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THOUGHT LEADERSHIP

PHYSICIAN COMPENSATION MODELS: NON-PRODUCTIVITY INCENTIVES

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INTRODUCTION

As Employed Physician Networks and their health systems progress on the journey toward value-based care and its reimbursement, they encounter third-party payers who are increasingly structuring reimbursement parameters around pay-for-value tenets and placing percentages of traditional pay-for-volume earnings at risk for performance that satisfy value-based metric targets.

Tightening health system margins and increasing practice-related losses fuel organizations' need and desire to receive all available revenue for care rendered by the physician group. This push leads employed network leadership to contemplate mechanisms to ensure that network performance nets the maximum possible revenue capture. One of the areas that receives focus during these contemplations is whether the physician compensation model can be leveraged to align with enhanced value-based metric performance. In other words, can non-productivity incentives be included in the physician compensation model to directly align performance with payer initiatives associated with value-based care tenets and metrics?

The "Base plus Incentives" compensation model can be designed to distribute incentives among productivity and non-productivity incentives. Furthermore, incentives can be individual provider and/or group-based. Common non-productivity incentives include the following areas:

CLINICAL QUALITY MEASURES

PATIENT EXPERIENCE AND ENGAGEMENT

CITIZENRY

OPERATIONAL EFFICIENCIES

COST OF CARE

CLINICAL QUALITY MEASURES

Clinical quality is often the first area considered for non-productivity incentive emphasis. There are numerous potential measures and metrics to consider in this area that can align physician efforts with organizational goals and objectives, including the following:

ACO Participation

Accountable Care Organization ("ACO") participation requires submission of CMS (or other payer) required quality data by its members and the ACO's payout depends on member performance on the measures. Target achievement is required for the ACO (and its members) to receive a distribution of any shared savings for which it qualifies. The quality metric targets (or the national benchmarks) can be used for local performance improvement initiatives – and associated compensation incentives. Although ACO metrics typically apply more to primary care than other specialties, many apply to all, such as patient satisfaction (CAHPS[1]), tobacco use screening, and others.

Quality Payment Program

Performance within the CMS Quality Payment Program (a.k.a. MACRA[2]) now determines physician and advanced practice provider ("APP") Medicare fee-for-service reimbursements. Whether participating in the Merit-based Incentive Payment System ("MIPS") pathway through ACO reporting or through individual/group reporting, three of the four Performance Categories, including Quality, Improvement Activities and Promoting Interoperability offer options for quality incentives. The CMS website delineates all potential options – including suggested specialty-specific quality measure sets.

Professional Societies

Most professional societies now list recommended measures/ metrics by specialty – or offer formal quality improvement registries in which to participate and gauge performance relative to peer generated benchmarks. That said, it's worth noting that, many of the registries have associated participation fees that may be prohibitive.

Co-Management Arrangements

Co-Management arrangements can be utilized to align independent and employed physicians with service line objectives, including achievement of quality objectives. Independent physicians can be directly compensated for improvement effort results whereas the employed physicians' efforts can be compensated through the incentive bonus pathway.

[1]*Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an AHRQ program that began in 1995. Its purpose is to advance our scientific understanding of patient experience with health care. The acronym "CAHPS" is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).*

[2]*Medicare Access and CHIP Reauthorization Act of 2015.*

PATIENT EXPERIENCE AND ENGAGEMENT

Patient experience can be directly assessed through the CMS CAHPS series. The CG-CAHPS (Clinician and Group CAHPS) survey measures patients' perception of care provided by physicians in the office setting and includes several provider-specific questions that can be used for incentive programs, including:

Question 18
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

Question 11
In the last 6 months, how often did this provider explain things in a way that was easy to understand?

Question 12
In the last 6 months, how often did this provider listen carefully to you?

Question 13
In the last 6 months, how often did this provider seem to know the important information about your medical history?

Question 14
In the last 6 months, how often did this provider show respect for what you had to say?

(Other questions deal with access to the practice and support staff interactions.)

Incentive metrics can be created using one or a combination of the above, such as achieving a score on Question 18 of 8 or higher for 80% of responses received during the incentive period – or – achieving an 8 or higher for Question 18 and top box scores on Questions 11-14 80% of responses received during the incentive period.

CITIZENRY

Measures often cited in this area include meeting attendance, provider recruitment efforts, medical records completion, CDI queries, and staff satisfaction. For example, metrics may indicate attending 75% of employed network All-Provider meetings per year; having 90% of office encounters locked within 2 business days; and achieving a staff satisfaction rating of 8 or higher.

Citizenry measures have been used in various ways depending on organizational philosophy. Some organizations establish these metrics as baseline expectations of network membership and base compensation, and performance is considered separately from compensation incentives. Other organizations use citizenry as a threshold determinant for incentive payout – meaning, the metric(s) must be fulfilled in order to be eligible for other incentive bonuses. Yet other organizations favor positive reinforcement for achieving the metric targets by adding to the compensation incentives, such as a 1% additional bonus per fulfilled metric. Still others use the metrics for negative reinforcement, such as failure to achieve the metric(s) results in a 1% decrease of achieved incentive bonus, or even base compensation, per "failed" metric.

OPERATIONAL EFFICIENCIES

Operational efficiencies represent a broad swathe of initiatives and associated measures and metrics. Some examples include the following:

Patient Access

Metrics might include time to 3rd next available appointment by appointment type with targets determined internally based on supply and demand realities. A target might be less than 7 days for new patients. Another metric might be % schedule fill rate (offset by the 'No Show' rate) to maximize daily utilization of scheduled appointments. A target might be 95%.

