Physician compensation in a confusing and disordered reimbursement environment (volume to value)

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Abstract The healthcare industry is changing from a reimbursement perspective, in that reimbursement is still predominantly fee-for-service but includes value-based elements. This dual system is widely affecting providers by pushing more of the payment and cost risk onto them (versus insurers). In short, the current reimbursement environment is confusing and disordered. This evolving paradigm calls for a new approach to how physicians' compensation is pursued, ensuring that a model structure is in place that aligns incentives and/or risk with the respective physicians relative to the reimbursement environment. Furthermore, it must be sufficiently flexible to adapt to the current frenzied nature that precedes this unfamiliar approach. This paper examines current and pending changes and their effect on the healthcare market. It discusses the various risks associated with different payment arrangements and reviews how the passage of the Medicare Access and CHIP Reauthorization Act of 2015 affects reimbursement. It then drills down into the corresponding compensation considerations that should be evaluated in light of the value-based reimbursement structures and strategies. The final focus is on navigating these changes to the healthcare environment.

KEYWORDS: value-based, reimbursements, compensation, volume to value, wRVUs, MACRA, MIPS, APM, ACO, CIN, fee-for-service, pay-for-performance, value-based purchasing, bundled payments, shared savings, global payments

VOLUME TO VALUE: MARKET CONSIDERATIONS (THE 'WHY')

As with any industry, healthcare has adapted and evolved, especially since the mid 1980s. Health care has always been provided, but it initially gained momentum in the United States (USA) in the mid- to late 1800s. This is when societies such as the American Medical Association and the American Hospital Association were formed. Medical insurance companies followed shortly after, with the likes of Blue Cross being founded in the early 1900s.[1] While various forms of reimbursement began to take hold in the 1970s, such as health maintenance organisations and capitation/managed care, the reimbursement methodology continued to be predominantly volume based and still follows this path. Other factors have also evolved. Since the 1990s, the average healthcare costs in the USA have more than tripled, with the number of uninsured patients increasing during the same period. Simultaneously, there has been a tremendous degree of innovation in the industry that has transformed the nature of care delivery, but, clearly, this has come at a cost, and the percentage of patients who have access to those innovations has decreased owing to the increase in uninsured patients.[2] As the healthcare industry continues to evolve, the important focal points are reversing the trends that we have seen since the late 1990s — that is, reducing costs, fostering innovation and paying for value rather than just volume.

As highlighted earlier, the healthcare industry has undoubtedly changed since the 1980s. This evolution is marked by some significant shifts. First, the reimbursement environment began to move slowly away from a pure fee-for-service system to one that is still predominantly fee-for-service but includes value-based elements. This transition started with the passage of the Affordable Care Act (ACA) and is strengthened by the adoption of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Second, and largely predicated on the first change, the healthcare market has consolidated. This union is reflected primarily by a merger of hospitals, wherein either for-profit health systems are acquiring facilities or non-profit health systems are acquiring hospitals in their outlying communities to expand their reach. Furthermore, this trend is evidenced by health systems purchasing physicians' practices and directly employing other physicians in an effort to create clinically integrated networks (CINs). These secondary movements have initiated the third significant change, which is a true modification to how health systems operate as they push towards greater coordination of care — a necessity for value-based reimbursement.

The government is not shy in its move to value-based reimbursement, as cited in a recent Centers for Medicare & Medicaid Services (CMS) posting. The paper states that by the end of 2016, 50 per cent of Medicare physician payments will be tied to value through alternative payment models (APMs). Furthermore, by the end of 2018 some 90 per cent of total Medicare payments will be tied to quality or value.[3] This statement does not mean that 100 per cent of every Medicare dollar will be paid only on the basis of value; rather, a portion of that dollar of reimbursement will be tied to value. This factor is evidenced by the Merit Incentive Payment System (MIPS), an important component of MACRA, which is discussed later.[4] The industry has demonstrated that where the government goes, third-party

payers typically follow. This principle was demonstrated through the establishment of the Medicare Shared Savings Program (MSSP),[5] an important component of the ACA. While the MSSP established Medicare accountable care organisations (ACOs), health systems quickly followed by developing CINs in order to enter into similar value-based arrangements with third parties.

These entities and their activities are a mixed bag. Some CINs are formed from a structural standpoint, with very little actual activity. More concretely, the health systems went through the process of developing and capitalising the entity, forming governance protocols and addressing other operational/infrastructural needs, but have not accomplished much with respect to value-based care. They have not gone out and contracted with third-party payers, employers and so forth to drive better care. Other CINs have been more successful or active. The strategy of many of them is to engage their self-insured population (the health system's insurance plan) and test the water with this population of patients. After using this as a testing ground, they have moved towards pursuing value-based initiatives with other parties.

With respect to MSSPs, the data from the first three years of activity demonstrate mixed results. Of the 392 MSSPs and 12 Pioneer ACOs, only 33 per cent achieved savings at a level that would generate bonus payments. Furthermore, during this period, CMS paid out more in bonuses than it generated in savings, questioning the viability of this tool as a means of generating true savings.[6] The 2016 results, released in October 2017, show similar results. Of the 432 ACOs, just over 31 per cent generated savings. Furthermore, US$701 million in bonuses was paid out to the 134 organisations that generated savings, with total savings being US$652 million.[7]

The primary push by the government and third-party payers is intended to increase provider risk. This initiative is illustrated in Figure 1, which demonstrates the increased risk associated with various payment arrangements.

We now define some of these payment arrangements to add some context to Figure 1:

- **Fee-for-service:** The traditional payment arrangement wherein for each service a provider performs a specific payment amount is reimbursed. The only factor in play in this payment arrangement is volume.

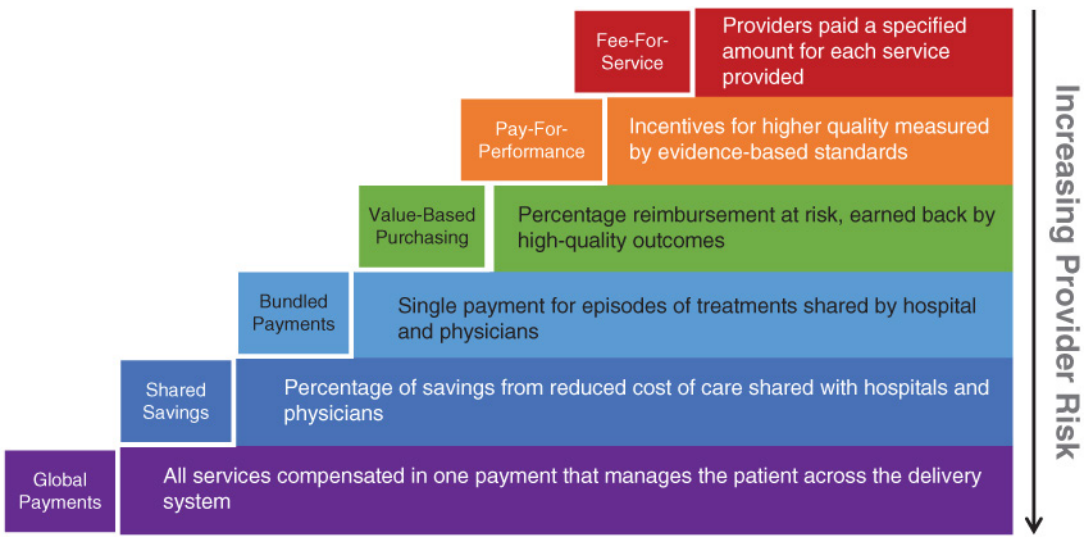

Figure 1: The shifting risk of payment models

- **Pay-for-performance:** This highlights various reimbursement arrangements wherein providers are paid an incentive to meet certain quality or performance metrics. In such arrangements, fee-for-service still tends to be the predominant form of reimbursement, but either a part of this reimbursement is at risk, depending on the performance scores, or the pay-for-performance is a bonus on top of fee-for-service reimbursement. MIPS is an example of this type of programme in that the incentive structure is still primarily volume based, but there is some amount at risk and available as incentive based on performance scores.
- **Bundled payments:** These have been pursued by the government on both a pilot basis and a mandatory basis, though some of its programmes have been scaled back in recent months.[8] Furthermore, third parties (eg hospitals) have independently pursued bundled payments with local employers. In this payment structure, a single payment covers a full episode of care. The most common example is a knee or hip replacement, where the payer would pay a specific amount to cover the full cost of providing the service. It is then incumbent on the providers (hospital, physicians, etc) to provide the service in a cost-efficient manner.
- **Shared savings:** As mentioned earlier, shared savings arrangements are pursued mostly within the MSSP but also by third-party payers. In this arrangement, fee-for-service reimbursement can still serve as a baseline, but there are risk and/or incentive opportunities based on the overall cost of care. In some models, there is an upside-only incentive, while others include a downside risk. The primary focus here is on controlling costs. If providers are successful in keeping costs down, they can receive an economic benefit.
- **Global payments:** This payment methodology implies a capitated arrangement. Here, a provider and/or health system receives a single payment (often defined as a per-member-per-month payment) to provide the full scope of care a patient requires.

So, as noted, the primary focus with respect to moving down the list of payment structures is increased provider risk. In this context, the provider is both the health system and the physician. The payment methodologies thus represent added risk to them and their approach to providing care, and the incentive structures involved must be adapted to drive the necessary behaviours.

Merit incentive payment system as a driver to the 'why'

As mentioned, one of the more recent paradigm shifts in the industry was the passage of MACRA, which included the provisions for MIPS. In essence, MIPS consolidated other important government incentive programmes into a single system. This included the Physician Quality Reporting System, the Value Payment Modifier and Meaningful Use. The scope of MIPS is rather broad, and only the following categories of providers are not subject to MIPS[9]:

- those participating in the first year with Medicare Part B;
- those who bill Medicare less than US$10,000 per year;
- those who care for 100 or fewer Medicare patients per year;
- those participating in an advanced APM;
- hospitals.

While the MIPS programme is designed to focus on four areas, namely quality, technology (advancing care information), clinical practice improvement and cost (resource use), the first three are in focus at the start of the programme and cost is

added later. As illustrated in Figure 2, the principal focus is on the quality component. The programme will continue to push more economics into the incentive realm, starting with 4 per cent of reimbursement at risk in 2019 (based on performance in 2017), increasing to 9 per cent at risk in 2022. With respect to the value at risk, this number represents a potential increase or decrease in baseline reimbursement. Thus ultimately there could be a swing in reimbursement of up to 18 per cent.[10]

A salient point with respect to the MIPS programme is that it is still fundamentally a volume-based reimbursement methodology, and how much a provider does will impact his or her reimbursement. Unlike traditional fee-for-service reimbursement, how well the work is performed, however, will affect reimbursement. Thus, now the focus is not just on 'how much you do' but also on 'how well you do how much you do'. This point is a critical consideration that will require physicians to reconsider how they work and health systems to reconsider how they incentivise physicians, as volume incentives alone could prove detrimental in such a reimbursement environment. A simple illustration of this changing paradigm is provided in Figure 2.

MIPS is the government's biggest push to date in the value-based realm. As the title of this paper indicates, the reimbursement market is confusing and disordered. The latest example of this lack of order is the government's pulling back of its bundled payment programmes. Nevertheless, as changes such as MIPS come onto the horizon, it is important for health systems and providers to consider possible ways of changing their practice patterns to function well in the new reimbursement paradigm. They also need to consider various means of ensuring that the incentives incorporated into physician compensation arrangements are aligned to drive the behaviours that will allow for success.

VOLUME TO VALUE: COMPENSATION CONSIDERATIONS (THE 'WHAT')

As highlighted earlier, there is a clear need to transition compensation strategies to

