



## The Fundamentals of ID Physician Compensation: What Are the Options for Deciding Which Compensation Model to Choose?

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Infectious Diseases Society of America

# Learning Objectives

1

Learn who the relevant decision-makers are for determining physician compensation.

2

Understand the various elements of compensation.

3

Review several types of compensation frameworks and how they apply to different employment arrangements and care settings.

4

Identify the potential benefits of incentive compensation.

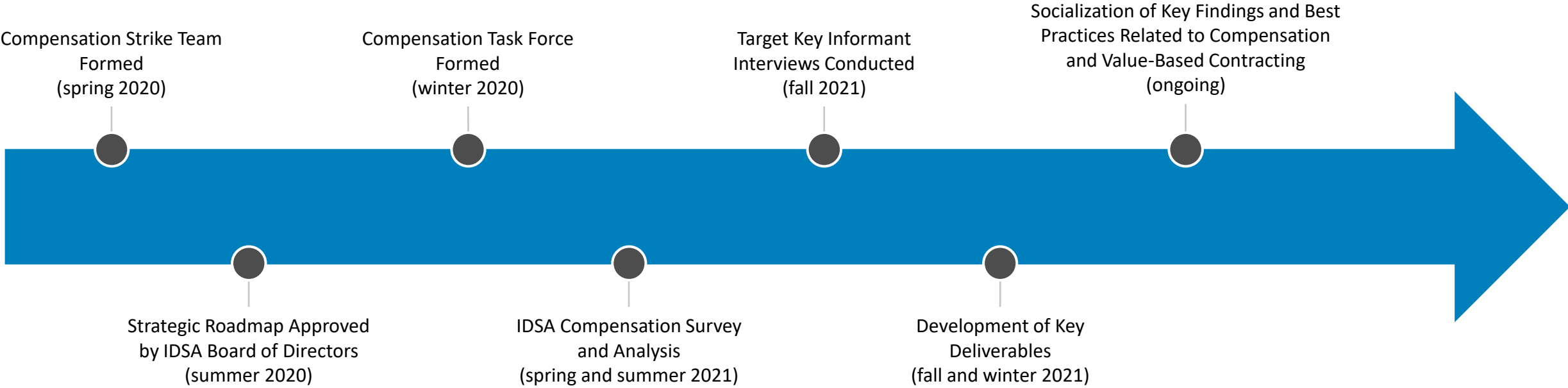
# Agenda

1. Infectious Diseases Society of America (IDSA)  
Physician Compensation Initiative
2. Compensation Decision-Makers
3. Compensation Elements and Frameworks
4. Incentive Compensation

# IDSA Physician Compensation Initiative


# Physician Compensation Initiative Overview

The IDSA Board of Directors established a Compensation Strike Team that was charged with developing a strategy and implementation plan for increasing ID physician compensation; this is a key component of IDSA’s strategic plan. The Compensation Task Force was established to then implement the plan.



## Future Key Deliverables

 Physician Compensation Negotiation Playbook

 Value-Based Contracting Guide

# Compensation Decision-Makers

# Common Compensation Decision-Makers



## Department Heads

Some organizations are structured with ID within a department instead of a division, and compensation is determined by a department head.



## Division Chiefs

It is common within a health system or with academic employment for compensation decisions to be conducted by the division chief.



## Medical Group Administration

An organization can have an established medical group that determines physician compensation or funding to departments or divisions.



## Hospital Administrators

Most organizations have defined hospital administrators who determine individual physician compensation or funding to departments or private practices.



## Private Practice Partners

Within a private practice, compensation is determined by the partners of the group or a management committee of partners.

## Human Resources

Some organizations involve human resources to determine a physician's compensation and contract terms.

