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# Hospital Review

**BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP**

## Hospital-Physician Relationships & Accountable Care Organizations



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### 3 Key Trends in Physician Compensation Design

Written by Lindsey Dunn | [April 19, 2011](#)

Healthcare reform introduced a number of initiatives with the goal of moving payment for healthcare services from a fee-for-service to a fee-for-performance system. However, these changes are trickling down slowly to physician compensation design, which still largely relies on productivity measures. As payment moves toward fee-for-performance, physician groups, either independent or hospital-owned, will need to determine the appropriate timing to introduce outcome measures as key determinates of physician compensation.

Here, Rudd Kierstead, a manager at DGA Partners, discusses how physician groups are walking the line of compensation driven by productivity to compensation driven by performance and other trends in physician compensation design.

**1. Compensation still largely driven by productivity.** Initiatives on the horizon such as medical homes and accountable care that reward performance are "hardly widespread," says Mr. Kierstead. Instead, most physician compensation plans are driven heavily by productivity. For instance, a practice may provide a base salary for a certain level of individual or group productivity with bonus opportunities above that level.

**2. Outcome metrics difficult to develop, generally only affect bonuses.** More sophisticated physician compensation plans may allow for bonuses — usually of no more than 20-25 percent of base salary — for high performance on patient satisfaction and quality standards. While adjusting compensation for quality aligns with efforts around reform, determining exactly how to measure quality is very challenging for most physician practices, says Mr. Kierstead.

"In our experience when practices start thinking about more of a quality oriented-compensation scheme, the quality tools are more of a safety net to ensure minimal quality," he says. "Practices want to identify problems easily and take care of them. The tools for [fully] bridging quality and compensation are still percolating."

To that end, Mr. Kierstead points to the fact that the Institute of Medicine just recently released its standards for developing clinical practice guidelines — "not guidelines for quality, but rather standards for developing clinical practice guidelines to assess quality," he says.

Additionally, there currently aren't significant dollars tied to quality standards. While pilot and other initiatives do exist, most physicians are still primarily paid for the number of services they provide. Further, electronic health records are critical to developing quality compensation tools at the individual level, and even then hospitals or physicians' groups have to design the metrics. Most metrics are designed for measuring group parameters, not necessarily individual indicators. Even those organizations that have developed quality guidelines for individual practice will likely test drive and refine them before incorporating them into compensation plans. The general applications of clinical guidelines are a very sensitive topic in the physician community.

**3. Compensation through hospital shared savings exist, but may face resistance.** In addition to compensation from physician services, some physicians are able to earn additional compensation by participating in various hospital shared savings incentive programs. These programs typically involve a payor, who shares any savings created through physician-hospital collaboration on various hospital services with the physicians and the hospital. While these programs do present the opportunity for some additional income — the Medicare Accountable Care Episode bundled payment demonstration, for example, allows physicians to earn up to 25 percent on top of Medicare fee-for-service rates — physicians may be resistant to their ability to bend the needle in terms of creating adequate savings.

This is because, according to Mr. Kierstead, many physicians see a great deal of cost drivers as not under their control. For example, if costs go up because of a hospital-acquired infection, the ability to reduce that falls more to a nurse or other allied health professional, rather than a physician. However, Mr. Kierstead says, we may see more control over processes of care going back into the hands of the physicians as hospitals seek their medical expertise in efforts to reduce infections, readmissions, etc. "That would be the next generation — putting the power and responsibility of these initiatives back into the hands of the physicians. That's on the horizon, but we're not there yet,"

he says.

Some hospitals are beginning to draw physicians into this process. For example, some facilities may compensate physician groups for meeting various benchmarks in care process development as a way to encourage them to provide guidance in development of care guidelines and best practices.

The idea of physician control also impacts the desirability of more traditional compensation plans. "If a physician is paid as a percent of collections, but he or she has no control over collections, that is not attractive to the physician," says Mr. Kierstead. "They don't want to be at the risk of a hospital's lousy collection processes." As a result, many expect to see more physician control over these areas of practice management in the near future.

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