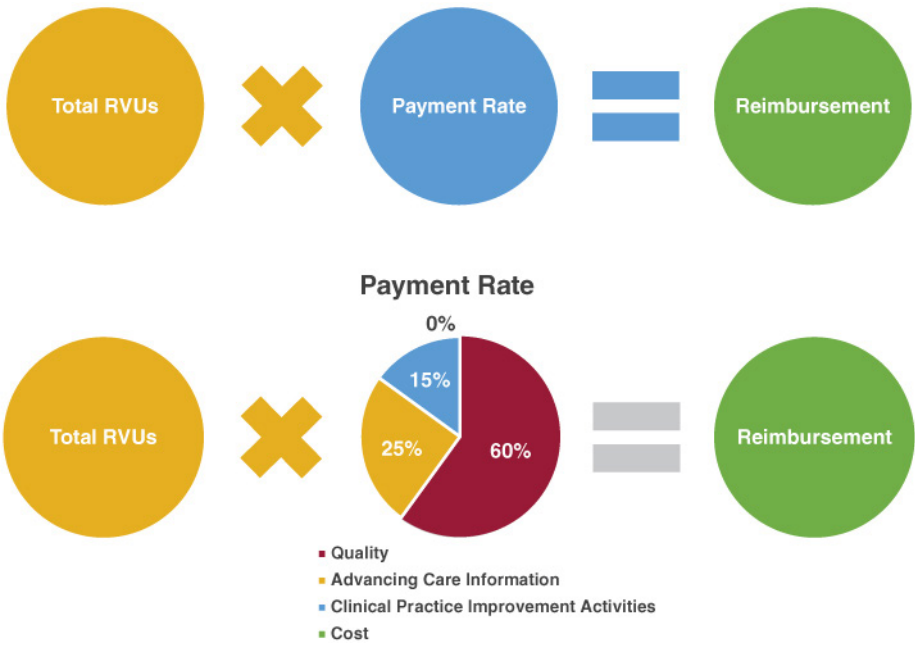

Figure 2: Impact of MIPS on FFS reimbursement

ensure incentives are aligned in the changing reimbursement environment. The primary question is what that means. Here, it is worthwhile to consider first the challenges that such a shift entails, some of which are highlighted in Figure 3.

While each of these factors could warrant a separate paper, the following descriptions will add context to some of these pivotal challenges:

- **Data capture:** One of the challenges presented by a shift to a value-based compensation arrangement is data. The beauty of a volume-based compensation model is that few data points are needed to effectuate the model. This paradigm shifts as the model becomes more value based. While many health systems have spent untold millions of dollars on new technology platforms, in our experience they continue to struggle in mining useful data from their systems. It is impossible to incentivise physicians on metrics where data are unavailable. Furthermore, data must be not only available but also accurate and timely. Data capture continues to represent a considerable challenge.
- **Lack of cohesive compensation philosophy:** Another challenge that health systems face in moving to a value-based compensation arrangement is the currently inconsistent compensation platform. There may be multiple physician compensation arrangements currently in play, making a shift to a value-based model a formidable task in view of the multiple compensation platforms that must be adapted. Even when a health system is operating on a single, overarching compensation philosophy, the move to a value-based system can prove challenging. This factor is exponentially multiplied when a single compensation philosophy does not exist. This, however, presents an opportunity too because a health system can take it upon itself to move to a single philosophy/platform while it is in the process of implementing value-based incentives.
- **Perceived 'decrease' in compensation:** In most environments, health systems are unable to add additional compensation to the model to incorporate value-based incentives. Rather, they are looking at the current compensation spend and deciding to reallocate a portion of it to new incentives. While this makes sense economically, because many of the value-based incentives are not adding to the overall reimbursement pool, especially long term, this reallocation is a hard sell for physicians. If 100 per cent of their compensation was tied to volume historically, and now 85 per cent is tied to volume and 15 per cent to value, the physician often sees this as a decrease in compensation because they compare only the volume-based elements, which they consider to be more in their control. Thus, physicians must receive much education and explanation to understand that the same opportunities for compensation

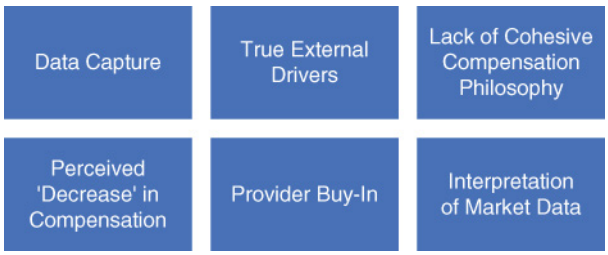

Figure 3: Challenges of the volume-to-value shift on compensation models

exist but that these are simply tied to new metrics. This then leads to a discussion about the issue of data capture, because a physician will not feel that the opportunity is there if the data is not available to support the established metrics.

- **True external drivers:** Another challenge is the market-specific drivers that exist. In markets that are less progressive with respect to reimbursement changes, it is harder to convince physicians of the need to change. While MIPS is fairly universal, other markets are considering more dynamic changes in addition to MIPS. In these markets, the physicians feel the change more dramatically and can be more accepting of the need for new incentives. In less progressive markets, this discussion is considerably harder.

The challenges are significant but can be overcome with solid planning, education and communication. The importance of these three crucial factors cannot be overstated. With respect to physician compensation, as well as many other areas, a lack of understanding tends to breed a lack of trust. Thus, the need for education and communication is significant.

One of the beauties of physicians' compensation is that models can take on many different forms. It would be impossible to focus on each type of compensation structure in this paper, so, while exploring the 'what' in more detail, we look towards fundamental concepts of model structure that can be implemented across multiple platforms.

The pace of change: How fast should we move?

An important consideration in moving from volume to value in terms of compensation structure is the pace of change. Owing to the frenzied nature of the volume-to-value shift, many organisations have decided to make a progressive push into a value-based compensation arrangement. An example of this is pursuing a panel-based, as opposed to work relative value unit (wRVU)-based, compensation model for primary care. While this idea is not necessarily a bad one in all environments, it could lead to a misalignment between the reimbursement structure and the compensation structure. If the reimbursement structure is still predominantly volume based, a panel-based compensation model that is more akin to capitation may not create economic success for the organisation. At the same time, if the reimbursement paradigm shifts and is largely capitation, a wRVU-based compensation structure likely will not lead to financial success. Thus it is important that the compensation structure and associated incentives are appropriately aligned with the reimbursement structure. While being in perfect lockstep with the reimbursement structure is unlikely, not being too far ahead or behind is the target.

Allocation of value: All for one and one for all?

Another important consideration is that what works for one speciality or subset of specialities may not work for others. In the current environment, much of the value-based activity is focused on primary care. Within ACOs and CINs, much of the activity is foundational in terms of population health. Thus, within a compensation structure, it may make sense to put more into the value-based realm for primary care than speciality care. There, however, may be some specialities wherein principal initiatives are in the works, such as bundled payments, where putting substantial emphasis on the value-based realm may indeed make sense. The ideal is to create a structure wherein this decision can be made on a speciality-by-speciality basis, or at least on a speciality subset (eg primary care, speciality care, surgical care).

Value-based reimbursement: Is it revenue or pass-through compensation?

One of the major challenges of moving into the value-based realm is deciding what to do with the new revenue streams that exist. Value-based reimbursement can take many forms. It can be distributions from ACOs and/or CINs for shared savings, MIPS incentive payments, pay-for-performance incentives from various third-party payers and so forth. In many instances, health systems have initially viewed these forms of reimbursement as a pass-through of additional compensation. In other words, they decided to pass the compensation through directly to the attributable physician on top of the existing compensation model. The rationale for this is multifaceted but is based on two fundamental considerations.

First, in many cases, these funds start out small. The payment per physician could be only a couple of thousand dollars. In the context of the compensation model, passing this money through is not perceived to cause any compliance issues with respect to fair market value, so it is the method of choice. The primary concern with this approach is that it sets a precedent. If the initial plan is to treat this reimbursement as pass-through payments, that will be the expectation going forward. This assumption presents challenges if the value-based reimbursement increases as it is expected to. Specifically, the pass-through of the value-based reimbursement must be reconciled with the baseline compensation plan to ensure that the passing through of all of the additional funds does not create compliance issues. Furthermore, the organisation needs to determine the viability of passing through 100 per cent of its new forms of revenue (which are intended to replace fee-for-service reimbursement) as compensation. Both of these issues present questions of viability with respect to pursuing this method.

Secondly, the concern is equitable treatment among private-practice and hospital-employed physicians. Using a CIN as an example, if both private-practice and hospital-employed physicians are involved, any funds earned will be passed through to the private physicians. Thus there is a concern about treating employed physicians differently. While it requires some communication and education to establish the difference between private and employed physicians, treating them differently with respect to these distributions makes perfect sense. This issue is all about risk. The private physicians may require these additional payments to achieve market-based compensation after all overheads have been paid, whereas the employed physicians already receive market-based compensation through their baseline compensation model. Thus, while only part (or potentially none) of the pass-through money may result in additional compensation for the private physicians, all of this compensation would accrue to the employed physicians as additional compensation when treated as a pass-through.

