Managing the Transition to Value-Based Physician Compensation

In August 2012, penalties associated with the Hospital Readmissions Reduction Program, stemming from the Affordable Care Act (ACA), were released by CMS. These penalties are for less-than-average performance in 30-day, all-cause readmissions for heart failure, myocardial infarction, and pneumonia; poorly performing hospitals will suffer a reduction to their full DRG base payment by as much as 1% in 2013, 2% in 2014, and 3% in 2015. These penalties will be extended either fully or partially to over 2,000 hospitals, many of which have a national reputation for excellence. In 2015, CMS has proposed phasing in the value-based modifier in accordance with 2013 physician cost and quality performance. This would redistribute payments between +/-2% based upon 62 preliminary measures. These programs will apply to almost all Medicare providers, and none of them are optional.

With this as a backdrop, healthcare organizations are mobilizing their physician and administrative leaders to expand their focus beyond volume to include access, service, cost, quality, and outcomes. While it is not difficult to energize healthcare professionals in these discussions, they appropriately struggle with how to move from a system based on volume (number of units and unit costs) to one based on value (the efficiency and effectiveness of care).
Incentives are a critical element of this transition, which with the passage of the ACA and the recent election have begun to shift at the macroeconomic level. If healthcare organizations are to succeed, substantial work is required of them to create the care delivery model of tomorrow while they continue to provide care today. Probably the most critical elements in this transition are physicians who have the direct line of sight on both cost and quality. As such, physician incentives must be rebalanced to incorporate a broader view of performance and remove barriers to this transition.

This issue of Insight will help you decide how to best manage the pace and implications of payment reform on physician compensation within your organization.

Determining how to pay doctors, as well as how much to pay them, has always been difficult and contentious. That said, all successful physician compensation models share a few key characteristics. They:

- Link physician incentives and organizational strategy.
- Include physician opinion leaders’ direction and input.
- Provide flexibility to adjust to changing market conditions.

The dominant compensation models today are work RVU-based systems that encourage productivity without any link to the actual economics of care or its resource utilization. These models proliferated as physicians were employed and moved from revenue-less-expense models toward payor-blind productivity-based systems. While there was initial resistance, most physician organizations made a fairly rapid and complete transition between the late 1990s and mid-2000s to RVU-based systems with tiers increasingly used to reward high producers.

More recently, both public and private sector initiatives have pointed to reimbursement based on the efficiency and effectiveness of care rather than the volume of services. This is generally known as value-based reimbursement, and both government and private payors are experimenting with new payment models. Not surprisingly, there has been a surge in interest among healthcare organizations about transitioning to physician compensation systems that are more closely aligned with the value-based future. However, in the flurry of activity surrounding paying doctors based on “value,” we repeatedly see healthcare organizations with a strong sense of urgency but a poorly defined direction. The fact is that the transition to value is not something that fits neatly into an annual plan. Rather, this is a long-term commitment that requires careful planning and substantial coordination between clinical delivery, managed care contracting, and organizational strategy.

Examining the Current Situation: Change Is Under Way

There is general agreement that physician and hospital reimbursement will require the assumption of more financial risk. Certainly, Medicare’s emphasis has been on transitioning hospital reimbursement through the Hospital Inpatient Quality Reporting Program, CMMI’s Bundled Payments for Care Improvement initiative, the Shared Savings Program (SSP), and Medicare Advantage, to name a few. Commercial carriers also have active first-generation programs initiated by large employers, such as Boeing’s Intensive Outpatient Care Program. These programs generally seek to invest in care management infrastructure for high-expenditure and chronically ill patients through advance payments (sometimes “thin capitation”) in return for future savings. After advance payments are repaid, payors and providers share in the resulting savings.

These types of arrangements, albeit small in initial scope, are driving substantial changes in care delivery, such as primary care medical home models that necessitate more team-based care. As a result, most organizations are considering a broader array of compensation incentives that balance the continued need for production with rewards for efficient clinical outcomes.

The data from ECG’s proprietary National Provider Compensation, Production, and Benefits Survey reflects a steady trend toward the redesign of existing physician compensation structures that recognize nonproduction metrics. The 2012 survey reported significant increases in plans that include quality and patient satisfaction metrics over our 2011 study.
PREVALENCE OF NONPRODUCTION-BASED COMPENSATION METRICS 2011–2012

<table>
<thead>
<tr>
<th>Metric</th>
<th>Percentage of Organizations</th>
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<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td>Quality</td>
<td>27%</td>
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<tr>
<td>Patient Satisfaction</td>
<td>20%</td>
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Additionally, over half of 2012 survey members are planning to incorporate nonproduction metrics this year aimed predominantly at quality (86%), patient satisfaction (76%), and patient access (29%).

