



COVID-19 and Employed Physician Compensation: Immediate and Long-Term Impacts





Immediate Impacts of COVID-19 on Employed Physician Compensation

While hospitals and health systems struggled to meet the demands arising from the COVID-19 pandemic, some emergency rooms and intensive care units were filled to capacity. Others were nearly empty or at less-than-normal capacity. Certain hospital and clinical services, such as elective surgery, were shut down. Some physician specialties were highly utilized, others were not. All considered, a hospital's contracts with physicians may contain compensation structures that do not adequately address these conditions and subsequently require amendment and/or future reconciliation.

Physicians particularly impacted are those whose compensation is based upon productivity, especially if such productivity is largely dependent upon elective procedures. The impact will also likely be felt by physicians supporting elective procedures, such as anesthesiologists. By contrast, an employed physician paid a straight salary likely will not have this issue; however, certain statistical threshold measures, such as personally performed work relative value units (wRVUs), may require attention.

In March 2020, PYA began researching, observing, and contemplating the immediate impacts of COVID-19 on employed physician compensation. To follow are five key areas for immediate consideration.

1 Consider Adjustments for Physician Employment Agreements Paid on Capacity- or Non-Productivity-Based Models

A concern of systems paying physicians on a fixed salary or non-productivity-based formula is whether compensation should be adjusted for the impacts of COVID-19—specifically, whether the negative impacts that may have reduced a physician’s work schedule, quality/bonus metrics, and/or base line productivity should have a corresponding impact on compensation. Many health systems that are eliminating non-essential positions, reducing employee compensation, and implementing furloughs are also considering reductions to physician compensation. Alternatively, some systems are attempting to make physicians “whole” for compensation opportunities lost due to COVID-19. At the end of the day, health systems are asking: What is reasonable and defensible?

A reasonable adjustment may mean setting total compensation near base compensation or implementing the same compensation reduction percentage as used for other employed nonphysician staff within the system. A system could also adjust total compensation to approximate the median benchmark for a particular specialty (if a physician’s base or total compensation historically was above the median). Another option would be to consider how much guaranteed compensation a physician would earn under a new hire agreement and adjust accordingly to this amount. Each of these scenarios considers the cost to replace a physician, which is but one factor in determining fair market value compensation. Further complicating these reductions is the fact that physician employees are, many times, under a written contract (unlike nonphysician staff) that would require amendment in order to reduce compensation.

2 Consider Adjustments to Physician Employment Agreements Paid on Productivity Models

At the beginning of the pandemic, patient volumes for many physician specialties dwindled, leaving administrators and physicians to struggle to assess the impact on individual physician compensation. If a physician is paid on a productivity-based model, the COVID-19 pandemic may have significant implications to one or more elements of the compensation structure, potentially reducing the totality of expected annual physician compensation.

A reasonable approach for health systems considering supplementing a physician’s compensation might be to guarantee a level of compensation approximating a median compensation benchmark. The rationale for this level of assistance is that: **(1) the disruption is temporary, (2) the disruption is entirely out of the control of the physician, and (3) in subsequent months the physician is likely to be able to generate productivity to support a median level of compensation once elective cases restart.** This approach would only be appropriate if the physician’s base or total compensation historically was in excess of the median as published in survey data. However, if this approach is used, it will be important to consider whether the physician will have any compensation “double counted” as the elective surgery backlog dissipates.

3 Prepare for Physician Contract Renewal Adjustments

Before reaching contract renewal periods, consider the reconciliation of a physician's productivity and quality performance during and after the COVID-19 pandemic. Potential methodologies for reconciling productivity and quality performance bonuses are outlined below. Any reconciliation should also consider the aforementioned compensation adjustment, if any.

- Eliminate consideration of wRVUs or quality performance during the applicable COVID-19 period (which may be different for each provider based on location and other facts and circumstances); review productivity and quality performance prior and subsequent to the COVID-19 period; and adjust targets as necessary by the number of months in the COVID-19 period.
- Evaluate productivity and quality performance by including in the reconciliation a portion of the prior calendar year and current calendar year leading up to the COVID-19 period productivity and quality performance. For example, a hospital or health system would evaluate a physician's productivity or quality performance from March 2019 through February 2020.
- Forgo payment of productivity and/or quality performance bonuses until 2021, and consider modification of the compensation structure of employed surgical and procedural specialists to a fixed annual salary. Changing to a fixed salary offers the potential to stabilize a physician's income level.





4 Engage Employed Physician Leaders

Outside of standard employed physician “clinical” compensation structures, now is a perfect opportunity to review your organization’s current physician leadership agreements, and, in light of the pandemic, consider such questions as:

- Should compensation be adjusted for physician leaders?
- Should special considerations be given to physician leaders in specific, more essential specialties?
- Are our physician leadership duties and responsibilities clearly defined in our agreements?
- Should duties and responsibilities be updated to include expectations during public health emergencies (PHE) or other widely impactful public health crises?

