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TRENDS IN INCENTIVE-BASED PHYSICIAN COMPENSATION

An Examination of How Physician Compensation Is Evolving From Volume to Value Based Metrics

TRENDS IN INCENTIVE-BASED PHYSICIAN COMPENSATION

Why do hospitals, health systems, medical groups and other organizations offer incentive-based compensation to physicians? Is the primary goal simply to allow physicians to earn more money?

Generally speaking, the answer is no. In most cases, incorporating an incentive-based component into a physician compensation model is primarily intended to reward certain physician behaviors.

Historically, compensation models encouraging physicians to "work harder" have been the most common. These compensation models typically reward physicians for two different though related behaviors: 1) seeing a higher volume of patients, or 2) generating a higher volume of gross billings or net collections.

In either case, physicians have been rewarded for "doing more" – seeing more patients, ordering more tests, performing more procedures. "Doing more" has been the way in which health facilities have sought to meet patient access needs and keep doctors productive. The by-product, of course, is potentially more revenue for the physician and for the facility, but the incentive itself is at its essence an exercise in physician behavior modification.

But the health system is changing, and so is the way in which physicians are being compensated.

In fact, one could argue that the health system is changing *because* the way physicians are compensated is changing. Since physicians control how some 75 to 80 percent of healthcare dollars are spent, health care reform is really is about changing how doctors practice and allocate resources.

The reality of healthcare today is that both healthcare facilities and physicians are charged with delivering better care for more people, while doing so at a lower cost.

These priorities will be difficult to balance, and a key to success will be engaging physicians and gaining their cooperation in establishing new delivery models. As the old axiom goes, you must reward those behaviors you wish to encourage.

No practice model will be immune to the pressure to evolve. Whether a community health center, a private practice, a critical access hospital, or a large integrated system, organizations of all types and sizes are beginning to incorporate qualitative and subjective metrics into their physician incentive models to prepare for the era of Accountable Care Organizations, medical homes and a system in which value will be at least as important as volume.

Based on Merritt Hawkins' observations of the market place, following are some of the more prominent trends in incentive-based physician compensation:

Volume will Remain a Factor

Even though the focus is shifting to value, physician compensation metrics built around volume (i.e., patients seen, revenue generated, work performed) will likely remain in use. One of the

realities of our evolving delivery system is that more patients will have to be seen, with or without full implementation of the Affordable Care Act. In order to encourage providers to see more patients, incentive plans will almost certainly maintain a volume-based component.

Many community health centers (CHCs) are offering a per-patient or per-visit bonus after physicians achieve a stipulated patient visit threshold. In private practice, incentive-based compensation is often directly related to collections, which tend to be a function of the individual provider's patient volume. In the hospital environment, incentive-based compensation has historically been tied to Relative Value Units. Merritt Hawkins has recently released a white paper exploring the RVU-based incentive model. To review this new paper, *RVU Based Physician Compensation and Productivity*, click here.

These volume based metrics will continue to be used for the foreseeable future, though no longer to the exclusion of other metrics.

Qualitative Metrics are Gaining Ground

Providing quality care has always been a focus for both healthcare facilities and physicians, but in today's evolving delivery system, more emphasis is being placed around formal quality-based metrics for incentive-based physician compensation. With increasing utilization of EHR platforms, administrators and physicians have access to more data and better data, allowing formal quality metrics to be developed and implemented.

As noted in MGMA's 2010 Physician Compensation and Production Survey, 62% of physicians had incentive-based compensation tied to quality metrics in 2009, compared to only 21% in 2008 – nearly a 300% increase in utilization in just one year. Specific quality metrics in some incentive models include detailed physician focus on chronic conditions such as asthma, congestive heart failure and diabetes. Data-supported protocols can dramatically improve both quality of outcomes in these common diseases and reduce the utilization of healthcare resources. Within these diseases, certain key indicators that are being benchmarked to monitor outcomes include blood glucose, cholesterol, blood pressure, eye exams, HbA1c, among others.

Physician compensation models we have seen employed by medical groups and hospitals tie anywhere between 1 percent and 10 percent of physician compensation to achieving certain qualitative measures.

Readmission Rates will have an Impact

As the health care systems moves toward various types of Accountable Care Organizations (Medicare and private sector), and as more attention is directed toward maximizing the utilization of healthcare resources, a portion of physician incentive-based compensation will be impacted by hospital readmission rates. Hospitals are in a period of transition from a culture in which filling beds was paramount to one in which the priority could be to keep beds empty.

Collaborative models of care, such ACOs and medical homes, have the potential to reduce hospital readmission rates and thereby impact physician incentive-based compensation. Under such models, dedicated resources will be allocated to follow up with patients to ensure that their post-discharge treatment plans are fully understood and the patients are following their protocols. With processes in place to ensure patients are well informed about their conditions and are an active part of their treatment plan, we should experience a dramatic improvement in patient compliance and thereby greatly reduce readmissions. Reduced readmissions will financially reward the hospital as well as the individual physicians.

