External Value-Based Incentives- What Should You Do With Them?

Justin Chamblee, CPA, Senior Vice President | Coker Group

As the healthcare reimbursement paradigm changes, reimbursement is coming from new places and in new forms. No longer is the totality of reimbursement fee for service; it now comprises all sorts of payments, whether they be capitation, shared savings distributions, pay for performance incentives from third-party payers, PQRS and/or Meaningful Use incentives, etc.

Fee-for-service revenue and capitation fees, in these different types of reimbursement, are always treated as revenue that is used to pay a practice's overhead and physician compensation. However, the other types of payments and their corresponding treatment is tricky. Often, these new forms of revenue start small, and many healthcare organizations decide to pass these dollars through to the respective physicians. As an example, the activities of a physician-hospital organization (PHO) results in an incentive payment that is clearly delineated as associated with the work performed by Physician A. The payment is quite small, let's say $1,000, and, therefore, the healthcare organization decides to give this $1,000 to Physician A as additional compensation, *on top of* the existing employed physician compensation arrangement. Generally, this makes sense. The funds are tied to Physician A, and the amount is small and, therefore, not significant from an FMV perspective. So, why not pass it through? Further, Physician B, who is in the same PHO but in private practice, is getting these funds directly; thus there is "parity."

This thinking may be okay in the short term, but it can prove problematic in the long run.

First, the idea of parity breaks down quickly. While Physician A (a hospital-employed physician) is getting the $1,000 as additional compensation, Physician B (who, remember, is in private practice) is getting the $1,000 as *additional revenue*, which is then used to pay overhead and may or may not drop to the bottom line as additional compensation. Thus, while there is perceived parity, due to the different practice structures, there really is no parity, as the comparison of Physician A and Physician B is like comparing apples and oranges.

Further, a compliance concern can creep up for Physician A in future years, if the $1,000 becomes $10,000 and then $30,000, and if the continued trend is passing these dollars through as additional compensation. These funds contribute to the Physician's total cash compensation and if the baseline compensation structure was not modified to accommodate these additional payments, Physician A's total compensation may be deemed to be outside of fair market value. In this context, it is important to keep in mind that the benchmarks often used (MGMA, AMGA, SCA) are reflective of total cash compensation and not productivity-based compensation. Thus,

if market-based pay was being provided *before* the addition of these pass-through payments, then a compliance concern could very well exist.

Finally, and most importantly, as new payment methodologies come into play, long term, they are not intended to be *in addition to* fee for service reimbursement, but a *replacement of* fee-for-service reimbursement. Medicare's PQRS program is one example of this. When the program was made permanent in 2008, it allowed for a potential *incentive* payment of 2.00%, whereas as the program evolved the incentive turned into a penalty. Specifically, those who did not adhere to the PQRS requirements in 2013 would see a 1.5% *reduction* in their reimbursement going forward. From our perspective, we see all these new forms of reimbursement ultimately being fee-for-service *replacements*. Thus, setting the expectation that these new sources of revenue can be passed through as compensation is eventually problematic. This activity would be equivalent to passing through 100% of fee-for-service revenue as compensation. Such is economically unsustainable.

So the question becomes, what do we do with these new forms of revenue? We recommend treating them as revenue.

The follow-up question is, how do we connect the dots between this revenue and the physicians' behavior? That is where the physician compensation model plays a role. It is incumbent upon health systems to continue to adapt their compensation models to align with what drives revenue. This alignment is no different than what was done in the past with paying based on wRVUs as such aligns with fee-for-service revenue generation. The same should apply to fee-for-value revenue generation. Incentives should be aligned and continually evaluated within the compensation structures to align with the behaviors that drive revenue in these realms.

Thus, the fee for value revenue should be viewed and treated no differently than fee-for-service revenue used to cover overhead and then fund physician compensation.

To learn more about how Coker can assist you and your organization, please contact Justin Chamblee, CPA, Senior Vice President at jchamblee@cokergroup.com or by calling 678-832-2021.