Additionally, there are other, more difficult issues to be addressed. For example:

- Physician leadership contracts often include a cap on the annual hours and/or total annual compensation. In the wake of a pandemic, and a PHE never before considered, it is prudent to ask the question: Should this methodology be reviewed to provide for flexibility in times of extraordinary need? While this may be an “across the board” type of review, additional consideration should be given to the flexibility needed within certain essential specialties to ensure adequate resources are available.
- Some physician leaders may have also been asked to serve in alternative roles as part of an organization’s crisis management plan and COVID-19 response. Do current agreements contemplate this potential, or are those circumstances covered by the waivers issued as part of the PHE?
- Hospitals experiencing a significant financial strain due to the COVID-19 pandemic may consider suspending or terminating other non-essential physician leadership positions. Hospitals should consider whether it is possible, on at least a temporary basis, to combine and consolidate leadership responsibilities as a cost-savings measure.

5 Plan for Employed Physician Committee Compensation

One avenue that hospitals are pursuing to address current and future preparedness is forming a special physician committee to develop pandemic-related action plans. In establishing such committees, hospitals will need to determine who should be included on the committee and if/when to pay physicians for their participation. Of those that are paid for participation, several reasons include, but are not limited to:

- Disruption to a physician's normal office hours.
- Preparation and active participation to address an emergent community need.
- Accomplishment of a specific goal or deliverable, usually under a tight deadline.
- A physician's service in committee leadership (e.g., Chairs and Vice Chairs).

To assist organizations considering the development of a physician pandemic committee, PYA has prepared the following non-exhaustive list of questions to ask in determining fair market value (FMV) and commercial reasonableness (CR) in these situations:

- Will committee duties be thoroughly documented?
- Will evidence of committee efforts and project milestones be maintained?
- Should compensation be based on an internal compensation plan tied to a specific specialty? Conversely, should a standard administrative or medical director rate be used (i.e., not specialty-specific)?
- Is the committee anticipated to be short-term or long-term in duration?
- Should length of service on the committee be considered?
- Should physicians document their committee participation and submit it to the organization in order to receive payment? If not, how will the organization substantiate the physician's work on the committee in support of the compensation paid?
- Are committee duties and related compensation already included as part of the physician's compensation or paid to the physician during times allocated for a physician to practice clinically, essentially resulting in double payment for the same period of time or services provided?
- Is another committee or administrative leadership effort duplicating the work of the pandemic readiness committee, resulting in payment to two different physicians for the same work effort?



Long-Term Impacts of COVID-19 on Employed Physician Compensation


In March 2020, PYA also began assessing the long-term impacts of COVID-19 on employed physician compensation. Soon, health system executives will stand before their boards to answer three questions:

What just happened?

What happens next?

What's the plan?





What just happened?

What just happened?

For years, health systems have been operating under a high-risk payment model: fee-for-service reimbursement, which is associated with productivity-based compensation models.

With this type of reimbursement, volume drives revenue. Accordingly, compensation structures were designed to incentivize highly productive/efficient physicians. Health system planning has focused on growing capacity to deliver more services assuming consumers would continue to demand at least the same level of healthcare services, if not more.

Value-based care has been viewed as fraught with risk because it requires successful care management, involving too many variables outside health system direct control. Similarly, value-based compensation is difficult to measure and not easy to explain. By comparison, fee-for-service reimbursement and productivity-based compensation models seem safe and predictable.

In planning scenarios, health systems considered what would happen if they lost a payer contract or reimbursement rules changed. It was never asked, “What happens if 30-50% of our volume dried up overnight and continued that way for several months?” And then, seemingly overnight, COVID-19 hit.


What happens next?

The answer isn't pretty. It will be months before volume returns to pre-COVID levels. The case mix index will likely be higher (individuals will defer care until an acute episode leaves them no choice), and the payer mix will be eroded (due to unemployment at levels not seen since the Great Depression).

Given the magnitude of losses and high fixed costs, health systems cannot manage this crisis on the expense side. They must grow back, not cut back, and embrace changes to reimbursement and compensation models.