Academic Medical Center Employed

Health System Employed

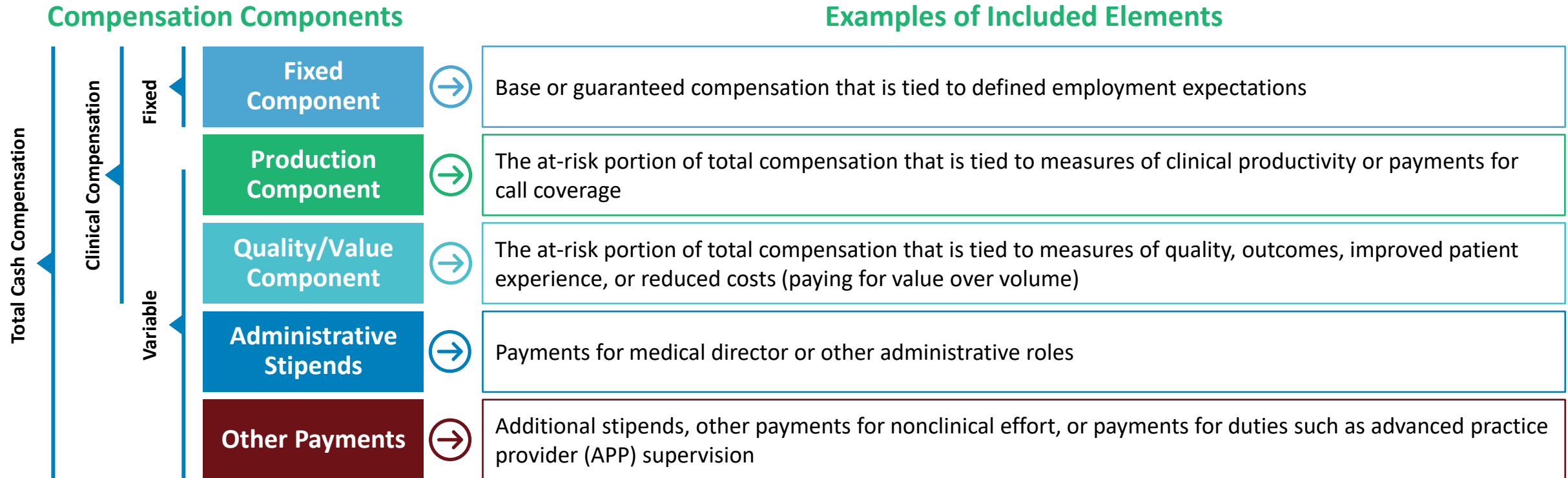
Private Practice Employed

# Compensation Elements and Frameworks



# Defining Elements of Physician Compensation

Categories of compensation paid to a physician depend on the activities performed by the physician and are flexible based on an organization's compensation methodology and strategic and financial objectives.



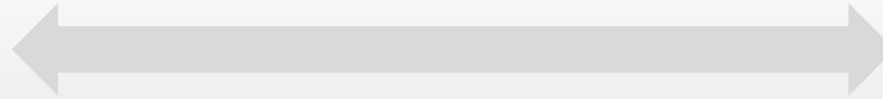
**Excluded Components:** Fringe benefits paid by the employer (i.e., retirement plan contributions and life and health insurance) and expense reimbursements; *these are outside the scope of benchmarks.*

# Fixed versus Variable Compensation

## Fixed Compensation



## Variable Compensation



### On One Hand

- Fixed compensation helps mitigate the potentially negative by-products of making work relative value unit (WRVU) production the primary focus.
- Fixed plans often simplify the methodology and reduce the complexity associated with compensation calculations.
- Many providers (particularly those who are newly trained) crave stable compensation systems that are understandable and minimize downside risk.


### On the Other Hand

- Fixed plans can result in significant misalignment between compensation and the full breadth of provider contributions.
- Any actual or perceived variance between compensation and contribution can create feelings of inequity.
- Fixed compensation plans require a strong organizational culture and highly effective governance and management.
- Relative to fixed plans, variable compensation plans are self-correcting in nature.






▶ **A balanced approach recognizes coverage-based requirements but rewards those who are more productive and deliver exceptional quality, service, and value.**

# Defining Relative Value Units (RVUs)

- The Medicare Resource-Based Relative Value Scale is the method by which Medicare sets reimbursement rates for each CPT code assigned to every physician encounter; thus, physicians' services are counted in RVUs.
- RVUs are periodically reviewed and adjusted for changes in technology and physician practice patterns, and updates are published annually.
- Medicare bases RVUs on the following:
  - **Physician Work (PWRVU):** The physician's expertise and the time and technical skill spent in performing the entire service, considering the mental effort and judgment expended by the physician prior to, during, and after the patient encounter terminates, including documentation of the service
  - **Practice Expense (PERVU):** The cost to operate a medical practice
  - **Malpractice (MPRVU):** Insurance expense, which estimates the relative risk of services and cost to insure against the risk of loss in providing the service
- Each component of the RVU is assigned to each CPT code.
- The Medicare Conversion Factor is a national value that converts total RVUs into dollar amounts paid by Medicare to physicians for the services they provide. Nearly all commercial payers have also adopted RVUs to set their payment rates.

