# How to Structure a Quality Incentive Program for Physicians

While the healthcare industry has been moving from volume to value for the last two decades, the movement toward true value-based care has really taken off within the last few years. This is because the way health systems are paid has been largely based on fee-for-service payments with a relatively small share of a health system's revenue being driven through "value."

The 2022 MGMA Practice Operations Survey found that health systems see approximately $31,000 in value-based revenue per FTE physician [1]. While that figure is just a small portion of what organizations bring in for the typical physician, the expectation among leaders in the healthcare provider and the payor industries is this trend of shifting revenue away from fee-for service and towards value-based care is going to grow significantly over the next several years. As the way organizations are reimbursed moves towards quality and other non-productivity-based metrics, how those organizations pay their physicians needs to evolve in similar ways. Many organizations we work with at VMG Health are engaging our firm in the following ways:

- Organizations without a quality program in the current compensation program are looking to operationalize quality. They are looking to do this both in selecting and building meaningful quality metrics within their EMR and in developing a compensation program that rewards physicians for high-quality care, in addition to just a high volume of care.
- Organizations with a quality program are looking to take quality to the next level. They are doing this by organizing the care model into an increased care-team type approach or moving away from just quality metrics in the comp plan for primary care physicians. In moving away from just quality metrics, they are focusing on a more robust panel/population health management system that rewards physicians for things like panel size, patient access, and outcomes-based metrics (vs. process metrics in other areas).

The remainder of this article will focus on common ways organizations are implementing value into their physician compensation plans. It will also include guidance to organizations on how to select meaningful value-based metrics to provide the most value to the organization.

## Determining the Magnitude of Compensation

For those organizations just starting on this journey from volume to value, the most important decision is how to start including quality in plans that have previously paid physicians solely based on the volume of their work. Organizations often start by adding a modest amount of compensation tied to value, and typically it is an amount that guarantees a physician's base salary or rate per wRVU does not need to decrease to make room for the quality incentive while staying within budgetary expectations.

For example, a productivity model at $55 per wRVU with an expected 2.5% budget increase in 2023 might leave the conversion factor at $55 and add a 2.5% quality incentive as a bonus. Over time, that percentage tied to quality can increase as physicians become more familiar with and trusting of value-based metric reports as they are with wRVU reports. However, this process generally starts small and typically tops out somewhere in the 10-20% range for organizations on the value-based side of the volume-to-value continuum.

## Structuring the Quality Incentive Program

Once the magnitude of compensation is determined, there are a few main ways organizations typically structure value-based incentives in their physician compensation plans. These structures are typically based on how the organization's leadership team answers the following question:

> **Question: "Should quality be the same for everyone, or should there be some variability for factors like productivity, tenure, base salary differences, or other factors?"**

Potential Answer 1: "Quality should be **the same for everyone." – The Flat Dollar Approach**

> These organizations typically pay all physicians the same flat dollar amount, regardless of physician subspecialty area. As an example, every physician, whether a neurosurgeon or a family practitioner, would have the same $20,000 quality opportunity.

Potential Answer 2: "Quality should be the **same for everyone within a specialty."- The % of Median Approach**

> These organizations typically use a percent of market (usually median) approach that pays everyone within the same specialty the same total dollars for quality. As an example, every family medicine doctor would receive up to $13,500 (~5% of median), and every neurosurgeon would receive $37,500 (~5% of median).

Potential Answer 3: "Quality should be **the same for everyone, with some small differences based on the physician's base salary** (typically based on years of experience, tenure, or other factors)." – **The % of Base Salary Approach**

> These organizations typically use a percentage of-base salary approach where the base salary is set according to organizational policies. This might provide a differentiated level of base compensation for factors like tenure, experience, productivity level, or other factors, and each physician can receive 5% of their individualized base salary as a quality bonus. As an example, Family Medicine Physician A with a $230,000 base salary is eligible for an incentive of up to $11,500, and Family Medicine Physician B with a $250,000 base salary can earn up to $12,500.

Potential Answer 4: "Quality **should vary with productivity** such that my highest producers should have the most at-risk for quality." – **The Rate per wRVU and/or the % of Production Comp Approach**

> These organizations typically use either a quality rate per wRVU or a percentage of total production-based comp approach. Under a pure productivity-based plan, if the compensation plan targets a compensation per wRVU rate of $50 then$47.50 per wRVU might be earmarked for wRVU productivity, and an additional $2.50 per wRVU is set aside, and paid based on quality performance. This type of incentive provides different (and sometimes significantly different) quality incentive opportunities for physicians with different levels of productivity.

## Selecting Meaningful Metrics

Regardless of which of these quality compensation structures is selected, when considering supporting quality bonus payments to physicians a key factor is having a substantive set of quality metrics.

VMG Health collected industry research and identified multiple healthcare articles, publications, and other sources related to quality bonuses paid to physicians. The takeaways about value driver considerations related to the metrics are summarized below. While this list is not exhaustive, it does provide the most common and important factors that support quality bonus payments to physicians.

