Physician Compensation: Adapting to a Changing Landscape

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As healthcare is evolving, including modifications in delivery and payment methods, physician compensation has to evolve as well. Nationwide, we are anticipating the advent of Accountable Care Organizations (ACOs), and Patient Centered Medical Homes (PCMHs) as well as universal coverage. In Massachusetts, we are beginning to live that change already and our experiences might be indicative of what the country will see in a few years.

Healthcare reform

By 2014 the Affordable Care Act will take full effect, providing high quality medical coverage for the uninsured. Massachusetts might just be a harbinger of what the rest of the country can expect when this happens. Many physicians are surprised when I tell them that we have had universal healthcare here in Massachusetts since 2006. Pre-existing conditions? Not a problem. Can't afford coverage? We'll subsidize it for you. More than 98% of Massachusetts residents have health insurance. In Essex County on Boston's North Shore, where I work, 97% of the population has a PCP.

Payment reform

In 2008, my employer, Northeast Health System (aka Beverly Hospital) along with several other pioneering hospital groups in the state, embarked on a partnership with Blue Cross and Blue Shield of Massachusetts to revamp the way providers and hospitals are reimbursed. Without going into all of the details*, the contract moves away from paying for every procedure and test and instead shifts towards compensating physicians on a per member per month basis (capitation), but with a twist. Whereas the knock on capitation when it was in vogue in the '90s was that quality of care suffered due to underuse, the caveat to this model is that it incorporates a 10% withhold that physicians can earn if their patients are healthy. These bonus payments for quality serve as a disincentive for underusè.

Physician compensation

While capitation was the physician compensation model in the 1990s, in the 2000s productivity compensation models have predominated. Most physicians are compensated in part or wholly based on Work Relative Value Units (WRVUs) which are considered to be an objective measure of a physician's productivity. According to the *New England Journal of Medicine*'s June 2, 2011 article on the subject, "production-based models are used or being considered by more large group practices than ever before." The WRVU model, however, has had the unintended consequence of rewarding quantity rather than quality. When providers and hospitals are paid on a fee-for-service (FFS) basis, utilization and therefore costs increase dramatically, too often without a corresponding increase in quality of care.

Here at Beverly Hospital, we have pioneered BCBS's new alternative quality contract and are becoming better prepared for PCMH and becoming an ACO. Our hospital and providers are being asked to provide exceptional care and outcomes at lower costs, and they are succeeding. To help accomplish this goal, we are adding quality measures to our physician employment agreements in order to better incentivize our physicians to help them adjust to the changing health care delivery landscape and economic realities.

For instance, our Physician Hospital Organization (PHO) monitors about 30 different patient quality measures for our primary care physician's patient panels, the top five being: Diabetes HbA1C, Diabetes LDL-C, Diabetes Blood Pressure, Hypertension Blood Pressure and Cardiovascular LDL-C. We also use Press Ganey to measure patient satisfaction for both our physicians and their practices. Using the proverbial carrot and stick, we pay bonuses to our physicians if they meet or exceed their quality targets in both areas. Conversely, we will withhold monies from their compensation if they don't hit their targets. The amount of money each physician has at risk isn't earth shaking, but it is enough to capture their attention. To their credit, most of our physicians are performing exceptionally well and stand to earn bonuses. In fact, Press Ganey wanted to know what we were doing that so dramatically enhanced our patient satisfaction scores.

Our contracts are still productivity based. However, by incentivizing physicians to take a more active role in keeping their patients compliant, healthy and happy, we have taken a step away from FFS and towards striking a balance between physician productivity and quality of care. If we do this successfully, everyone will share in the savings while quality of care is improved. Granted, this is a pilot program, but BCBS of Massachusetts has been consulted by Congress due to the program's success and Beverly Hospital's experience with healthcare and payment reform may have national implications as reimbursement models change and ACOs and PCMH gain momentum.

There is no template

Have you heard the running joke about ACOs? They are like unicorns. Everyone knows what they look like but nobody has ever seen one. As with ACOs and PCMH, there are many ways to skin a cat. Likewise, developing the right mix of productivity, quality and patient satisfaction incentives for physicians will depend on what is right for your institution and how your hospital and providers are being reimbursed. What works for one group might not work for another. We've only just dipped our toe in the water. There will be many more changes to come. But one thing is certain: As the healthcare landscape is transformed, physician compensation will undoubtedly be a hot topic in your hospital's executive suite in the years to come.

* *For more information about the BCBS AQC plan, go to http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf*