Physician Performance Trends

By Maria C. Hayduk and James W. Lord, ECG Management Consultant

After more than a year of development and debate, two healthcare reform bills, the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA), were signed into law in March. Key provisions of these laws are still in development but clearly are aimed at increasing the number of insured patients while creating greater value (cost/quality) and accountability for patient outcomes. This is a monumental undertaking that will challenge the ability of hospitals to deliver high-quality care with the same or fewer resources. Ultimately, as outcomes become more measurable through the proliferation of electronic health records and agreement on care protocols, the "playing field" among hospitals will level. In response, many hospitals are developing strategies aimed at aligning with physicians through the concepts of accountable care. Clearly, many perceive that future success will be based on the ability to demonstrate higher quality through measurable outcomes, which will require the unique talents of engaged physicians and hospitals.

Access to Care

Under reform, Medicaid coverage for children ages 6 through 19 is mandatory for families between 100 percent and 133 percent of the federal poverty level (FPL). Furthermore, funding for facilities that serve low-income and uninsured patients will increase by $11 billion over the next 5 years. By 2019, it is estimated that 94 percent of the population will be insured, including an additional 32 million people covered as a result of health reform. In the near term, the cost of expanded coverage will be paid by the federal government, with more cost shifting to states over time. However, hospitals and physician organizations are concerned about the impact of expanded coverage.

Expanded insurance coverage, coupled with an acute shortage of physicians, will further affect access to timely care. In addition, the top recruited specialties continue to be in primary care, with a majority of organizations reporting a medium to high degree of difficulty in filling these open positions.

Table 1 – Five Most Highly Recruited Specialties

Specialty	Percentage of Organizations Recruiting	Percentage of Organizations Reporting Medium to High Difficulty in Recruiting
Family Practice Without OB	71%	75%
Internal Medicine	66%	54%
Gastroenterology	31%	25%
Neurology	31%	23%
Pediatrics	31%	15%

Strategies Addressing the Physician Shortage

One component of healthcare reform provides new (temporary) federal funding to states to bring Medicaid payments up to Medicare levels (for 2013 and 2014) for evaluation and management (E&M) services provided by physicians in family medicine, general internal medicine, and pediatric medicine.

Another reform strategy aimed at addressing the physician shortage is the creation of a loan forgiveness program, which appropriates $30 million for fiscal years 2010 to 2014 to pediatric medical and surgical subspecialists who agree to provide services in a health professional shortage area, in a medically underserved area, or for a medically underserved population.

In addition to offering recruits traditional signing bonuses, relocation assistance, and malpractice nose/tail coverage, organizations are beginning to develop more creative offerings as part of their overall recruitment strategy. As evidence, education loan forgiveness was offered by 21 percent of ECG Management Consultants, Inc., survey organizations. Furthermore, many organizations are resorting to combining recruitment offerings in order to attract recruits.

In addition to enhanced recruitment packages, starting salaries for recruits continue to increase and, on occasion, have surpassed compensation levels of established physicians. Specifically, starting salary offers to physicians in family practice without OB and internal medicine were greater than 2010 median compensation for these subspecialists. Despite higher overall compensation, 59 percent of organizations reported that the primary reason recruits turned down offers was due to compensation/financial considerations, highlighting the highly competitive recruiting environment.

Compensation and Production Trends

Median physician compensation continues to increase across most specialties. Compensation increased by 2.3 percent compared to 2009 across all specialties, with primary care physicians experiencing a slightly lower compensation gain than medical and surgical specialists with an increase of 2.4 percent compared to 5.4 and 2.6 percent, respectively. Hospital-based physician compensation remained flat over 2009. Compensation gains are likely to continue to trend upward as a result of the physician shortage and increased competition.

Table 2 – Comparison of Starting Salaries and Median Compensation

Specialty	Average Starting Salaries	Median Compensation
Family Practice Without OB	$203,590	$194,919
Internal Medicine	$197,493	$192,676

Despite the increased compensation levels, work relative value units (WRVUs) decreased overall by 2.1 percent. This change, coupled with an increase in compensation, led to an overall increase of 3.6 percent in compensation per WRVU. Compensation per WRVU for medical and hospital-based specialists increased more than for primary care physicians and surgical specialists (5.5 percent and 5.1 percent).