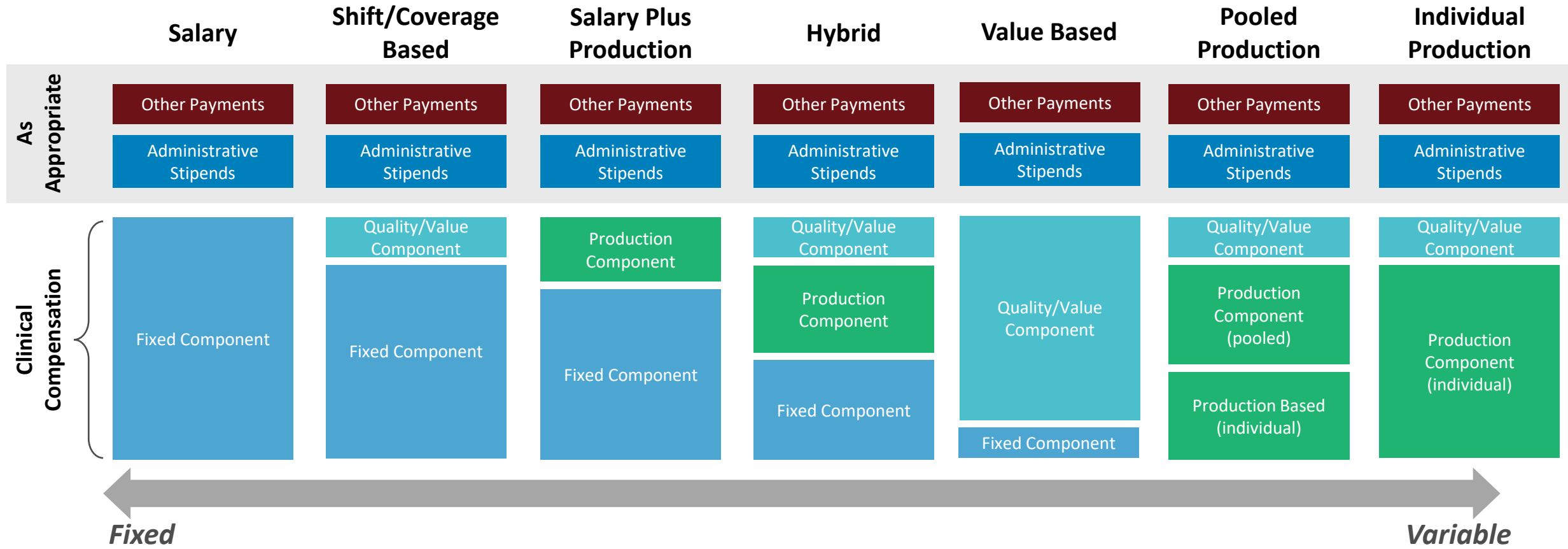
 *Most used in physician compensation*

# Defining Potential Categories of Effort

|   |  |
|---|--|
|  <b>C</b> linical      | <ul style="list-style-type: none"><li>• Is based on patient-facing and related effort</li><li>• Includes activities such as documentation in the EHR, patient calls, interdisciplinary conferences, and teaching in the usual course of clinical care</li></ul>                                  |
|  <b>A</b> ministrative | <ul style="list-style-type: none"><li>• Consists of formally defined roles, such as medical director and other administrative roles</li><li>• Includes clinical leadership roles if time is protected and/or compensated</li></ul>   |
|  <b>R</b> esearch      | Includes funded and unfunded research responsibilities, active grant management, and the pursuit of grant opportunities  |
|  <b>T</b> eaching      | <ul style="list-style-type: none"><li>• Is didactic teaching that occurs during nonclinical, nonbillable time</li><li>• Consists of formal teaching positions and responsibilities (fellowship director, residency director, or clerkship director)</li></ul>                                    |
|  <b>S</b> trategic   | <ul style="list-style-type: none"><li>• Includes other identified activities that support the institution (e.g., new provider practice start-up, new facility planning, EHR implementation)</li><li>• Consists of short-term administrative effort that might not always be recognized</li></ul> |

