

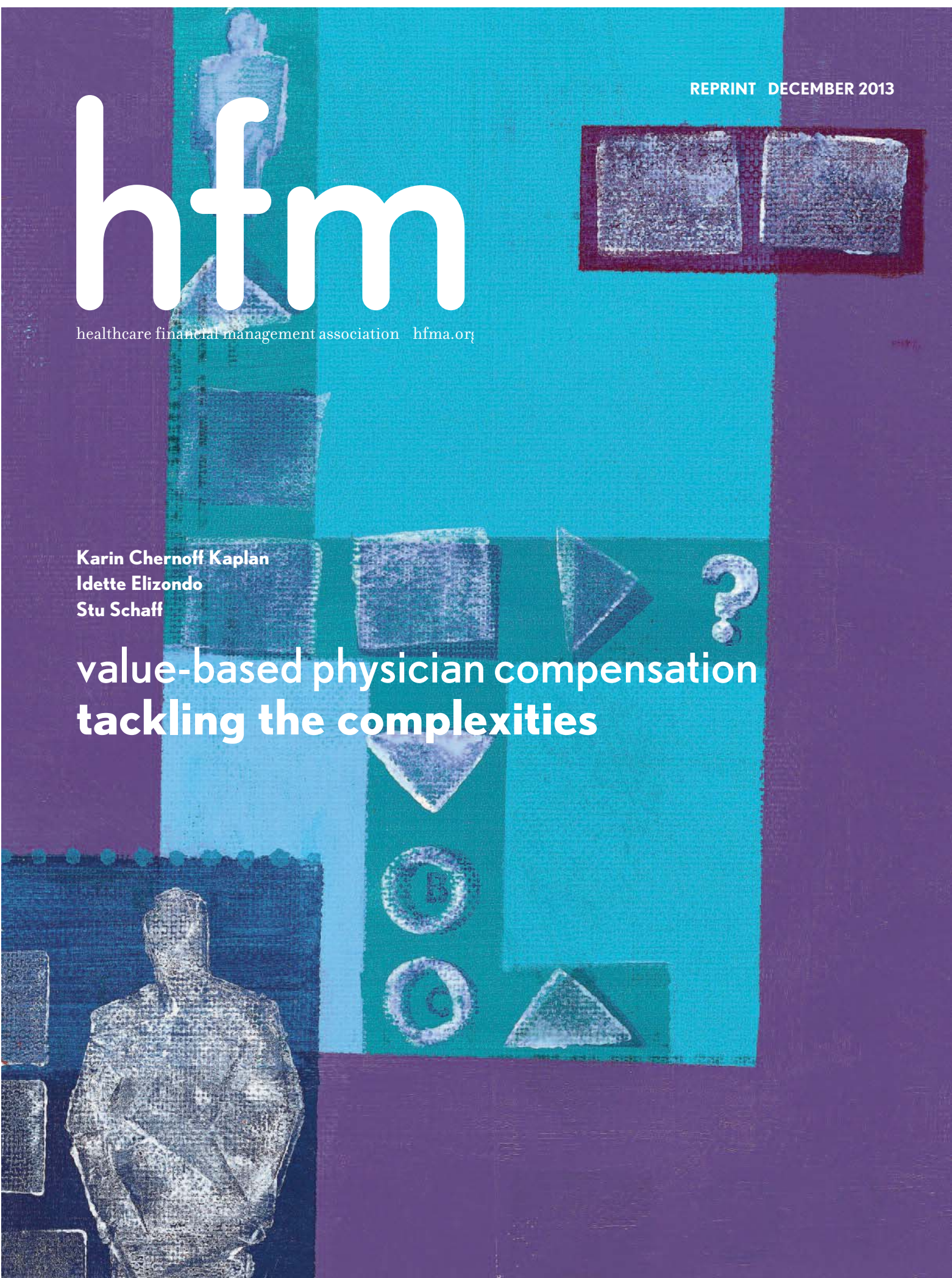
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value-based physician compensation tackling the complexities



FEATURE STORY

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As the healthcare industry continues its historical shift from productivity-based to quality-based payment, new physician compensation models will be needed to keep pace with this trend.

