COVID-19, burnout and beyond: Physician compensation plan essentials for 2021 market forces

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For decades, the United States' healthcare finance and delivery system has been in a state of ongoing change and evolution.

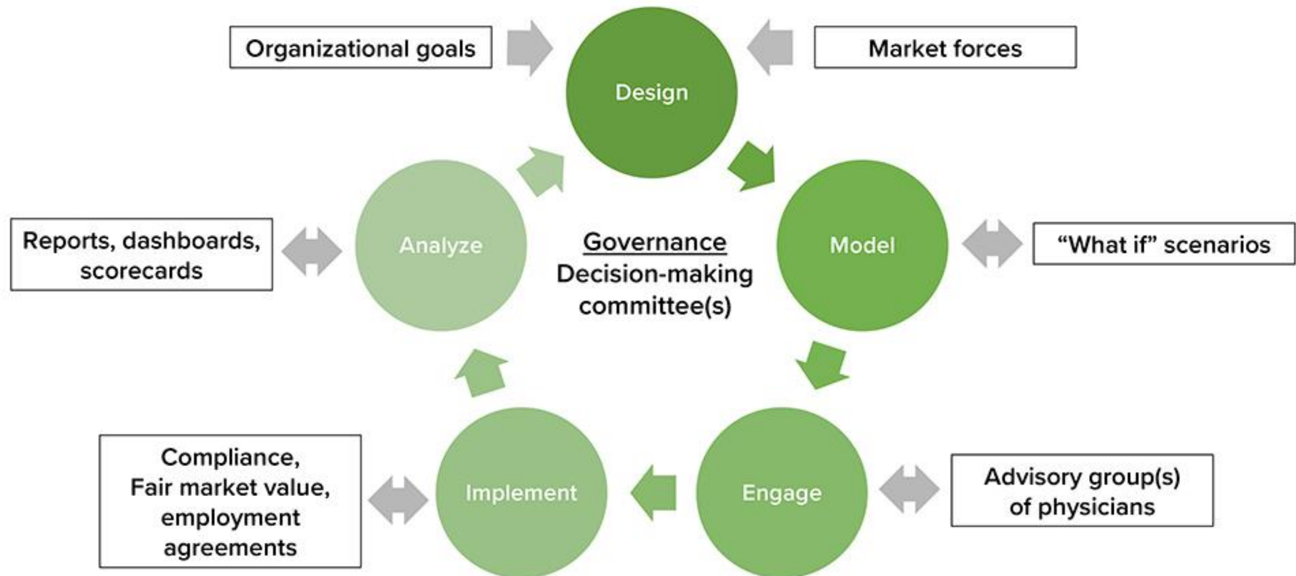
Governmental bodies, licensing and regulatory agencies, accreditation organizations, health policy and clinical research institutes, and payers are continuously proposing and testing healthcare system enhancements toward optimizing:

1. How care delivery is organized
2. How care delivery is prioritized
3. How care delivery is paid for
4. How care delivery value is demonstrated.

Amid all this change, the physician compensation plan must be dynamic and adaptable.

A successful and enduring physician compensation plan is built to achieve organizational goals by translating healthcare system market forces into principles, variables, values and formulas (Design) that are assessed under test conditions (Model) through a collaboration of physicians and administrators (Engage) to create a program of achievement rewards (Implement) the results of which are continuously monitored, assessed and shared (Analyze) to achieve the desired level of physician recruitment and retention (see Figure 1).

The physician compensation plan is much more than a set of equations to calculate pay. It is an organized entity with a governance structure, responsibilities and functions necessary to align organizational goals with compensation plan principles and tactics.



KEY MARKET FORCES FOR 2021

To be dynamic and adaptable, the physician compensation plan must be attuned to present and evolving market forces that may impact the healthcare system and organizational goals. Market forces can vary in form and magnitude and may have national or regional implications.

For 2021, some noteworthy U.S. healthcare system market forces to monitor and assess include:

1. The prevalence of physician burnout
2. The continuing evolution of value-based care initiatives
3. The Center for Medicare & Medicaid Services (CMS) 2021 physician fee schedule (PFS) standards
4. The future of the Affordable Care Act (ACA) and the state of uninsured persons
5. The COVID-19-generated shifts in the U.S. economy and healthcare system.