# Continuum of Conceptual Model Frameworks

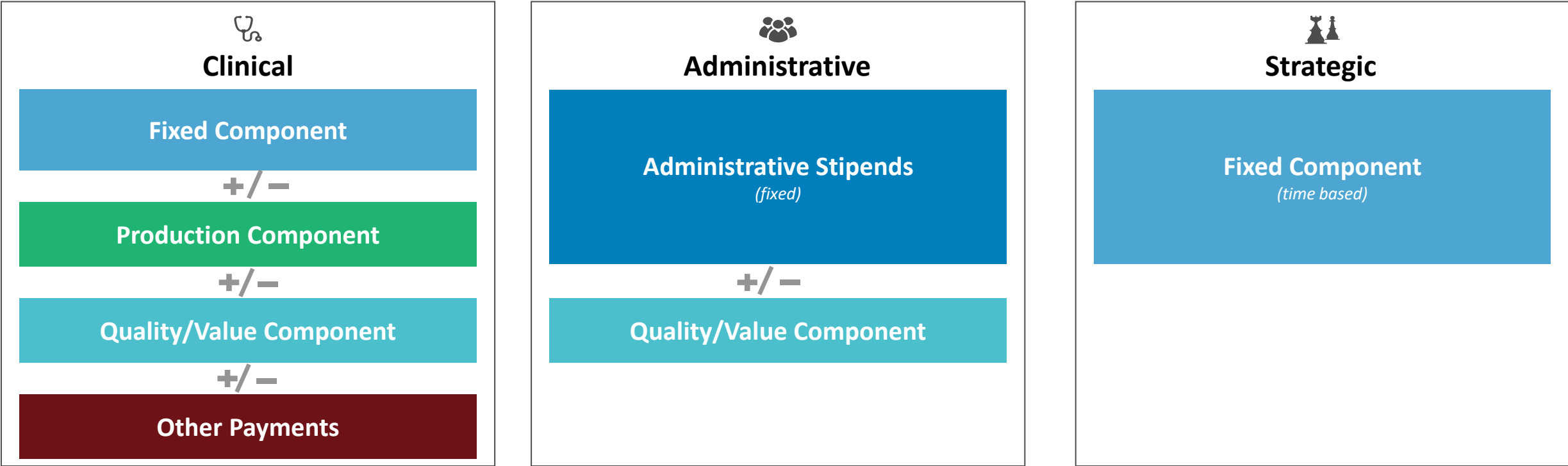
Using the five building blocks of physician compensation, various plan types can be developed to accommodate the needs of various clinical specialties.



► Salary and individual production models are common for ID physicians.

# Nonacademic Structure of Compensation by Category

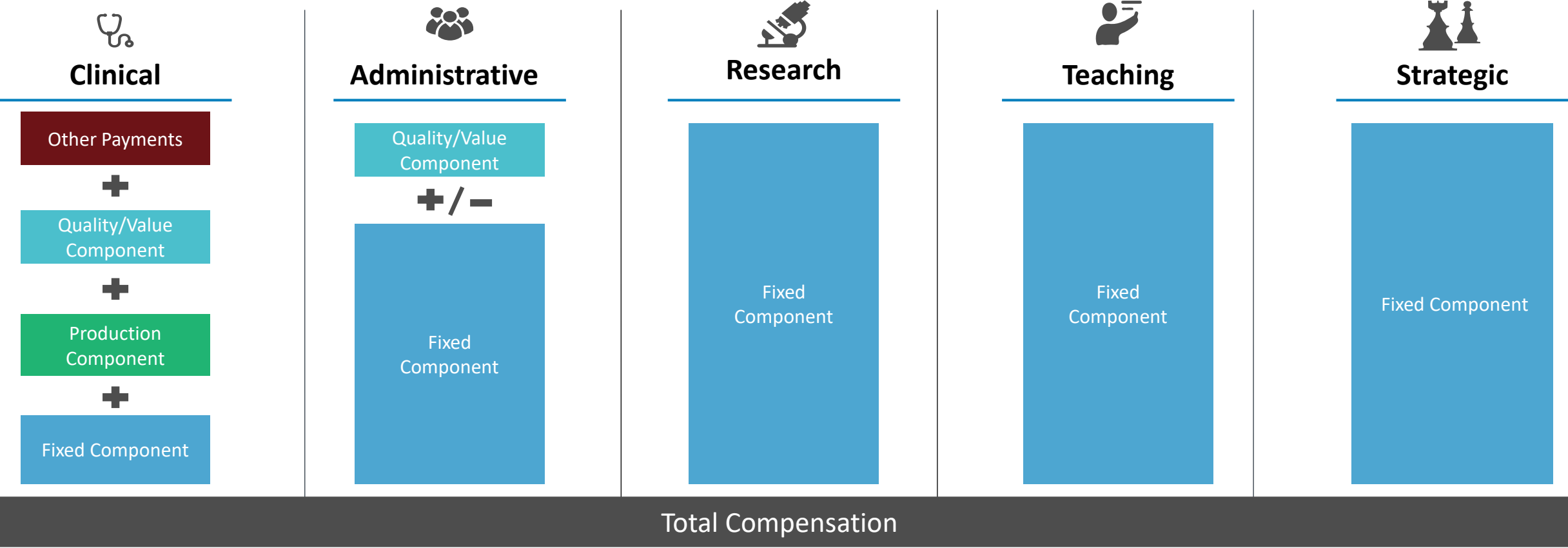
The categories of compensation paid to individual physicians depend on what activities are performed. The proportions of the components of compensation are flexible and vary based on third-party reimbursement and the business objectives of the organization.