Today's wisdom holds that physician compensation models need to change to provide incentives for quality of care and cost-effectiveness while encouraging optimal levels of productivity. Making the change work, however, is anything but simple. Hospitals and health systems must manage a complicated balancing act between working within the existing volume-based payment system and preparing for a value-based payment world.

The goal of physician compensation models is to ensure physicians are compensated appropriately according to their performance, yet an inevitable outcome will be the creation of physician winners and losers. For this reason, any new model for

physician compensation should be designed and implemented carefully in a way that accounts for this reality. New compensation models also must fit their local market environment to prevent unintended consequences for the organization.

Quality Incentives: Today's Reality

For the past several decades, physician compensation has been established primarily through the use of productivity-based models, which have ensured that health system and physician interests are aligned as physicians have transitioned from independent practice to employment. The most common measures of productivity used in these compensation models are work relative value units (wRVUs) and, to a lesser extent, collections.

With the emphasis on productivity, quality has taken somewhat of a backseat in compensation models. Patient outcomes in the broadest sense

are rarely reflected in physician compensation models. Under productivity-based compensation, the simple reality is that physicians may receive higher compensation from recommending surgery instead of physical therapy; therefore, they do not have a clear incentive to choose the lower-cost option. This is not to suggest that physicians are likely to opt for self-interest over what's best for the patient. It is simply to say that, under productivity-based compensation models, even an exemplary and well-intentioned physician's recommended course of treatment could be influenced to some degree, consciously or unconsciously, by financial incentives inherent in the payment model.

Although quality measurement and reporting have been slowly creeping from the hospital to the physician practice, with reporting requirements such as the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures and the

patient satisfaction measures monitored by the Centers for Medicare & Medicaid Services (CMS) under the Medicare Shared Savings Program, this trend has not significantly affected compensation models.

The incentive component of compensation usually ranges from 0 to 30 percent of total compensation. Quality incentives, however, typically account for less than 10 percent. Further, many organizations report that their compensation models reward quality, but may only be paying for patient satisfaction or other non-productivity measures—that is, “quality light.”

Why haven't true quality outcomes taken more of a role in compensation models? There are three primary reasons.

It's still a fee-for-service world. Payment is still predominately based on fee for service, thereby encouraging volume and productivity.

The Impact of New Payment Models

Despite the limitations in quality measurement, quality is likely to take a larger role in future compensation models. Through health reform and the emergence of many innovative payment arrangements (e.g., ACOs, global or bundled payments, episode-of-care payment), physicians are being asked to manage quality and cost (see “The Transition to Emerging Revenue Models,” *hfm*, April 2013).

In some instances, physicians themselves are driving the new payment models through physician-led accountable care organizations (ACOs). In others, hospitals are working with aligned physicians (employed and affiliated) to form tight care management networks to make it easier to manage patient costs and quality.

As a result, physicians who are accustomed to a fee-for-service model are being forced to shift their mindset to think about utilization as an expense instead of as a source of revenue. For instance, a patient's total cost of care may include inpatient, outpatient, post-acute, or other healthcare services across the year. Providers are now being offered shared savings models (e.g., accountable care, bundled payment) that encourage them to manage the cost of care, and that allow them to participate in the gainsharing payments that result.

To prevent care from being inappropriately withheld, many of these shared savings payment models also require that providers maintain or improve quality to share in the savings. Healthcare organizations are beginning to recognize that compensation models focused on productivity need to be adjusted to consider quality and cost, so that incentives for frontline providers are aligned with the incentives of new payment models.

AT A GLANCE

Hospital and health system leaders should address six important questions before shifting to a quality-focused physician compensation plan:

- > Does the shift to a value-based compensation model present opportunities beyond the addition of quality incentives?
- > Should measures be universal or aligned with specific payer initiatives?
- > How much of an incentive is enough?
- > How should quality and cost-effectiveness be measured?
- > How should performance on the measures be assessed?
- > How will total and individual compensation be affected?