Table 3 – Percentage Change in Median Statistics[1]

	Primary Care	Medical	Surgical	Hospital-Based	All
Compensation	2.4%	5.4%	2.6%	0.0%	2.3%
WRVUs	-1.1%	1.2%	-1.7%	-14.8%	-2.1%
Compensation Per WRVU	1.3%	5.5%	1.3%	5.1%	3.6%

Compensation Plan Components

Historically, many medical groups have established distribution formulas that reflect the methodology by which the group receives its funding. By creating a compensation model that parallels reimbursement, groups have aligned the incentives of both the individual physician and the group as a whole. With healthcare reform setting the stage for changes in provider reimbursement, groups will need to review new compensation mechanisms to keep incentives aligned toward value-based care. While traditional incentives have focused on productivity, the future reimbursement system is expected to reward a combination of resource management and, ultimately, health outcomes. Other measurables (e.g., patient satisfaction) where group comparisons are likely are also key metrics of differentiation.

Still, the increase in the insured population, coupled with a severe physician shortage, will require production-based components as well. As such, WRVUs continue to be the preferred primary performance measure in determining physician incentive/variable compensation even though patient satisfaction and net professional collections were also reported as primary drivers for the incentive portion of total compensation.

Implication of Changing RVUs

Key Changes Beginning With 2007 PFS

Beginning with the implementation of the 2007 PFS, CMS upwardly adjusted the WRVUs for several E&M visit procedure CPT codes, which resulted in physicians generating more WRVUs for similar work effort. As part of our surveys, ECG calculated provider WRVUs and WRVU compensation ratios using the 2006, 2009, and 2010 PFSs. Overall, as a result of changes to the E&M RVU values, physicians are producing 13.9 percent more WRVUs under the 2009 PFS compared to the 2006 PFS for the same effort. This increase in WRVUs resulted in a corresponding decrease in compensation per WRVU ratios of 13.6 percent.

Key Changes Beginning With 2010 PFS

Beginning with the implementation of the 2010 PFS, CMS eliminated payments for the use of consultation codes, except for G-codes associated with telehealth consultations. This includes inpatient (99251 to 99255) and outpatient (99241 to 99245) codes. Physicians were expected to start billing for consultations under the outpatient and inpatient visit codes. Because this change is a Medicare payment policy only and has not been adopted by all other payors, the consultation codes (and the RVU values associated with them) have not been removed from the PFS. However, in order to reflect expected reimbursement, ECG calculated RVUs under the 2010 PFS using the RVU values associated with the outpatient and inpatient visit codes (versus the RVU values for the consultation codes). Overall, the impact of this change resulted in physicians producing 2.4 percent more WRVUs under the 2010 PFS compared to

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Figure 1 – Primary Performance Measures for Variable/Incentive Compensation

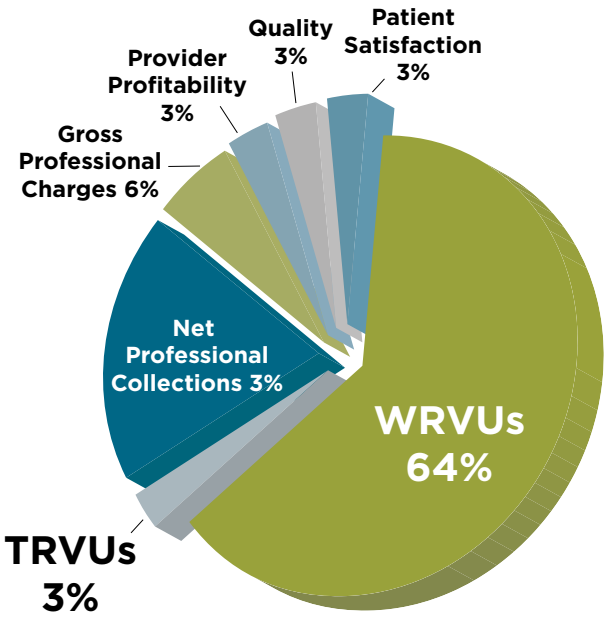
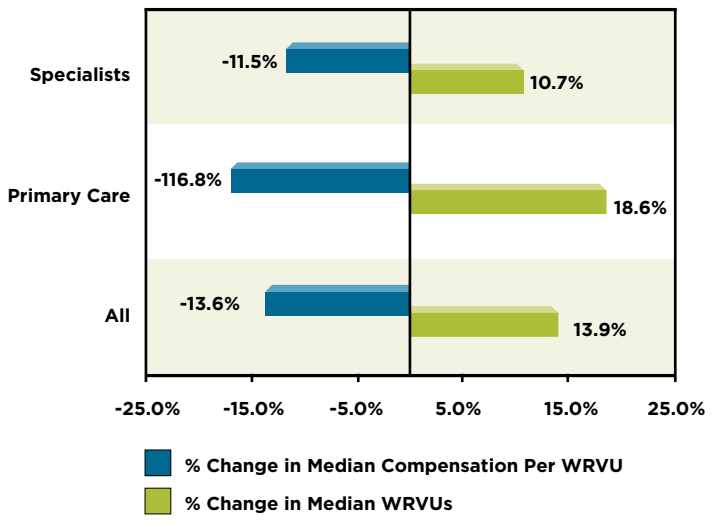