Total Compensation

# Academic Structure of Compensation by Category

In response to changing market dynamics, many academic healthcare organizations are employing more progressive payment structures that segment compensation elements.



# Incentive Compensation



# Key Performance Indicators

WRVUs remain the most common measure within incentive plans, whereas quality and patient satisfaction continue to be prevalent within physician compensation plans. On average, 5.8% of compensation is based on quality and/or patient satisfaction performance measures, which is down from 6.9% in 2020.

## Compensation Plan Key Performance Indicators

|                      | Percentage of Organizations Using Component |         |          |                |       |
|----------------------|---|---------|----------|----------------|-------|
|                      | Primary Care                                | Medical | Surgical | Hospital Based | APPs  |
| WRVUs                | 91.1%                                       | 89.2%   | 92.9%    | 63.0%          | 30.4% |
| Quality              | 73.3%                                       | 64.9%   | 57.1%    | 58.7%          | 32.6% |
| Patient Satisfaction | 15.6%                                       | 16.2%   | 14.3%    | 8.7%           | 6.5%  |

## Quality and Patient Satisfaction Compensation by Specialty Category

| Specialty Category | Market Average   |   |
|--------------------|--|---|
|                    | Percentage of Total Compensation Dependent on Quality and Patient Satisfaction | Quality and Patient Satisfaction Compensation per FTE |
| Primary Care       | 6.4%   | \$16,530  |
| Medical            | 5.1%   | \$20,522  |
| Surgical           | 4.9%   | \$23,810  |
| Hospital Based     | 6.3%   | \$21,389  |
| Total Physicians   | 5.8%   | \$20,000  |

▶ Other key performance indicators include value-based metrics such as panel size and access, as well as profitability.

Source: ECG's 2021 Physician Compensation Survey.

# Performance Incentives: Value-Based Considerations

Aligning compensation with the organization's strategy and market forces increasingly means considering a value-based component.

## Increasing Payer Focus

The growing market penetration of shared risk and prospective payment models make adopting value-based concepts financially viable and supportable from a fair market value perspective.



## Risk Mitigation

Further diversification of the patient base and models can help to mitigate major market risk in the event of future disruptions (e.g., COVID-19, Medicare Physician Fee Schedule updates).



## Deemphasizing the WRVU

There is a desire to deemphasize the focus on WRVU production and shift to economic factors that tie to payer-focused metrics and the contributions of providers toward wellness and patient health.



