

Trends in Physician Compensation: ‘Quality Incentives’ in Physician Compensation Plans

The future success of the shift from private practice to hospital employment relies heavily on learning from past mistakes. Developing physical compensation plans that provide performance assurances, without discarding quality, is the optimum goal.

A direct result of past experience with long-term physician employment agreements has led to a predominance of productivity based compensation plans. Under such plans, physician compensation is directly tied to productivity. The Work Relative Value Unit (WRVU) is most commonly used to measure productivity, but hospitals occasionally use alternative measures, such as charges or collections. One alternative measure is that of a net revenue compensation model, under which physicians are paid based on the professional “net income” of their department.

The various production-based compensation models tend to have a common component: they are predominantly quantitative. This poses a challenge when attempting to measure quality.

Quality Goals Compensation Challenges

While the rules surrounding quality criteria are unclear, there has been an increase in compensation formulas allocating a certain amount to quality. A challenge in developing these compensation plans is determining the amount of compensation necessary to affect behavior. The goal is to create an incentive to positively impact quality; however, it can be difficult to define the abstract. Allocating too much compensation to quality may negatively impact attributes affecting the bottom line and production. Allocating too little will not have the desired effect on behavior. As long as compensation is generally based on a fee-for-service model, the primary measure of practice performance will continue to be volume over quality.

From a philosophical perspective, there is merit in tying compensation to quality improvement. It responds to the appropriate behaviors and aligns with the direction of the healthcare reimbursement market. There is a belief that improved quality in healthcare will reduce the overall cost to maintain a healthy population; however, getting there will be a monumental task.

Recently, the United States Department of Health and Human Services announced goals for Medicare’s value-based payment system, tying 30 percent of fee-for-service payments to quality or alternative payment models by the end of 2016, and 50 percent by the end of 2018. However, the Medical Group Management Association (MGMA) analyzed the announced goals and determined that little was said that is not already being done. Virtually all physicians are currently being evaluated under the Value-Based Payment Modifier, which provides for differential payment to physicians under the Medicare Physician Fee Schedule based on the quality and cost of care provided.

In summary, until material reimbursement dollars are tied to quality, compensation plans will continue to reward productivity first, with quality as a distant second.

This article is part of a series that delves into the economic, compliance and relationship issues that are relevant in hospital physician relationships. To view past articles, [click here](#).



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