PLANNED ADDITION OF NONPRODUCTION-BASED COMPENSATION METRICS

<table>
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<tr>
<th>Metric</th>
<th>Percentage of Organizations Planning to Add Metric</th>
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<tbody>
<tr>
<td>Quality</td>
<td>86%</td>
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<td>Patient Satisfaction</td>
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<tr>
<td>Patient Access</td>
<td>29%</td>
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<tr>
<td>Cost</td>
<td>19%</td>
</tr>
<tr>
<td>Utilization</td>
<td>19%</td>
</tr>
<tr>
<td>Physician Satisfaction</td>
<td>14%</td>
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While organizations are adding nonproductivity variables to compensation equations, nearly 90% of compensation remains productivity-based. To some, it may be surprising that the percentage of cash compensation tied to productivity remains high, but we are seeing incremental steps to balance productivity, quality, and service initiatives and expect this to continue as the reality of value-based reimbursement catches up with the rhetoric. In the meantime, it is important to note that adjusting even 5% of a physician’s compensation toward nonproductivity-based incentives is significant when you consider the impact on behavior of merely tracking and reporting these metrics. For a group of high achievers like physicians, “winning” the pool is often as important as the corresponding dollars. This is especially true in a quality pool where little of the incentive is actually financial. Recent project work and discussions with leaders of large multispecialty physician groups reinforce ECG’s recommendation that:

- The production component of physician compensation remains a key factor in determining pay levels. That said, we are moving many from individual production systems to group or site-based production models to encourage team-based care and access over individual performance.
- Nonproduction incentives are meaningful (even at between 5% to 15% of pay) and often require fairly simple reallocations of existing funds available for compensation into pools that are distributed according to nonproductivity performance. The politics of these adjustments are much more complicated than the technical modifications.
- Other investments will be required (e.g., disease registries, population health modules, data analytics) to ensure the long-term adoption of this transition, but they shouldn’t delay incentive design. Funding levels can be finalized and adjusted later.
- The recruitment and integration of advanced practice clinicians (APCs) is critical to the transition to value, as they enable highly trained physicians to manage care and extend their reach to facilitate population health management. Compensation systems must take this into account.

Tying Compensation to Reimbursement: No Easy Answers

One of the most difficult issues in the migration to value-based reimbursement is how to keep the incentives of physicians (the compensation plan) aligned with the incentives of the organization (payor reimbursement). Some extol the virtue of salary-based models given this conundrum. The reality is that very few organizations have successfully deployed salary models. Those that have been successful generally have strong cultures and peer pressure to reinforce desired behaviors. These features can take decades to develop, and trying to rush this process can quickly lead to organizational confusion, provider turnover, and operating losses. It is instructive that large capitated systems, such as Kaiser Permanente, which have traditionally paid a flat salary, are moving toward increasing levels of variable incentives, including volume measures, as part of their

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1 Source: ECG 2012 National Provider Compensation, Production, and Benefits Survey and National Pediatric Subspecialty Physician Compensation, Production, and Benefits Survey
2 Ibid.
3 Ibid.
physician compensation plan. These systems, whose physicians have often been at the lower end of productivity indicators, are seeking a more balanced approach to rewarding high performers and promoting access. Contrast this with the traditional fee-for-service (FFS) provider world wherein RVU-based systems have become the norm and physicians often resist replacing productivity with quality, safety, and efficiency metrics.

Managing the Volume-to-Value Transition
It’s clear changes in reimbursement necessitate modifications to how physicians are paid. If your organization has not yet implemented value-based compensation methodologies for physicians, it is not cause for panic. It is, however, time to move forward. The graphic below depicts a framework for a productivity-oriented group’s transition to including value-based incentives.

<table>
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<th>VALUE-BASED INCENTIVES INCLUSION TRANSITION</th>
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<tr>
<td><strong>Current Plan</strong></td>
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<tr>
<td>100% Production</td>
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<td><strong>Production</strong></td>
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<td><strong>Nonproduction Performance Pool</strong></td>
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<td><strong>Measurement and Reporting</strong></td>
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While the specifics of how to proceed will depend on the capabilities and culture of your organization, both the balance of production versus nonproduction incentives and the balance of team-based versus individual incentives must be considered. The term “team-based” includes performance of a site or specialty group and is likely to play an increasing role in individual physician pay. Globally, the above example moves to a balance of 75% production and 25% nonproduction over 3 to 5 years. We expect production measures to evolve over time to metrics such as panel size that encourage day-to-day efficient care. We also expect the focus to be increasingly on team-based performance to encourage the growth of APC practices that treat lower-acuity patients and enable physicians to extend themselves to better manage and direct care. It is not difficult to imagine a future in which these incentive types are more equally in balance. Operationally, team-based compensation models will support care delivery models that improve patient access and ensure the rightsizing of provider manpower.