Subjective Metrics Added to the Mix

Given the increasing focus on the overall patient experience, subjective criteria are being applied to many physician incentive models to encourage doctors to work well in a collaborative environment and to provide high quality care and a positive patient experience. These trends are highlighted in MGMA's 2010 Physician Compensation and Production Survey.

% of physician providers reporting incentive compensation per category

Metric	2008	2009
Patient Satisfaction	20%	61%
Peer Review	6%	18%
Administrative/Governance Responsibility	15%	39%
Community Outreach	2%	9%

Patient satisfaction, a subjective metric, is emerging in virtually all models of care. Whether in community health centers, private practices, or hospitals of any size, patients are being polled not only about the quality of care that they feel they were provided, but also about their impression of each visit. From an internal perspective, physicians are also being encouraged to participate in committees and various corporate initiatives (QI, EMR implementation/training, etc.), and are being incentivized to do so. Incentive programs are beginning to include a citizenship component for participation in such committees, meeting attendance, and other corporate activities. Additionally, some organizations are starting to tie a portion of incentive compensation to peer review as well.

Often these metrics are included in a physician annual performance bonus plan that may be based on a point system. Out of 100 possible points, physicians can accrue points for high patient satisfaction scores, accurate documentation and group governance. A score of 91 to 100 points may yield a physician a 5 percent bonus, 81 to 90 points may yield a 4 percent bonus, etc., (though other scoring systems and bonus amounts also may be used – see "Example A" below).

The Impact of Bundled Payments on Compensation

Health reform (both the Affordable Care Act and system changes driven by the market) are leading the drive toward efficiency. In select markets, some private insurance carriers are conducting bundled payment pilot projects. On the Medicare front, CMS announced on August 23, 2011, its Bundled Payments for Care Improvement Initiative, which is comprised of four pilot models. For more information about the Payments for Care Improvement Initiative, click here.

Under both private and CMS models, reimbursement for a procedure which typically would have resulted in numerous claims from various providers would be consolidated into a single, "bundled" payment for the procedure or episode. Hospitals and private practices will be working in concert to provide high quality care with an overall reduction in reimbursement for the event.

In one of CMS' models, hospitals would cut checks to physicians out of a fixed prospective payment they would receive for all services furnished during a particular type of inpatient episode. In the three others, CMS and participating providers would set a bundled payment amount for a particular episode of care by applying a discount to what Medicare normally pays (the discounts appear to be in the 0-3% range). Providers would then bill Medicare as usual, though at the negotiated discount. If total fee-for-service payments are less than the bundled payment target, providers would share the difference.

Hospitals and private practices would work in concert to provide high quality care with an overall reduction in reimbursement for particular events.

Three Examples

In preparation for a more value-based payment environment, some early adopters have implemented a variety of qualitative and subjective metrics into their physician compensation plans. In many cases, they have given these metrics a proportionally small weight when compared to volume-based incentive compensation, so that physicians can become accustomed to these new components.

As can be seen in the following three examples, compensation models and specific criteria vary significantly, as does the amount that physicians can earn for reaching each metric:

> **Example A** – A physician can earn up to 5 percent of his or her base salary as additional bonus income for achieving a minimum average level of patients per day, by exceeding practice average for patient satisfaction scores, for correctly documenting in charts, for appropriate coding and billing, and for citizenship (peer review, networking, community relations, etc). Each component is given a specific weight and the cumulative analysis determines how much bonus is earned annually.
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> **Example B** – The physician can earn a fixed $20,000 bonus annually (the amount does not fluctuate based on specialty or base salary) if thresholds are met for sufficient patient

satisfaction scores, accuracy of charting/EMR data input, and participation in a quality improvement project annually.

Example C – A physician can earn nearly ten percent of his or her base salary as a quality bonus if thresholds for certain key indicators are met or exceed. These key indicators are unique per specialty. Additionally, the provider can earn an additional five percent of their base salary for a citizenship component which includes peer review, participation in committees, and participation in corporate initiatives (for example EMR implementation, quality improvement, etc.).

Early adoption of these components that initially minimizes their impact may be more appealing to physicians, as they will be able to adapt to the new metrics without feeling that their compensation level will be unduly compromised. When physician reimbursement structures eventually change, early adopters will be well-positioned, as they can simply dial up the weight of each component, so that volume-based compensation is given a lower priority and more emphasis is given to value and cost-based metrics.

This transformation in physician compensation is the cornerstone on which health reform is based. It will not be easy to move the needle from the volume driven mindset that has become deeply entrenched among health facilities and providers toward a value and cost driven mindset. The process will no doubt proceed incrementally and with many starts and stops along the way. But changing is coming, and it is prudent to be prepared.

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