Quality measurement remains challenging. Measuring quality is an imperfect science. There are many measures and approaches, but no standard view on how best to approach it.

Providers fear the “bleeding edge.” As with many innovations, hospitals fear that change may lead to a near-term decline in revenues. Many hospital finance leaders don’t want to test the new models and implications, preferring to wait and catch the innovation curve when they can be in the early majority.

Transitioning to Incentives for Quality and Cost: Potential Risks

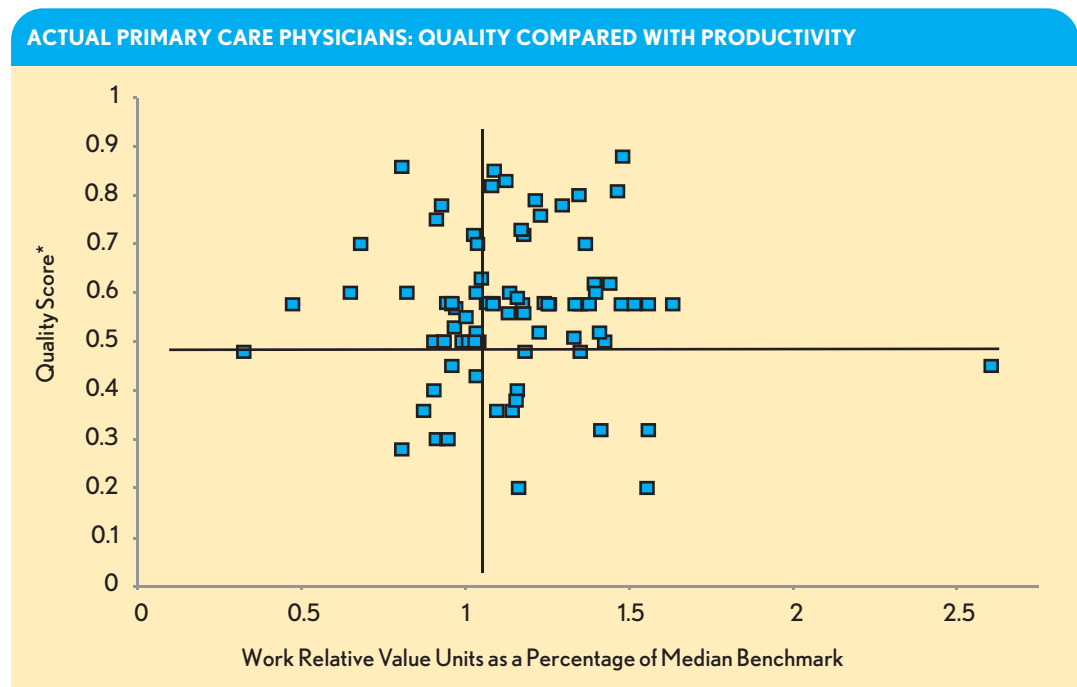
Changes in physician compensation models are required immediately in some markets, and they will soon become necessary in others. There are, however, risks if the shift toward a quality-focused physician compensation plan is not handled properly.

Individual physicians can take a compensation hit.

Physicians who earned significant incentives based on productivity may or may not earn them based on their quality and cost management scores. Not all

In general, physicians are not likely to change their behavior if they have less than \$10,000 at stake.

highly productive physicians score highly on measures of quality, nor are all physicians with high quality scores highly productive, as can be seen in the exhibit below. The exhibit compares the performance of 80 primary care physicians employed by a health system. Individual physician wRVU productivity (as compared with a median benchmark) is plotted against the individual physician quality score (a composite score based on clinical, patient satisfaction, and engagement indicators). About 25 of these physicians stood to be significant winners or losers if incentives were shifted unilaterally. Physicians in the upper left quadrant, with lower productivity and higher quality scores, could come out ahead, while physicians in the lower right are at risk of taking a hit.