Evidence of each market force is described below along with examples of how the physician compensation plan can prepare and adapt.

ADVERSE WORK CONDITIONS AND PHYSICIAN BURNOUT

Physician burnout is a market force that impacts physician supply and performance. The compensation plan needs to account for the impact that adverse work conditions have on physician burnout and adopt tactics that recognize and value such conditions.

As defined by the Agency for Healthcare Research and Quality (AHRQ), burnout is "a long-term

stress reaction marked by emotional exhaustion, depersonalization and a lack of sense of personal accomplishment," and work conditions commonly found in healthcare — time pressure, chaotic environments and low control over work pace, among others — are "strongly associated with physicians' feelings of dissatisfaction, stress, burnout and intent to leave the practice."[1]

AHRQ-sponsored studies have found physician burnout increasing in prevalence, which intensifies other outcomes: *Burned-out doctors are more likely to leave practice, which reduces patients' access to and continuity of care. Burnout can also threaten patient safety and care quality when depersonalization leads to poor interactions with patients and when burned-out physicians suffer from impaired attention, memory, and executive function.*[2]

The *Medscape National Physician Burnout & Suicide Report 2020: The Generational Divide* examines physician burnout and suicide with a focus on generational differences. Many of the report findings echo results from the AHRQ studies on what contributes most to burnout:

- Too many bureaucratic tasks (e.g., charting, paperwork): 55%
- Spending too many hours at work: 33%
- Lack of respect from administrators, employers, colleagues or staff: 32%
- Increasing computerization of practice (EHRs): 30%
- Insufficient compensation, reimbursement: 29%
- Lack of control, autonomy: 24%
- Feeling like a cog in a wheel: 22%
- Decreasing reimbursements: 19%
- Lack of respect from patients: 17%
- Government regulations: 16%
- Other: 7%[3]

To prepare for this market force, the physician compensation plan can acknowledge adverse work conditions that contribute to physician burnout by recognizing and valuing:

- Physician time required to allow for organizational engagement (e.g., meeting attendance and participation on committees and teams)
- Physician time required to allow for leadership, advisory and mentorship roles
- Physician interest in flexible or part-time work schedules as opposed to the only alternatives being retirement, leaves of absence or seeking employment elsewhere.

VALUE-BASED CARE INITIATIVES AND REQUIREMENTS FOR SUCCESS

The continuing evolution of value-based care initiatives is a market force that impacts how healthcare delivery is organized, prioritized and financed. The physician compensation plan needs to account for how value-based care requirements affect physician performance measures and adopt tactics that recognize and value such requirements.

Governmental and commercial healthcare payers are driving the implementation of value-based care initiatives. Even with mixed results from some of its many value-based care programs, CMS is making changes to existing programs while also introducing new initiatives, such as the Primary Care First models.

CMS Administrator Seema Verma called value-based care "an agency-wide strategic objective" and stressed that "Medicare can't be on this journey alone; we need every player in the healthcare system, public and private, to be engaged."[4] To that end, major private payers such as Aetna, Cigna, Humana and UnitedHealth Group actively promote their respective versions of value-based care.[5,6,7,8]

Recent federal action by the Department of Health & Human Services (HHS) Office of Inspector General (OIG) to revise the Physician Self-referral (Stark) Law and Anti-kickback Statute provide some group practices with lower barriers and greater protections when entering care coordination arrangements.[9]

To prepare for this market force, the physician compensation plan can acknowledge value-based care requirements for physician success by recognizing and valuing:

- Physician and staff time required to learn about governmental and commercial value-based care arrangements, Healthcare Effectiveness Data and Information Set (*HEDIS*) measures, Hierarchical Condition Category (HCC) coding and risk adjustment factor (RAF) scores
- Physician and staff time required for collaboration on population health improvement initiatives, and the development of policies, procedures and workflows
- Physician and staff time required for collaboration on new information systems, reports on care delivery, care management, care transitions and the development of patient engagement tactics.