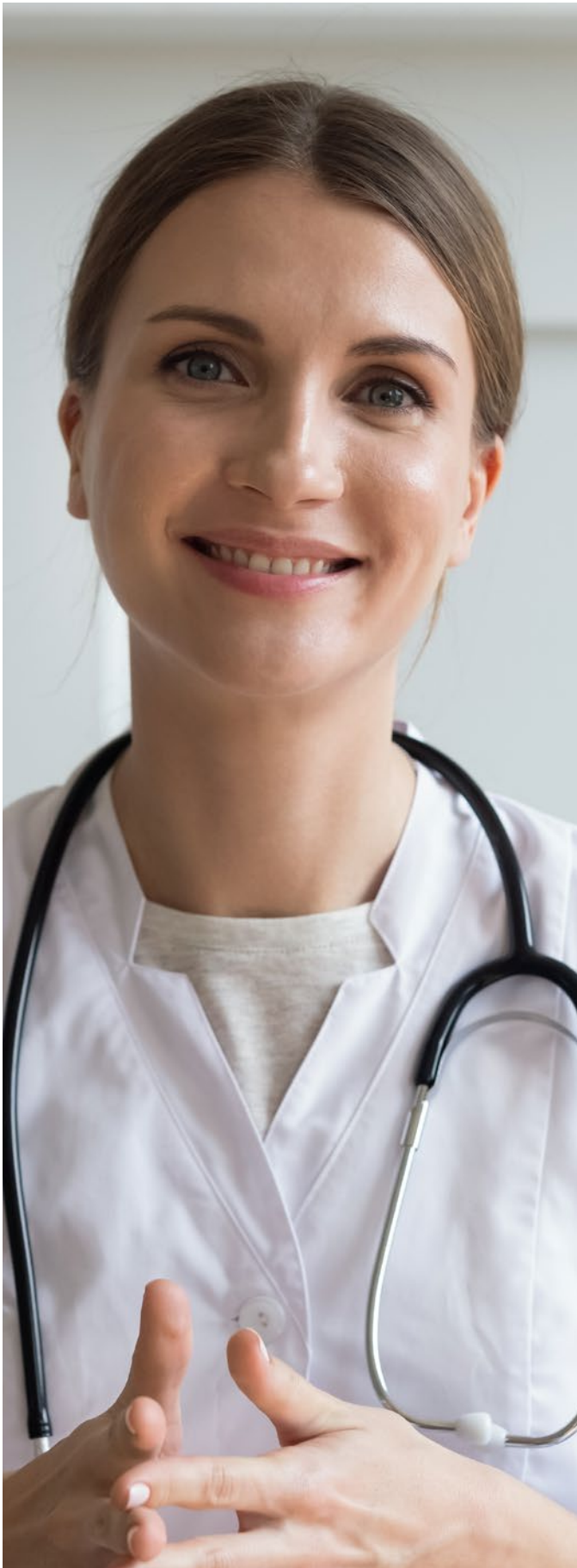
What happens next?



What's the plan?

What's the plan?

Health systems are not restarting; they must reinvent and recreate themselves. Health systems must go forward. To follow are five considerations, among many, for long-term employed physician compensation planning.



1 Health Systems Cannot Wait for Volume to Return and Will Need Physician Leaders to Help

Until now, healthcare providers/systems were places where patients sought medical treatment. Now, health systems must become a presence in people's lives.

Health systems are building strategies to make it easier for a patient to receive care. Now, health systems must become even more patient-centered and driven by a culture of safety. They must meet people where they are through virtual care, and by addressing their obstacles to good health (social determinants). Health systems must more readily contribute to an individual's continuum of care.

To do so, health systems will need to further engage with physician leaders. Physician leader compensation, like that of many chief executive officers around the country, will become more outcome-based than time-based. Physician leaders able to run a more effective outcome-based service line will earn more than physician leaders who fail in this area. There will likely always be a place for physician leaders who are paid by the hour to provide administrative services requiring clinical expertise, but a new breed of physician leaders will start to emerge, overtaking general medical directorships health systems have seen in the past. Health systems that embrace this concept early will be more successful and better prepared for the future.

2 Revisit Physician Compensation for Telehealth

Many predict one lasting impact of the COVID-19 pandemic will be expanded use of telehealth. As patients and providers now appreciate the convenience of virtual home visits, the traditional office visit will become the exception, not the rule, assuming regulatory change in reimbursement is pushed forward.

I. Pre-Pandemic

Pre-pandemic, telehealth comprised a fraction of a percentage of Medicare spending. The story wasn't much different for state Medicaid programs and commercial health plans. According to an October 2019 report from JD Power, "Nationwide consumer adoption of telehealth services has been stubbornly low, with just 10% of healthcare consumers having used such services." Lack of reimbursement vehicles was a primary driver of slower adoption by providers.

II. Pandemic

Essentially overnight, physician practices pivoted from clinic visits to virtual visits. According to a Merritt Hawkins survey released April 22, 2020, 48% of physicians are now treating patients with telehealth. New market research shows 59% of patients are more likely to use telehealth services now than pre-pandemic, and more than a third would switch their physician to have access to virtual care.