Within nonproductivity incentives, a balance of metrics will include:

- **Financial Performance** – Whereby funds are available to physicians based on a site’s financial performance relative to its budget.
- **Quality** – Whereby funds are distributed to physicians in accordance with individual and/or site-based quality parameters.
- **Service** – Whereby funds are distributed to each physician based on access and patient satisfaction metrics.

A key to such a framework is that the incentives and their weighting can be reviewed annually in coordination with the organization’s contracting strategy and “dialed in” to meet the changing reimbursement environment.

Empowering Physicians in the Transformation
Engagement of physician leaders is critical to improving clinical processes and understanding the implications for physician compensation and payor contracting revisions. Simply put, if physicians are to truly be partners in the transition of the enterprise as a whole, they must have leadership roles in redefining clinical, contracting, and compensation incentives.

Enterprise-wide clinical leadership, contracting, and compensation committees are effective structures to
ensure input from all stakeholders, including physicians. In addition to allowing physicians to serve in decision-sharing roles (as contrasted with advisory roles, which are more typical), this structure acknowledges that physicians must do much of the heavy lifting required to impact both quality and efficiency, including but not limited to:

- Determining and implementing new clinical standards.
- Improving EHR systems to support population health management.
- Reconstructing operational processes to support the coordination of patient care.
- Engaging peers with data to identify variation and opportunities for improvement.

Given this central role, physicians must be engaged in both the strategic and tactical components of payor contracting, as well as understand the implications of contracting initiatives for their compensation.

This level of integration often requires organizational restructuring and data transparency to effectively engage enterprise leadership. Data transparency should not just mean that the source of data is known. It should also mean that performance improvement is explicitly defined; that physicians receive, review, and correctly interpret data on a regular basis; and that physicians are ranked according to performance. Effective transformation includes providing a forum for feedback; connecting physician concerns to group action; informing physicians about new initiatives, quality and financial performance, and key decisions; and reinforcing the vision and strategy of the organization. Not coincidentally, these are features that organizations need to develop if they are to become clinically integrated.

Investing in Innovation
We have stressed the importance of matching compensation to reimbursement, but there is an obvious chicken/egg dilemma. If you move into value-based compensation in advance of securing contracts that reimburse services according to value, you risk a drop in production and revenue. If you move into pay-for-performance (P4P) or population-based third-party contracts while physicians are paid based on productivity, your costs are likely to exceed revenue. Potential external revenue sources to offset a move to value-based compensation include:

- Incentives from commercial and Medicare Advantage payors.
- Medicare programs (e.g., Physician Quality Reporting System [PQRS], SSPs).
- Grant funding.
- Meaningful use payments.

External funding is of course preferred, but reconciliation of these payments occurs typically 18 to 24 months in the future and is often limited in size. Committing to establish internal funds that link your organization’s culture and transformational priorities is often a more expedient path. Take a lesson from government and commercial payors that are providing advance infrastructure payments and recouping those investments on future savings and enhanced margins. While incremental funds may be provided by the organization to enhance physician incentives, physicians must understand both that improvement in efficiency is expected, and that the organization wants a return on this investment. Specifically, the amount invested in the incentive pool should be clearly identified and agreed to, and an arrangement to recapture at least a part of these funds from future physician revenue streams should be put in place. Taking these steps establishes both that you are willing to fund needed innovation and that the physicians bear responsibility for improving performance and sharing the developmental costs.

Dealing With Uncertainty
When facing a future full of “could be” and “might happen,” it is helpful to reflect on what is likely to be true rather than what is unknown. Our thoughts on those things that are likely true relative to physician compensation include:

- Payment reform is happening, and (significant) revenue will move to value-based systems.
- The value-based systems movement will have a meaningful impact on physician compensation.
- Migration to value-based compensation systems will maintain a steady pace.
- While payment reform is playing out, reimbursement will continue to stagnate or be constrained.
- Efficiency is critical for the foreseeable future and must be the highest organizational priority.
Given this vision of the likely direction of change, it is important that compensation be linked to reimbursement and that changes be driven by internal strategy rather than external forces. Waiting for the “answer” to emerge externally just about guarantees that your responses will be too late to be competitive. Instead, develop the central tenets of your reimbursement and physician compensation policies, be clear about this strategy with payors and providers, charge the physicians with the development of compensation plans that can be dialed in as your system evolves, and work in partnership with physicians on reducing the cost of the care provided.

**About ECG**

ECG offers a broad range of strategic, financial, operational, and technology-related consulting services to healthcare providers. As a leader in the healthcare industry, ECG provides specialized expertise in developing and implementing innovative and customized solutions that effectively address the complexities of healthcare reform, strategic and business planning, specialty program development, hospital/physician relationships, IT, and the academic healthcare enterprise.

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