**Service Excellence**



**Citizenship**



**Access**



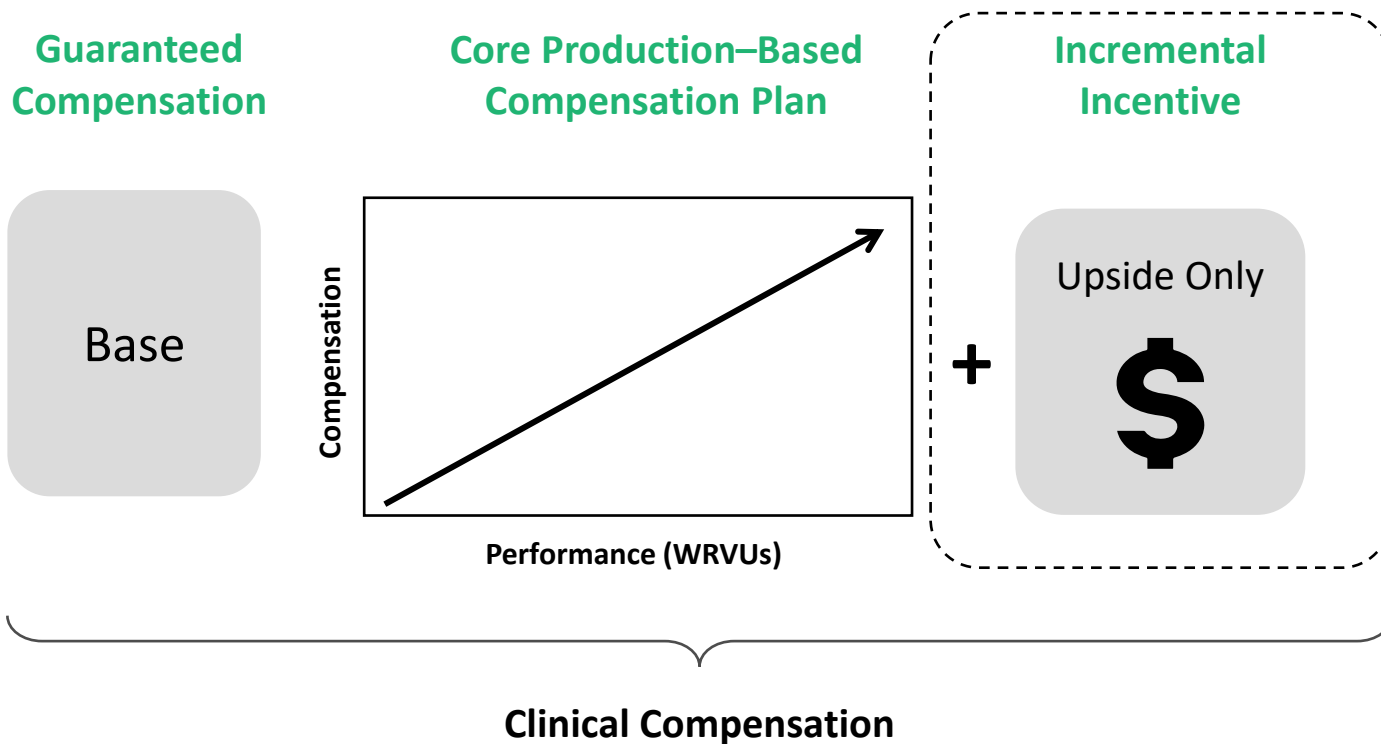
**Quality and Safety**



**Financial Stewardship**

# Value-Based Compensation: Upside-Only Reward

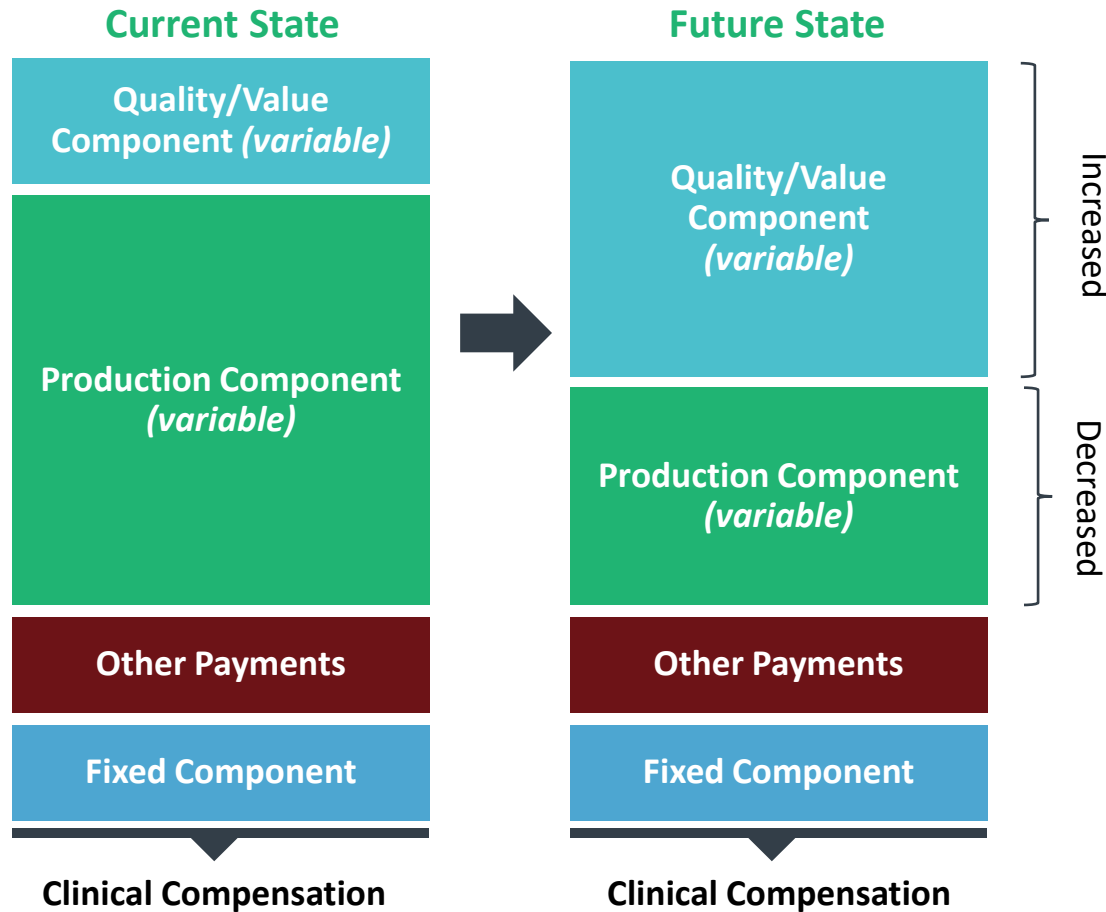
A common innovation is to introduce an incentive and make distributions available to physicians based on performance in risk contracts.