* Each quality score is a composite score based on clinical, patient satisfaction, and engagement indicators.

Productivity could decline. Shifting the scale toward quality could result in productivity declines as physicians with lower quality scores slow down to focus on processes. Depending on the market and the physicians, this response could result in a need for more physicians, higher expenses, and other unintended consequences.

Physicians can become disgruntled. Although lost compensation can create dissatisfaction, it's not the only factor that can. Even "winner" physicians can become dissatisfied if they perceive that a new plan is unfair, inequitable, or too complex, which also can reduce the positive impact of quality incentives and slow quality improvement efforts.

With care, it is possible to increase the focus on quality and value while minimizing the amount of change to total compensation, or at least avoiding large swings in compensation for individual physicians. The right compensation model can keep things steady in a world of change.

Minimizing the Pain and Maximizing Results

In adjusting physician compensation models to effectively incorporate quality-based incentives, organizational leaders should thoughtfully consider six important questions.

Does the shift to a value-based compensation model present opportunities beyond the addition of quality incentives? If an organization has multiple compensation plans for different physician groups or specialties, or compensation plans that are overly complex, developing a new plan that will provide incentives for quality may also offer other opportunities for change. For instance, an organization may be able to move away from plans with 30 or more measures to one with fewer than 10. It also may be possible to improve transparency or reduce or eliminate discrepancies between plans. In some cases, hospitals have more than a handful of different employment arrangements, with different mixes of productivity and quality driving each one. Developing a new compensation plan also may be an opportunity to further align physicians with system goals and strategic plans.

Should measures be universal or aligned with specific payer initiatives? Some providers will develop programs specific to their preferred payment innovation. For instance, a Medicare ACO may implement the 33 measures specific to that program.^a Others may seek to develop their own measures and program through more of a clinical integration approach.

Although there are often commonalities among different payer arrangements in terms of the quality requirements, there are few systems for tracking which physician is in what contract and how individual physicians perform on quality measures related to that contract. For this reason, having all physicians focus on meeting a single set of expectations is clearly more practical than trying to define expectations contract by contract.

Getting payers to buy into your model and fund a pool that you distribute is the optimal solution. It helps to build statistical significance on measurement, and it can sometimes be used for incentives with independent physicians as well, such as an IPA or PHO.

How much of an incentive is enough? If changes in a compensation model are budget neutral, there are likely to be physicians who are significant winners or losers. The addition of quality dollars to an existing total physician compensation pool allows the organization flexibility to "experiment" with compensating physicians based on performance against quality metrics without the risk of alienating physicians by subjecting them to significant payment reductions. In particular, this option may be available to hospitals that have pay-for-performance arrangements with payers that focus, in part, on physician performance, where the payments under these arrangements could be used to fund physician compensation.

a. See *Accountable Care Organization 2013 Program Analysis Quality Performance Standards Narrative Measure Specifications*, prepared by RTI International and Telligen for the CMS Quality Measurement & Health Assessment Group, Dec. 21, 2012, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf.

CASE STUDY

Whether to pursue this option will be up to the discretion of hospital leaders, and many will find that increasing the size of the compensation pool is not possible, feeling compelled instead to use any additional revenue to fund required capital expenditures or operating expenses.

Nonetheless, most organizations will want to put at least what they are getting from payers in pay-for-performance and other new payment models on the table. The challenge is that the amounts being received may not be sufficient to engender a near-term change in physician behavior. It is important to put enough money on the table to be able to influence physician behavior meaningfully. Because most of the payer-funded initiatives are focusing on primary care, through covered lives attribution methodologies, the reality is that most organizations are rewarding primary care and specialty physicians differently.