MEDICARE 2021 PHYSICIAN FEE SCHEDULE (PFS) STANDARDS

The 2021 Medicare PFS is a market force that impacts how healthcare delivery is organized, prioritized and financed. The physician compensation plan should take into account the CMS 2021 PFS standards regarding measures of physician performance, as well as adopt tactics that recognize and value these standards.

In brief, some of the 2021 Medicare PFS standards include:

1. The conversion factor set at $32.41, down from $36.09 in 2020;
2. Some E/M office work relative value units (wRVUs) have increased;
3. Nine services are added to the telehealth list; and
4. The performance threshold to avoid a negative adjustment under MIPS is being set at 60 points.[10]

According to analysis completed by SullivanCotter, CMS maintained reduced documentation requirements to save physicians 180 hours of paperwork per year and increased wRVUs for some E/M codes to acknowledge the length of office visits, electronic medical record documentation demands, and the introduction of new demands related to value-based care and population health initiatives.[11]

Some wRVU changes extracted from Table 28 of the final rule include: [12]

Code	Current minimum minutes per visit	Current wRVU for code	2021 minutes per visit	2021 wRVU for code	Percentage increase in wRVU
99203	29	1.42	40	1.60	13%
99204	45	2.43	60	2.60	7%
99205	67	3.17	85	3.50	10%
99213	23	0.97	30	1.30	34%
99214	40	1.50	49	1.92	28%
99215	55	2.11	70	2.80	33%
G2212*	N/A	N/A	15	0.61	N/A

* An add-on code for every 15 minutes of extended visit time.

The intention to increase wRVU weights for some E/M codes may be a factor in physicians generating more wRVUs in calendar year (CY) 2021 versus CY 2020. The intention to decrease the conversion factor may result in organizations generating less revenue in CY 2021 versus CY 2020. The overall impact of these new standards will be determined by physician services rendered, documentation, coding and whether commercial payers follow the CMS plan.[13]

To prepare for this market force, the physician compensation plan can acknowledge the impact of CMS 2021 PFS standards by recognizing and valuing:

- The "what if" scenario of rising wRVU-based compensation with simultaneously decreasing practice revenue
- The "what if" scenario of rising wRVU-based compensation triggering conflicts with compliance and fair market value (FMV) standards
- The "what if" scenario of retaining existing physician compensation plan design elements and forgoing adoption of new CMS 2021 PFS standards.

THE ACA AND DEMANDS OF UNINSURED PERSONS

The ACA and the overall state of health insurance coverage in the United States is a market force that impacts access to, demand for and payment of healthcare services. The physician compensation plan needs to account for the impact that the ACA's status and the demands of uninsured persons have on measures of physician performance, and adopt tactics that recognize and value the demands of uninsured persons.

A challenge to the ACA before the U.S. Supreme Court raises key issues:

- Do the parties have standing to raise issues of constitutionality?
- If so, is the individual mandate constitutional?
- If the individual mandate is unconstitutional, can it be severed from the ACA while leaving the rest of the law intact?[14]

A decision from the Supreme Court is due later this year. Based on CY 2020 ACA enrollment results, approximately 11.4 million persons selected or were automatically reenrolled in one of the state or federal insurance exchange plans.[15]

The number of uninsured persons in the United States may be between 29 and 30 million, but it's fluid and impacted by many economic and social factors:

- According to the Kaiser Family Foundation, the number of uninsured nonelderly was 28.9 million in CY 2019.[16]
- The 2019 National Health Interview survey projected that between 33 and 35 million were uninsured at different times during CY 2019.[17]
- The Commonwealth Fund biennial health insurance survey conducted in 2020 estimated the uninsured population to be 30 million at the start of CY 2020.[18]

Together, the ACA enrollment of approximately 11 million and uninsured estimates of approximately 30 million constitute a total population of 41 million people at risk for being uninsured if the ACA is deemed unconstitutional. Adding millions to the ranks of the uninsured lowers the likelihood those patients receive preventive care and services for major health conditions and chronic diseases,[19] and the cost of care impedes follow-through on recommended prescriptions, tests, treatments, specialty care and sick care by uninsured persons.[20]

To prepare for this market force, the compensation plan can acknowledge the demands of uninsured persons by recognizing and valuing:

- Physician and staff time required to address the complex economic, social and healthcare needs of uninsured persons who score low on social determinants of health (SDoH) assessments
- Physician and staff time required to address the complex care management needs of uninsured persons who do not follow through on recommended prescriptions, tests, treatments and specialty care.