- In this approach, the existing core compensation plan remains intact.
- However, physicians have access to a supplemental incentive.
  - The size of the incentive is based on performance in risk contracts.
- Distributing incentive funds to physicians is often based on:
  - Predefined metrics (either by the organizations or the payers).
  - The number of risk-contract patients.
- By definition, this approach is an **upside-only** reward to physicians.

# Value-Based Compensation

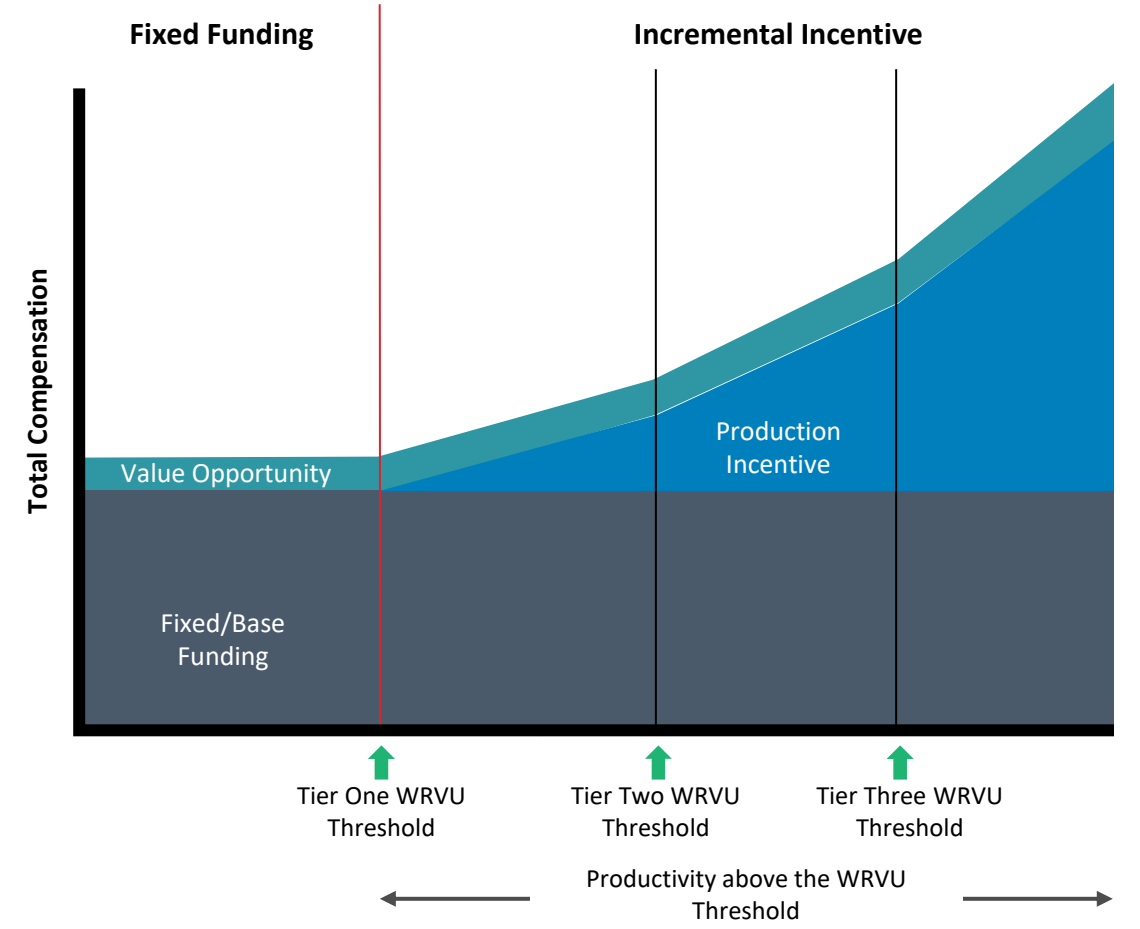
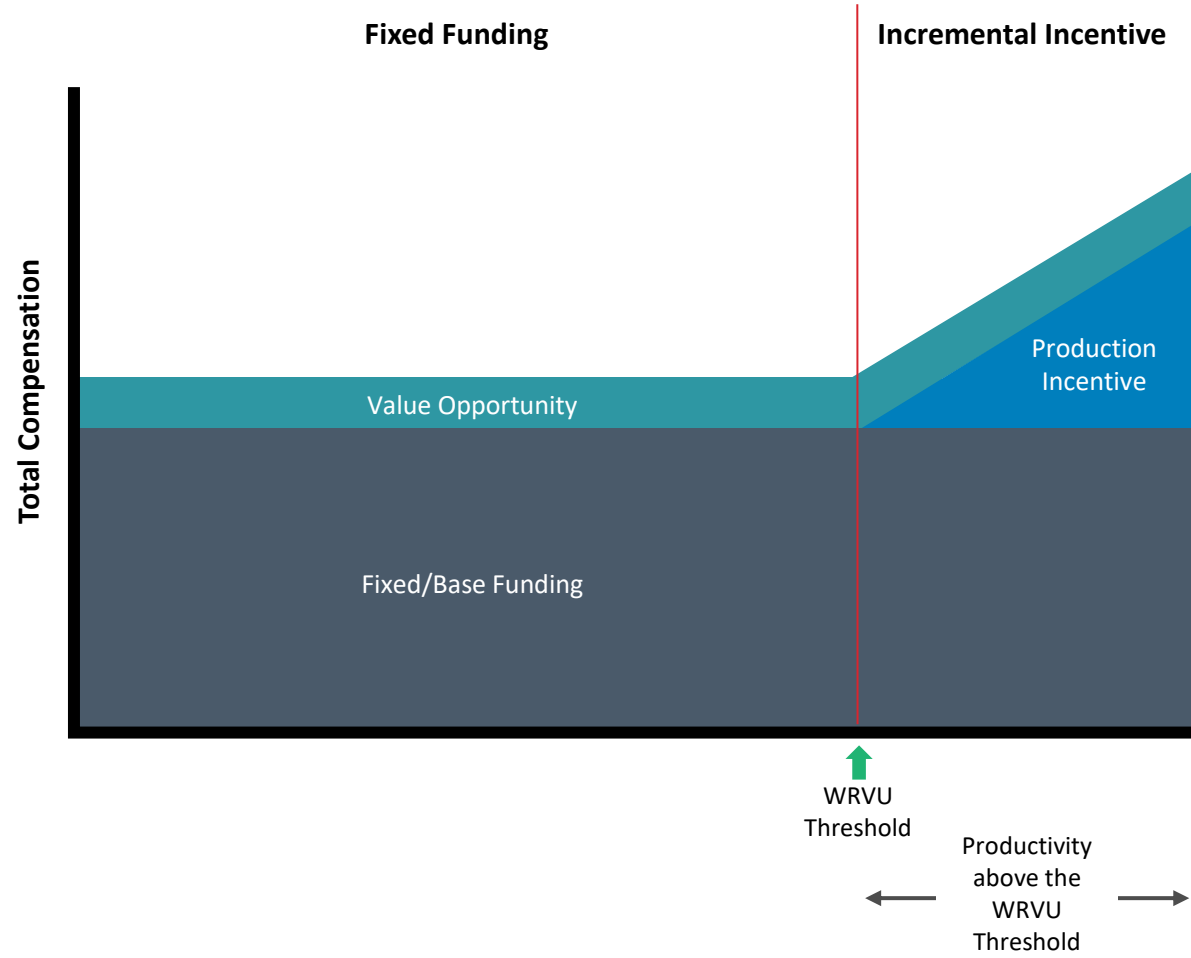
Among organizations seeking to deemphasize production, compensation is minimized for production, and there is an increase in quality, value, and patient satisfaction metrics that are tied to compensation.



- Increasing the emphasis on value-based elements:
  - Increases the reward for value relative to productivity.
  - Provides the opportunity to incorporate other metrics, such as:
    - C. difficile infection rate.
    - CLABSI rate.
    - CAUTI rate.
  - Facilitates greater compensation alignment relative to value-based reimbursement strategies.
- Value-based metrics are increasingly measured beyond the individual level.
- This approach usually creates upside and downside risks for physicians.

# Hybrid Models

Hybrid models that have FTE-based, volume, and value components have grown in popularity, replacing pure production models.



# Questions & Discussion



# Thank you for participating in today's session.

## Additional Information



<https://www.idsociety.org/clinical-practice/compensation/compensation-initiative>

## Next Webinar



Please consider joining the next webinar. IDSA will host an informative discussion with its webinar titled “Physician Compensation Regulatory Compliance” —what physicians should know about how compensation is federally regulated, who these rules apply to, and which performance measures can and cannot influence fair market value.