In general, physicians are not likely to change their behavior if they have less than \$10,000 at stake—whether the amount is potentially incremental, or whether some portion of current income is at risk. In some instances, however, physicians may be happy to just get something, without being so concerned about the absolute amount. A compensation model employed in a four-hospital system in the Northeast pays \$1,000 per measure for

performance exceeding benchmark on each of 10 HEDIS measures. Given that these physicians previously received nothing related to quality, they welcomed this addition. However, it is not clear whether \$1,000 would have been sufficient to motivate the physicians to focus on any one of the 10 measures, separately.

How should quality and cost-effectiveness be measured? The choice of metrics is important, as that choice is the organization's key lever in controlling the impact of the new model. It may be desirable to set the bar low initially to obtain broader physician acceptance and adoption of the concept of quality/cost incentives and to keep too many physicians from either losing income or getting an overly substantial boost.

As with other aspects of compensation plans, transparency is desirable. Physicians should be able to immediately grasp how the incentives work and how they can benefit from the incentives. Usually, three to five clinical measures are sufficient to ensure physicians do not feel overwhelmed, but feel empowered to improve their performance on the measures and affect their compensation accordingly.

Quality measures for compensation are fast-evolving from softer measures like patient

COMPARED IMPACT OF BUDGET NEUTRAL COMPENSATION MODEL VERSUS MODEL WITH ADDITIONAL QUALITY DOLLARS

	Dr. X and Y Current Compensation	Budget Neutral		Additional Dollars	
		Dr. X	Dr. Y	Dr. X	Dr. Y
Base Compensation	\$200,000	\$190,000	\$190,000	\$200,000	\$200,000
Productivity Incentive	20,000	15,000	15,000	15,000	15,000
Quality Incentive	-	20,000	10,000	20,000	7,500
Total Compensation	\$220,000	\$225,000	\$215,000	\$235,000	\$222,500
Percentage Change		2%	-2%	7%	1%
Physician Reaction		Relieved to receive a small increase, but what's all the fuss about?	Not happy with decrease	Very pleased with significant increase	Satisfied with steady state, but thinks the quality metrics were flawed

satisfaction, community outreach, peer review, and service quality to more quantitative measures that track compliance with protocols and guidelines, as well as outcomes. More recently developed quality incentive programs consider performance related to factors such as HEDIS scores, disease-specific outcomes, initiative-specific quality goals, clinical outcomes, use of care guidelines, and use of IT.

Because the actual cost of care is often difficult to calculate, and the data for doing so are often maintained outside the organization, metrics that are proxy for cost can be used, including readmission rates, emergency department (ED) use, admission rates, and use of specialists.

Ideally, an organization will choose measures aligned with its strategic plan. A mix of more traditional measures and outcomes measures can be developed, such as that shown in the exhibit at right.

How should performance on the measures be assessed? Performance can be assessed based on three types of measures:

- > Improvement in quality scores, where each physician is scored against his/her previous performance

SAMPLE MIX OF TRADITIONAL AND OUTCOME MEASURES OF QUALITY

Type of Metric	Illustrative Measures	Sample Weight
Outcome Measures	Measures for relevant patient populations (e.g., congestive heart failure, diabetes) > Blood pressure under 130/80 > LDL cholesterol <100	60%
Patient Satisfaction	Overall increase in scores or absolute value over X	20%
Process Measures	Visit process > Flu vaccine in past year > Tobacco assessment (smoking history assessed)	15%
	Outcome process > Hemoglobin A1C in past year > LDL cholesterol in past year	5%
Physician Engagement	Attendance at grand rounds	5%

- > Absolute quality scores, where physicians receive a fixed dollar amount per quality measure or for overall score within a specified range
- > Comparison with peers, where compensation is based on a percentile group compared with peers—an approach that, by definition, will produce winners and losers