Utilization

Another broad category of measures and metrics depends on organizational focus at the time. Options include ED utilization rates; care coordination (such as, Transitional Care Management process measures leading to decreased readmission rate outcome measure); and patient portal use (percent of appointments created online and/or numbers of secure messages or % increase in secure messages).

Co-Management Arrangements

Co-Management Arrangements can also focus on streamlining operational processes to effectively and efficiently utilize staff, minimize day of procedure cancellations, and other pertinent operational issues. Metrics associated with these initiatives could be incorporated to effect alignment and reward efforts associated with these metrics.

COST OF CARE

Cost of care assumes a central role in value-based care transitions. The value equation pits the quality care delivered against the cost to provide that care – with high quality and low cost producing the desired high value of care. Cost of care is a pillar of the Triple (or Quadruple) Aim.

Candidates for compensation model cost metrics and targets have become relatively abundant and include the following:

ACO Participation

Decreasing total cost of care while providing high quality care is the foundation of ACO programs. The ACO cost performance metrics can be translated into compensation incentives.

Quality Payment Program

Cost is one of the four (4) MIPS Performance Categories and one of the evolving elements of which can be used to develop compensation incentive metrics and targets.

Budget

Employed network or individual practice budgetary performance and associated goals and objectives are keen focuses for aligned incentives.

Co-Management Arrangements

Cost is another focus of Co-Management Arrangements. Points of emphasis may include standardizing implants or other devices to effect better procurement costs or streamline inventory and ordering – each of which can decrease the associated cost per case. A sample metric and target might be achieving a 10% decrease in cost per case realized by standardizing implants or other procedural devices.

OTHER CONSIDERATIONS

How difficult is it to add non-productivity incentives to a compensation model?

The ability to effectively include non-productivity incentives in physician compensation models depends on the status of the current model, the ability of the network to reliably capture and report the metrics, and the culture of the network – including the level of compensation plan complexity that physicians and administrators can tolerate.

Introducing non-productivity incentives usually necessitates annual review of the included measures, metrics, and targets to ensure that each continues to represent opportunities for improvement and optimally aligns physician efforts with current organizational goals and objectives. The annual review process also allows other aspects of the model to be reviewed at the same time – including the percentages dedicated to the non-productivity incentives to ensure that the amounts are sufficient to promote behavioral change.
Adopting incremental changes to the incentives and increasing percentages of total compensation over time is usually the most palatable approach to adopt. This allows progressive acceptance by the physicians and progressive evolution of administrative resources to adequately support the model components.

Do targets have to represent an 'all or none' phenomenon?

Simply stated, they do not have to. In fact, in many cases an 'all or none' approach can create a disincentive. If the 'all or none' question is not well thought out, significant provider effort and improvement can go unrewarded, creating apathy or even resentment towards the incentive and the behaviors the incentive was designed to elicit. Performance improvement initiatives often include progressive target evolution to sequentially move from the current level of achievement to an ultimate future goal (e.g., 100% compliance). The initiative anticipates annual improvement of performance toward the desired future level.

A similar model can exist for non-productivity measure achievement that mirrors the performance improvement plan goals/targets. For instance, rather than defining the entirety of the incentive payment as $XXX if the provider achieves 80% performance level, the incentive can be defined in tiers (i.e., $XXX for 80%, $YYY for 85%, $ZZZ for 90%). The tiered approach allows the opportunity to incentivize "stretch" performances rather than just meeting the "minimum" target. This approach has been applied to individual productivity incentives in some organizations through increasing $/wRVU rates for escalating levels of wRVU achievement over the base expectations.

CONCLUSION

Progressing along the path to value-based care and reimbursement and promoting a team-based culture will necessarily lead employed networks to pursue non-productivity incentives within the physician compensation model to more fully align physician effort with the desired organizational culture, goals and objectives. Tactically increasing their presence and complexity can increase their effectiveness over time. To learn more, or to start a conversation about how HSG can help you realize these physician compensation model optimizations, contact Dr. Terry McWilliams at (502) 614-4292.

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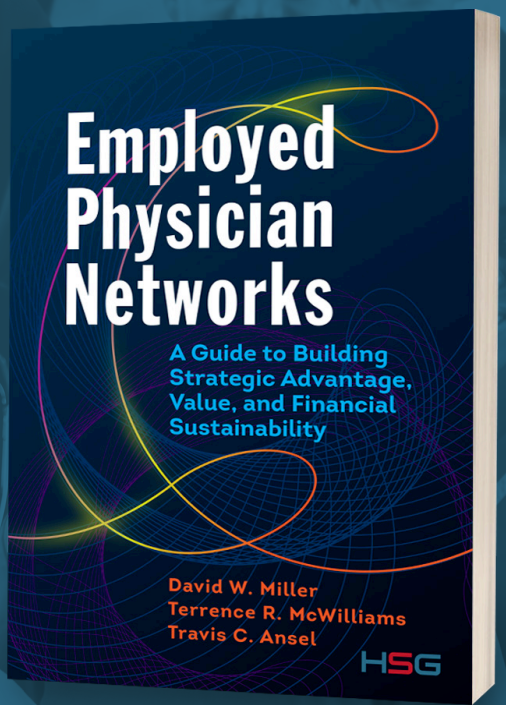

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