Figure 1.1 – Percentage Change in Key Metrics by Specialty Type: 2009 PFS Compared to 2006 PFS



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the 2009 PFS for the same effort. This results in a corresponding decrease in compensation per WRVU of 1.1 percent.

About ECG's Surveys

ECG's physician surveys emerged from our experience working with medical groups to redesign their compensation plans. These projects rely on industry benchmarks and require physician acceptance of those benchmarks. In our experience, physicians will challenge industry data as irrelevant if it varies significantly from year to year, has a small sample size, includes self-reported physician data, or is not geographically relevant. Our surveys were specifically designed to address these issues.

Today, our surveys include region-specific annual studies (e.g., Northwest, Midwest, Southeast), specialty-specific annual studies (e.g., national pediatric subspecialty), and industry trend studies (e.g., ECG/AMGA Pay-for-Performance Survey). Participation in our surveys has grown steadily over time due in part to our ability to provide sponsors with customized benchmarking reports that compare their compensation, production, and other metrics to all other participants. The data in this article represents proprietary data gathered via ECG's 2010 Northwest, Midwest, and Southeast Provider Compensation, Production and Benefits Surveys, as well as our National Pediatric Subspecialty Physician Compensation, Production and Benefits Survey. In 2010, ECG collected compensation and production data from 110 organizations representing more than 12,000 providers. ECG reports compensation and production benchmarks for nearly 100 physician specialties and 10 midlevel provider specialties.

This article was written by Ms. Maria C. Hayduk, Senior Manager, and Mr. James W. Lord, Principal. For more information about these studies, or if you have questions regarding physician performance, please contact mhayduk@ecgmc.com or jlord@ecgmc.com.

Notes

1. *The percentage increase/decrease represents the change in weighted medians from ECG's 2009 to 2010 survey.*
2. *RVUs were calculated from CPT-level provider data by attributing RVUs from the 2009 Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule (PFS) (October 2009 release) to 2009 and 2008 CPT activity, unless otherwise indicated.*

➔ *New Realities cont'd from page 20*

tion successfully to their new role and geographic region has gained caché as an effective tool to ensure that new recruits will stay after they are hired. Another trend is that more institutions are relying on in-house offices that centralize recruiting, rather than leaving the responsibility for hiring diffused across institutional departments.

Cultural change

Fundamentally, these new directions in recruitment and retention suggest that broad changes in culture may be necessary across academic medicine. Two AAMC initiatives are helping to foster reform at that level.

The Faculty Forward™ initiative is a new collaboration between the AAMC and US medical schools "to create the vital, dynamic institutional cultures that attract and retain the best faculty," said Faculty Forward Director Shannon Fox, PhD. Twenty-three medical schools are already engaged in evaluating and improving their faculty culture as part of the first two-year cohort. A new cohort of Faculty Forward institutions will convene in January.

In September, the AAMC launched an "action research" pilot initiative that seeks to help medical schools maximize their recruitment efforts. The AAMC is working with four academic medical centers to develop "best in class" practices that make more effective use of search processes and link searches more definitively with organizational missions.

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On-boarding is our chance to create a positive first impression of what it is like to work for us. If a physician (and their family) feels well taken care of, special and appreciated during on-boarding it will set the tone for their experience as an employee. On-boarding is a valuable tool in retention. Continued follow-up from the on-boarding team will ensure that they continue to feel included. Creating an organized and thoughtful on-boarding program will help guarantee that the physicians we hire will be happy with their decision to work for us.

At a minimum, on-boarding should begin once a physician has signed their contract to work with us. Ideally, though, on-boarding will begin during the interview process; knowing that they will have an advocate and assistant to manage everything that goes into becoming employed by us can be a powerful selling point to a recruit.

A provider who has been **effectively and thoroughly oriented** for their new position will be able to become an active and **fully functioning member** of the practice much faster than one who has not and they are more likely to stay with the organization long-term. It is important for the efficiency of the practice that the new physician can practice medicine and begin seeing patients as quickly as possible; a well organized on-boarding program will ensure that this will happen.

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