PROS AND CONS OF QUALITY PERFORMANCE ASSESSMENT OPTIONS

Basis for Payment	Pro	Con	Example
Improvement in Quality Scores	Rewards improvement and may have most impact on overall population health.	Penalizes those with strong quality at the outset.	Readmission rates: 10% if any reduction occurs; 0% if there is no change.
Absolute Quality Scores	Easy to describe and understand. Dollars available to all.	Difficult to find relevant benchmarks.	HbA1c control: If 10% of diabetes patients or more have score >9, then 0%; if none have score >9, full score.
Comparisons with Peers	Easy to implement. Physicians can't argue that targets are not achievable or are unrealistic, because peers are achieving them.	Targets vary based on group performance. Targets are constantly moving. Can slow the progress of change. By definition, will produce winners and losers.	Diabetes patient visits, blood pressure and LDL-C measurement: > Top quartile—10% > Second quartile—5% > Third and fourth quartiles—0%

CASE STUDY

How will total and individual compensation be affected?

Each measurement approach will have a different impact on ultimate compensation and the extent to which physician income may change. Any model being considered therefore should be tested for material changes in compensation and to strike a balance between improvements in quality and major compensation impacts.

Simulating the model is critical to determining the impact on individual compensation and on organization budgetary targets. Once the model is developed, simulation involves using actual historical performance data, both productivity and quality, and applying those data to the proposed compensation model. The result of the simulation is a projection of future compensation, by physician. This process involves the following key steps:

- > Understand historical physician compensation, including base compensation, incentives, and comparison with benchmark and internal variation.
- > Determine the quality metrics to be used in the compensation model.
- > Apply new proposed compensation model (including revised base and productivity and quality incentive structure) to historical performance data (including productivity and quality) to determine compensation that would be earned under prior-year performance.
- > Compare historical and proposed physician compensation to evaluate whether organizational/budget targets have been met.
- > Determine numbers of winners and losers relative to historical compensation.

- > Evaluate likelihood that new compensation model will meet other identified goals.
- > Refine the model, as required, to maximize physician buy-in.

Use of actual quality data is essential because:

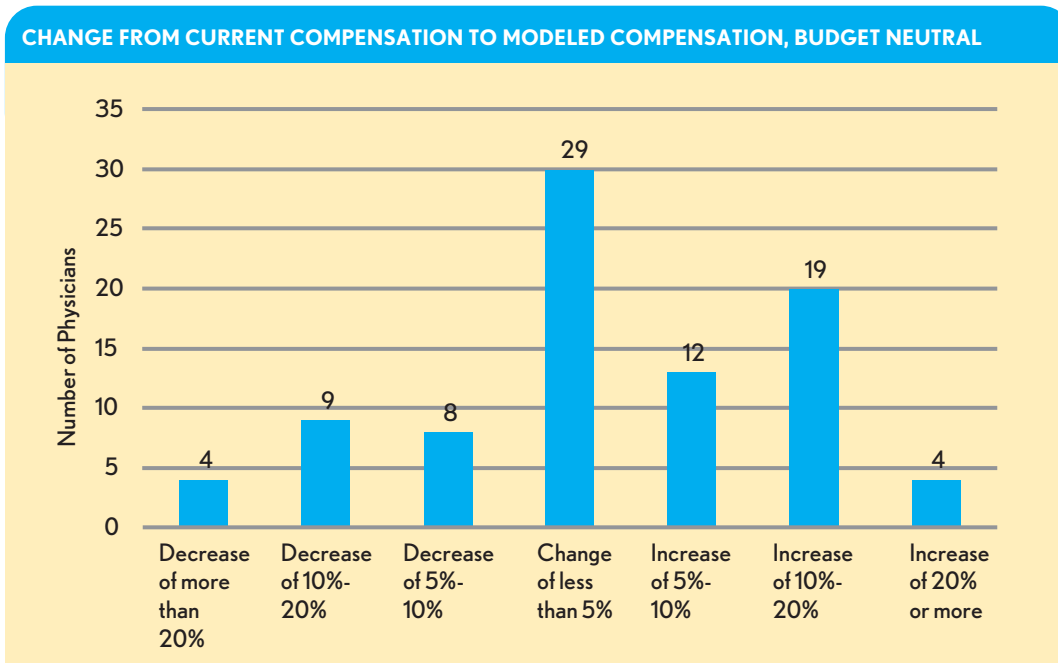
- > It is the only way to know the impact on individual physicians.
- > It is a way to evaluate the integrity and credibility of the data from the EHR.
- > It will inform the organizational budget process.

