effectiveness of billing/collections office.
Gross Charges	Aligned with financial strategy.	Influenced by fee schedules, which can vary widely and are not necessarily representative of productivity or reimbursement.
Visits/Patient Encounters	Easily measurable and understandable to providers.	• Does not consider acuity or length of visit. • May be more applicable for midlevels acting as extenders, since physicians may receive a higher proportion of WRVUs.

Increasingly, organizations that employ providers have moved to RVU metrics, which incentivize providers to care for all types of patients.

Service Metrics

Potential Metrics	Examples
Clinical Quality	• Adherence to selected Physician Quality Reporting Initiative (PQRI) quality guidelines. • Achievement of three unique quality metrics (e.g., a 5% reduction in door-to-balloon time or CHF readmissions) as approved by the service line governance committee.
Practice Operations	• Participation in at least three service line committees. • Active involvement in supply chain improvement initiatives.
Patient Satisfaction Scores	• Achievement of predetermined patient satisfaction scores (e.g., internal benchmarks, indicators from the Press Ganey Associates, Inc., survey).
Financial Indicators	• Cost reductions of 5% each year. • Revenue gains of 5% each year.
Outreach/Referral Relationships	• At least 20 hours per month provided to community outreach in designated key areas. • Market share gains of 5% each year.
Access	• Time to third available appointment. • Percentage of patients successfully able to obtain an appointment within 2 weeks.
Program Development	• Achievement of program targets related to clinical research and/or program development (e.g., percutaneous valve program). • At least 20 hours per month provided to clinical research initiatives.

Additional Issues to Consider

Issue	Consideration
Part-time providers and shared practices.	Adjust FTE/target as necessary.
Administrative roles/nonclinical income.	• Adjust FTE/target as necessary. • Pay stipend.
Benchmark data/sample size issues.	Consider blended benchmarks when sample size is a concern.
Draw and reconciliation methodologies.	Set regular true-up periods to adjust compensation (e.g., quarterly).
Providers who leave or join at midyear.	N/A.
Transition planning.	N/A.
Impact of benefits on total compensation.	Adjust compensation given benefit levels in comparison to benchmarks.
Income protection for newly recruited providers.	Provide guaranteed salary for initial employment term (e.g., 2 years).