Another issue is the perception that the value-based payments are incentives and that it, therefore, makes sense to pass them through as additional compensation. While this may be the case at the onset, the government has a long history of initiating programmes as an incentive but then transitioning them to an at-risk payment over time. The paradigm starts out as receiving US$1.00 of fee-for-service reimbursement and the opportunity to receive US$0.10 in incentives. Over time, fee-for-service may drop to US$0.90, so to stay at a total of US$1.00 one must earn the US$0.10 in incentives. Generally, if a transition to value-based reimbursement is ever to occur, all of the value-based payments cannot be in addition to fee-for-service reimbursement but at some point must be a replacement for fee-for-service reimbursement. Once again, if the initial perception is that the payments are all incentives and the treatment is pass-through,

this move could set a dangerous precedent that leads to both financial and operational complications in the future.

A potential solution is to treat these new forms of reimbursement as revenue rather than compensation and then develop the value-based incentives in the compensation formula such that the drivers of payment are aligned with the drivers of reimbursement. As an example, if a broad look at the reimbursement environment indicates that 90 per cent of reimbursement is fee-for-service and 10 per cent is value based, this may be a good indication of the value split that should occur in a compensation model. The 90 per cent will by nature be aligned with the driver of reimbursement if a wRVU-based model is in place. For the remaining 10 per cent, it would make sense to look at what is driving those revenue streams and to align the incentive metrics accordingly. For instance, if a health system is participating in MIPS and a CIN, it would make sense to incorporate MIPS and the appropriate CIN metrics into the scorecard that dictates the payment of the 10 per cent incentive.

Integrative versus additive: How do we build the model?

The foregoing discussion prompts us to ask how a model should be developed. Does it make the most sense to develop each of the components of a compensation model independently and then stack them together or to determine a total targeted value proposition and then decide where to allocate the respective funds?

The former option could be referred to as an additive approach and the latter an integrated approach. In the former, the wRVU-based incentive is derived, followed by the panel incentive (if applicable), the value-based incentive and so on. These incentives are then all stacked together to create the overarching compensation model. While this approach is functional, there are many moving parts, and the question becomes, how flexible or malleable is this model to small changes in the reimbursement environment? If several new value-based reimbursement streams come online, how easily will the model be able to adapt to those? In an additive approach, the moving parts make this difficult. Furthermore, ensuring compliance at the end of the day, owing to the stacked nature of the compensation arrangement, could make economic and compliance management difficult.

In an integrated approach, an overall economic value is targeted. In today's environment, this could be best stated by a dollar value per wRVU, but it could also be stated by a total cash compensation value, an hourly rate and so forth. Then the question is, where is the value allocated among the essential components of compensation? This is shown in Figure 4.

For an illustration, let us assume that the targeted compensation per wRVU ratio is US$50.00 and that 85 per cent is tied to wRVU productivity, so the straight wRVU-based component would be worth US$42.50. Then the performance incentive would be worth US$5.00 per wRVU, and

Figure 4: Illustration of integrated approach

the placeholder for other incentives would equate to US$2.50 per wRVU.

In this approach, there is total control over the economics because all of the components add back to a maximum payout of US$50.00 per wRVU. Furthermore, there is an easy means of tweaking the overall economics to the extent necessary. Thus, if in the following year the targeted compensation per wRVU ratio needed to decrease to US$48.00 or increase to US$52.00, this could easily be effectuated.

Also, if the value allocation within the components needs to change, this too is a rather simple, formulaic shift. It is easy to change to a 90 per cent wRVU incentive, 10 per cent performance incentive structure from one year to the next, if necessary, without changing the overall model paradigm.

Each component of this structure can be built out further. The wRVU-based component does not have to be a single-tiered structure. A multi-tiered structure could still be pursued, with the wRVU allocation being the targeted effective rate for such.

While either an additive or an integrative approach can be successful, in today's disordered reimbursement environment, flexibility is essential. Therefore, an approach that provides maximum flexibility to allow year-to-year tweaks to model structure should be pursued.

CONCLUSION

It goes without saying that the healthcare industry is moving away from a reimbursement perspective, and this change is widely affecting providers by pushing more of the payment and cost risk on them (versus insurers). This shifting paradigm necessitates some reconsideration of how physicians' compensation is pursued, ensuring that a model structure exists that aligns incentives and/or risk with the respective physicians in relation to the reimbursement environment. Furthermore, it must be flexible enough to adapt to the frenzied nature of changes that are currently occurring.

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