- **Metric Type:** Outcomes metrics are more valuable than process metrics.
- **Benchmark Endorsement:** Nationally endorsed benchmarks are more valuable than internal benchmarks.
- **Superior Performance Benchmark:** Superior performance targets based on top decile performance are the most valuable targets.
- **Difficulty of Metric:** Stretch goals are more valuable than minor improvements and/or maintaining performance.
- **Selection and Number of Meaningful Metrics:** Including a substantial number of meaningful metrics (usually five to 10 metrics).

Generally, factors such as paying for the achievement of "superior" performance standards and selecting patient clinical quality metrics demonstrably impacted by the subject physician(s) help to justify higher-quality bonus payments.

***Further, the following chart outlines some best practices to consider for identifying and selecting meaningful metrics, as well as factors to consider before including value-based incentives in a compensation model.***

**PROFESSIONAL COMPENSATION**
The physician's professional compensation is at-risk (i.e., billed fee for service, compensation per work relative value unit model, no fixed/guaranteed salary); or if fixed/guaranteed, ensure professional compensation has been evaluated to be consistent with FMV and commensurate with productivity before stacking on any value-based incentive.

**PHYSICIAN IMPACT**
The physician will be instrumental to the quality outcomes and will have a direct and demonstrable impact on the chosen quality metrics (versus the hospital or hospital staff).*
*Avoid metrics in which the physician(s) do not drive outcomes, such as billing/coding metrics, and metrics that are generally for nursing or administrative staff such as some operational efficiency metrics.

**METRICS BASED ON NEED**
The selected metrics are based on the need of the facility and/or patient population.

**CREDIBLE MEDICAL EVIDENCE**
The selected metrics are supported by credible medical evidence for improving quality, efficiency, and/or patient outcomes.

**NO OVERLAP OR DUPLICATIVE METRICS**
The selected metrics do not overlap and/or are duplicative with any services required under medical staff bylaws and/or other arrangements.

**MEANINGFUL PERFORMANCE TARGETS**
Management has established meaningful superior performance benchmarks for each metric based on a material improvement from baseline performance or difficult-to-achieve goals (typically consistent with national top decile or industry standards for maintaining excellence).*
*Avoid "low-hanging fruit" metrics that don't appear commercially reasonable, such as having several metrics where historical performance already surpasses the stretch goal or tiny improvements earning a large payout.

**REMEMBER TO REBASE ANNUALLY**
The metrics will be rebased/reassessed annually.

**AVOID METRICS THAT COULD BE TIED TO VALUE OR VOLUME OF REFERRALS**
Avoid financial metrics related to operating margins or any metric measuring referrals or accounting for an increase in volume (Note: May need to be careful with certain care coordination metrics).

**AVOID TIME-BASED METRICS**
Avoid time-based metrics that are already paid for under an hourly rate (may be common with employment), or have a substantial value assigned that cannot be supported by time.

**TRACKING AND MONITORING PERFORMANCE**
Infrastructure has been put into place to track and monitor performance in a reliable manner.

**APPROPRIATE SAFEGUARDS**
Appropriate safeguards have been put into place to ensure patient safety and prevent a reduction in patient care.

It is important to note the considerations described herein are most pertinent when a party wishes to fund its own value-based compensation program. Alternatively, and subject to certain facts and circumstances, if the funding for a value-based compensation program were to be tied to incremental quality or savings payments from a governmental or commercial payor, other factors may be relevant to consider. Some examples of factors are the incremental revenue/actual savings generated, and the risk and responsibility of the parties.

## Non-Productivity Incentives – The Next Evolution

Organizations that are already far along on the value-based care continuum with a robust quality department/program are starting to expand beyond the quality incentive programs outlined above. These groups are starting to include patient access or acuity-adjusted panel size factors to further focus their compensation plans on population health management. Patient access can include incentives for things like open panels, time to third-next-available appointments, or other factors that get layered on top of productivity and quality compensation.

Acuity-adjusted panel size is an alternative productivity metric to wRVUs that attempts to measure how large a panel of patients a particular physician is charged with caring for. Raw panels (actual number of patients) are adjusted for some level of patient acuity factor – an age and sex adjustment factor, hierarchical condition categories (HCCs), or a multitude of other factors to ensure panel comparability. Unfortunately, there is no perfect acuity-adjustment factor, which makes comparing panel sizes to the external market a unique challenge.

Finally, some organizations are using incentives embedded in payor contracts – quality incentives, shared savings, and other payments – as additional incentives in the provider compensation formula. Typically, organizations take some percentage of dollars received from payors to cover costs incurred by the system and to provide some level of additional remuneration to physicians.

## Conclusion

As these value-based programs continue to evolve, organizations have many levers to provide competitive levels of compensation to their physicians. These options help move physicians' focus from being solely on production to providing high-quality care to patients and reducing unnecessary procedures.
With this complexity, however, organizations must be more diligent than ever to ensure their provider compensation programs continue to align with federal fraud and abuse laws. These regulations are also changing and providing additional levels of protection to organizations that ask physicians to take on meaningful downside risk in their compensation plans. Therefore, careful consideration should be taken in establishing a compensation strategy to ensure the compensation levels remain both competitive and compliant.

## Sources & Endnotes

1 Medical Group Management Association. (2022). "Data Report: Patient Access and Value-Based Outcomes Amid the Great Attrition."

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