It's also essential to identify implementation barriers and tweaks that may be necessary. Consider, for example, the exhibit below, which shows the impact at a practice level where total compensation was budget neutral but the quality/cost effectiveness incentive moved from almost 0 percent to 8 percent of total compensation.

Although the overall impact may appear acceptable in that the result is budget neutral to the organization while providing incentives for quality care, the impact on individual physicians is critical to the process. The exhibit at the top of page 9, for example, shows simulation results of the same model as was used in the previous example at a physician level. This result could produce group dynamics that could block its implementation. No one wants an overnight decrease in compensation. Tweaks in the quality indicators were needed to smooth the transition. This potential effect can be identified only through a simulation with real productivity and quality data.

ILLUSTRATION: IMPACT OF ADDING QUALITY INCENTIVES TO COMPENSATION, BUDGET NEUTRAL

	Historical	Percentage of Compensation	Estimated Model Results	Percentage of Compensation	Change from Historical to Model I
Physician FTEs	85		85		-
Work RVUs	430,000		430,000		-
Base Compensation	\$11,850,000	96.7%	\$ 9,808,000	80.0%	\$(2,042,000)
Productivity Compensation	370,000	3.0%	1,471,200	12.0%	1,101,200
Incentive/Quality Compensation	40,000	0.3%	980,800	8.0%	940,800
Total Compensation	\$12,260,000	100.0%	\$12,260,000	100.0%	\$ -
Compensation/FTE	\$ 144,235		\$ 144,235		\$ -



Alternatively, as suggested previously, the incentive pool could be enhanced with additional funds to give physicians time to change behavior. The exhibit below presents actual results of a simulation of scores, using actual quality data for a 65-physician group. In this example, the quality score was a composite based on performance against five clinical metrics. These preliminary results indicate that only eight of 65 physicians would earn the full potential quality incentive (in this case, \$15,000).

Again, enhancing the compensation pool with incremental dollars for quality and preventing declines in compensation prevents physicians from being negatively impacted while enabling the organization to achieve its goals of increased focus on outcomes. This assertion, of course, assumes that current compensation is accurately

and appropriately aligned with performance and production and perhaps cost. It is always helpful to perform a thorough review and audit of current compensation levels and make any necessary adjustments prior to implementing a new program. This approach was used with the actual model that provides the basis for the examples shown here. As shown in the exhibit on page 10, adoption of this model minimized disruption and laid a foundation for physicians to respond to the quality metrics over time.

Phasing in the Plan

Putting the new compensation plan in place all at once, organizationwide, is unlikely to be a recipe for success. There are many possible approaches to phasing in the quality incentives program, including the following.

Start with a single specialty. Many organizations may want to start with primary care physicians, given that payers are tending to put more money on the table for these physicians in an effort to find ways to engage them. Some organizations, however, might find it simpler to start with a specialty with well-defined quality metrics, or one that has long experience with an emphasis on outcomes (e.g., cardiac surgery). This approach,

DISTRIBUTION OF PHYSICIANS BY QUALITY SCORE

Score Range	No. of Physicians
20% to 39%	7
40% to 59%	32
60% to 79%	18
80% to 100%	8
Total	65

CASE STUDY

however, can delay the focus on quality indicators for the rest of the organization, making it less likely the needed cultural shift will happen; physicians may not be clear about whether to focus on productivity and/or quality, thereby leaving the organization in a state of ongoing transition and uncertainty.

Start with a section of the organization. This could be a grouping of departments (e.g., surgery as a whole), or for a larger health system, it might be a single hospital. The same concern applies with respect to managing the timeframe of the overall effort.