III. Post-Pandemic

It's hard to find any silver lining to the COVID-19 cloud under which health systems now operate, but one might be that they are a part of a real-life experiment demonstrating the value of virtual care. However, any gains made will be fleeting unless providers and patients push policymakers to cement them into law. Similarly, physician compensation models must change to embrace the provision of telehealth services. No one wants to work for free.

IV. Telehealth Employed Physician Compensation

As the use of telehealth grows, the design of physician compensation models will need to consider a portion of an employed physician's time spent providing telehealth. This will be especially true in the area of primary care and other high-volume medical specialties such as neurology, and even critical care medicine. If no other specialty's compensation model is redesigned, an overhaul to primary care should be considered.

3 Prepare for Value-Based Physician Compensation

If, like the insurance companies, health systems had been receiving per member, per month (PMPM) payments to provide the level of care required in the population, the bottom would not have fallen out as a result of COVID-19. Health systems would have managed those payments to maintain operations. However, health systems cannot manage the fee-for-service risk when volumes decline. There may not be an opportunity in 2021, but health systems need to be ready in 2022 to pursue migration to more value-based reimbursement structures on a per-patient-managed basis. However, a key to the move to PMPM will be to change physician compensation structures to focus on better patient care, not generating more wRVUs.

According to Merritt Hawkins, physician compensation models are moving toward the “Goldilocks Zone,” defined as “physician payment models that encourage physicians to see the patients and generate the revenue that healthcare facilities still need, but also reward doctors for adopting behaviors and practices that will drive reimbursement in emerging value-based payment models.” Further, based on PYA’s experience, many well-performing health systems are already considering some sort of value-based physician compensation. These models often align with value-based reimbursement models. Currently, the most popular models consider 70% to 90% of compensation to be based on productivity, with 10% to 30% tied to quality or other value-added metrics. However, as a result of COVID-19, more and more physician compensation will likely become fixed or based on outcomes, and be less dependent upon physician productivity. The physicians earning the highest compensation will be the physicians adding the most value.

4 Plan for COVID-19 Impact on Benchmark Survey Data

Many system-wide physician compensation models are dependent on published benchmark survey data. A compensation plan may specifically use such data to determine physician compensation, assess wRVU productivity, and determine a target compensation per wRVU. COVID-19 will likely change this dependency. Many who have completed benchmark survey questionnaires often have reservations about the reliability of compensation survey data. Others question whether benchmark surveys are representative of their market and specific circumstances. Appraisers often make adjustments to benchmarks for these and other market-specific reasons. Fair market value opinions should be made in consideration of all facts and circumstances, and not based solely



on a reiteration of benchmark data. Further, the impact of COVID-19 on benchmark survey data is currently unknown. COVID-19 continues to affect different geographic regions of the United States at different times and at different levels of intensity.

Generally, benchmark surveys are issued once a year or every two years. These surveys are based on prior-year data. As a result, survey benchmarks reflecting COVID-19 will not be available until some point in 2021. Until then, health system administrators (and appraisers) will need to make decisions regarding physician compensation levels and the proportion of reliance upon the benchmark survey data. In doing so, it will be important to consider more than just the productivity level of physicians. In fact, one could argue there is no better time to start the move to physician compensation models less dependent on wRVUs and compensation-per-wRVU benchmark data, such as quality and outcome-based models, which are not solely dependent upon benchmark survey data.

5 Strategize Surrounding Stark Law Revisions

The Stark Law blanket waivers published March 30, 2020—although effective back to March 1—gave healthcare organizations greater flexibility in crafting financial arrangements with referring physicians and their immediate family members in response to the COVID-19 national emergency. In addition to supporting those physicians on the front lines caring for COVID-19 patients, the waivers permitted healthcare organizations to “[a]ddress...medical practice or business interruption due to the COVID-19 outbreak in the United States in order to maintain the availability of medical care and related services for patients and the community.”





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According to the March 30 document, a hospital relying on the blanket waivers “must make records relating to the use of the blanket waivers available to the Secretary upon request.... Although the blanket waivers...do not require the submission of specific documentation or notice to the Secretary or the Centers for Medicare & Medicaid Services (CMS) in advance of their use, we encourage parties to develop and maintain records in a timely manner as a best practice.”

As these blanket waivers “expire,” health systems and regulators will face the question—and have new evidence for the surrounding debate—should certain regulations contained in the Stark Law be amended? While not likely to happen immediately, changes to the Stark Law, especially with regard to outcomes-based and telehealth services compensation, will become probable.

Conclusion

It may be years before the ultimate impact of COVID-19 on employed physician compensation is realized. However, with a well-planned physician compensation strategy and careful assessment of these 10 key considerations, a health system will be in a better position to more successfully navigate the uncertainty.