COVID-19-GENERATED SHIFTS IN THE U.S. ECONOMY AND HEALTHCARE INDUSTRY

COVID-19 has been a societal event of significant scope and magnitude. It has been a healthcare system market force that no one anticipated and for which no one was prepared. The physician compensation plan needs to account for the impact that COVID-19 pandemic-generated shifts in the U.S. economy and healthcare system have on measures of physician performance and adopt tactics that recognize and value these shifts.

The pandemic disrupted normal, day-to-day medical practice operations, such as the delivery of preventive care and chronic care. The pandemic created new clinical demands for testing and results tracking to develop and implement tactics to contain the virus' spread. New care delivery challenges emerged as hospitals and medical practices worked to balance the demand for COVID-19 care for acutely ill patients with the demand for preventive and chronic care for existing patients.

The virus as disruptor necessitated social distancing and other infection control measures that limit the capacity of medical practices and access to services, which led to the introduction of drive-through testing and the expanded adoption and acceptance of telehealth-based services as a means to supplement access to care.

Physicians have been impacted personally and professionally by the pandemic leading to introspection on their careers and care delivery in general. A survey by Jackson Physician Search found that two-thirds of responding physicians indicated that the COVID-19 virus has led them to look for a new job.[21]

A survey of physicians regarding the impact on their own well-being, their patients and the future of the healthcare industry by The Physicians Foundation found that loss of income, symptoms of burnout and concerns about health insurance coverage availability were the most common examples of the impact of COVID-19 on patients.[22,23,24]
To prepare for this market force, the physician compensation plan can acknowledge the impact of COVID-19-generated shifts in the U.S. economy and healthcare market by recognizing and valuing:

- Physician time required to participate in more frequent compensation plan governance committee and advisory group meetings
- Physician productivity reductions resulting from reduced practice capacity and overall reduced demand for care.

CONCLUSION

"The next compensation plan will be the best compensation plan" might be a familiar saying in healthcare, but the accuracy of this statement depends on how an organization defines and manages its plan.

An effective physician compensation plan plays a pivotal role in organizational success. It is not a static plan; it is a complex entity with a physician-administrator partnership at its foundation with assigned responsibilities for and functions of design, model, engage, implement and analyze.

As the U.S. healthcare system changes — driven by numerous and sometimes disruptive market forces — the resilient physician compensation plan is built to consider and accommodate change (whether anticipated or unforeseen) in 2021 and beyond.

ADDITIONAL RESOURCES

- MGMA members can access the MGMA 2021 E/M Coding, Billing and Auditing Toolkit, with tools to provide a comprehensive understanding of 2021 E/M coding changes, chart audits and elements of medical decision making (MDM): mgma.com/em-toolkit21.
- For a full analysis of the 2021 Medicare PFS final rule, visit **mgma.com/pfs21**.

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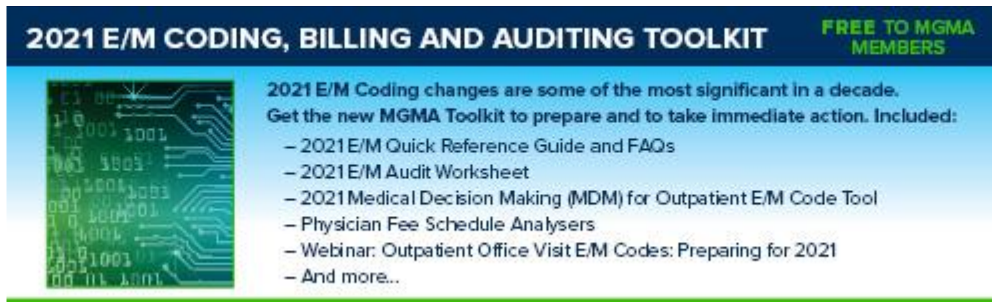

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