Let each physician decide. Physicians can be given a choice of whether to participate during the first year (or another defined period). This approach may soften the transition, as physicians with strong quality performance may transition earlier, and experience no impact or a positive impact, while those who could be negatively affected would have more time to improve and adjust to the model.

Phase in the incentives over two years. For example, the initiative could put only half of physicians' compensation at risk in the first year, and 75 percent the second year.

Eliminate downside risk during the first year. This approach gets the new incentive program started

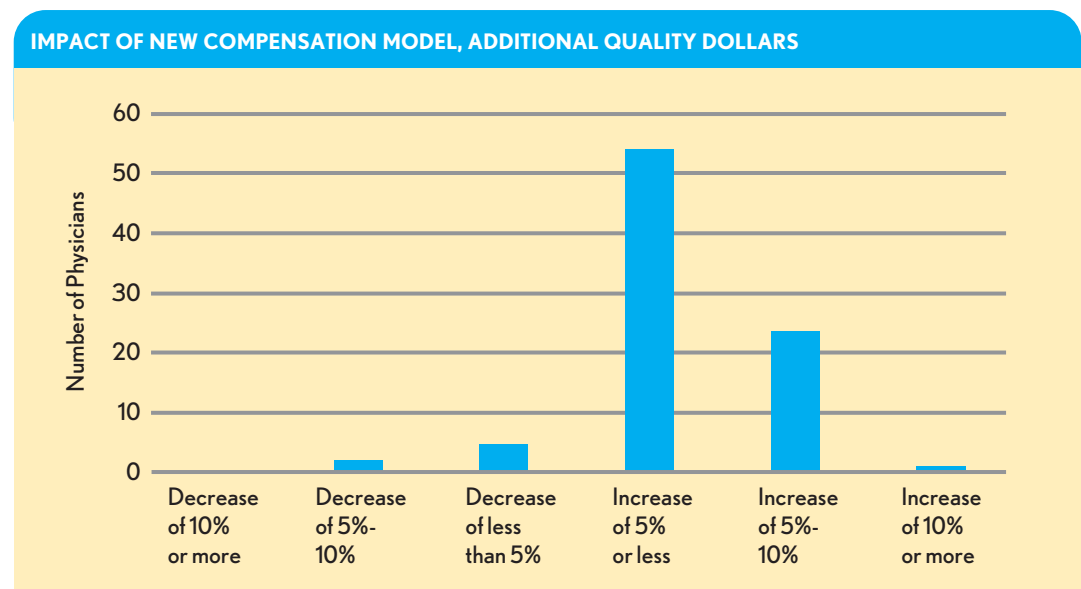
while giving physicians who have lower quality scores some time to improve.

Run as a "shadow program" for a year. With this approach, physicians would continue to be paid under the existing plan for a year, while the new quality incentive program runs in a test mode. This approach allows physicians to observe how they would have performed, had the program been fully implemented, and to see the implications for their compensation. It also affords IT some time to work out any reporting issues that could taint the data and undermine physician attitudes.

Of course, these options can also be varied and combined in many ways to customize the transition approach for the organization. It also should be stressed that involving physicians in developing and monitoring performance metrics is critical to the success of the transition.

Supporting the Transition

During any transition to performance-based physician compensation, it is critical to provide physicians with accurate performance data as well as compensation implications (whether actual or shadowed) so they will know how they are doing. Meeting this requirement may require a significant investment in reporting. The organizations also must strive to eliminate—or minimize to the



fullest extent possible—discrepancies between actual care delivered and care recorded in the EHR. Some reporting, such as total cost of patient care, may require outside data. Performance reporting must be performed clearly and correctly. Even one cycle of significantly inaccurate reporting can undermine trust and increase resistance to the new compensation program. The key to a successful transition is communication with physicians. This information should be timely, accurate, and easy to access.

Building performance-based incentives into a compensation program will be essential as payers continue to move toward value-based purchasing. The question is not whether to proceed, but when and how. With careful planning that addresses the issues above, healthcare organizations can create compensation programs that work for them in their markets. ●

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