Incentive Compensation, Interview with Dr. Neal Little

In 1999, Dr. Neal Little was faced with the daunting task of managing an increasingly complex incentive payment program for a growing provider group. He met that challenge by implementing a computer system to handle the idiosyncrasies of a diverse set of requirements needed by each medical director for each facility to fairly pay each clinician. Fifteen years later, as a practicing clinician and a former medical director, he knows a lot more about fair compensation for emergency physicians and the benefits a computer system can deliver. Sheila Conant, CEO, COREmatica spoke with Dr. Little about incentive payment systems and here is what he had to say:

"Every physician wants to be paid in what they view is a "fair" way and the definition of "fair" changes with their circumstances and various incentives that you can put in place. So from a physician's perspective, they want to look at themselves compared to their peers and say "I'm being fairly compensated." So "fair" may mean to some people being paid more for seeing more patients or more for seeing more difficult patients or more for working unpopular shifts (evenings, weekends, midnights) or it may be staying extra, staying late when their shift is done to see more patients. So everybody has their own view of what "fair" is and it depends somewhat on the ER as well. If you have a double-coverage ER you want to make sure that everyone has the same incentive to see difficult or undesirable patients so you don't have what is called cherry-picking to get the easy cases or to get cases with an incentive payment attached to them. So, you can generally get a director or somebody to design what people think is "fair" but the software to support the design becomes very complicated when questions have to be answered, like, what is a more difficult patient? Is it more RVUs? More time spent with a patient? What are you willing to pay someone to work more midnight shifts than you do? And when do midnights start? That's where a good computer system can help, to be able to handle all that without having to use a spreadsheet. So generally, people can come up with a scheme and you need software to support that scheme. In a single-coverage ER, the idea of being paid more to see more patients doesn't make a whole lot of sense because you have to see every patient anyway. So maybe the incentive should be to pick up that last chart before a shift change to get them in and out. For this incentive, you need to know the time the patient checked in and then there are little bits of data you can use to put all this together. Then you can get even more sophisticated in saying, you get an incentive payment only if you work x number of undesirable shifts and then you are paid extra because everyone is expected to work some number and those doing more get extra pay, and that's another nuance that software needs to handle. People know that they may work more undesirable shifts this period and that it can be made up for in the next period, if you have software to track that. You want the data input to be easily accessible data, like billing data."

So why couldn't you do that with Excel?

"Perhaps you can write all these macros to support some of these things but it's not sophisticated enough to handle all types of incentives; it's not a real database, you need to have a real database that you can store things in and do calculations on. It's [Excel] just too simple and is simply prohibitive for large groups and across multiple sites. The other thing is, the next level up for a larger group is to track all

these things for sites that have different fee schedules , different work schedules, different definitions of midnights, or double-coverage facilities, or whatever, so that then kicks it up another notch for complications and complexity.

Here's a good example. If you are called in early, there can be a bonus. If you are called in because it's so busy, then the bonus isn't necessary if a physician is paid based on productivity. But when productivity doesn't measure up as enough, then you can use a bonus. This type of either/or logic is too complicated for Excel."

So what does a large group do to manage incentives without a software system?

"It's extremely labor intensive. Another one of the principles of using something like COREmatica, is that you should only touch the data once, every time you touch it you have the potential for error, for data input error, and then tracking them back without a sophisticated system becomes more work that putting the data in to begin with! So, if every time you touch the data there is a chance to make a mistake on it you just multiplied the potential of error and there is nothing that builds distrust among physicians more than what they think is an error - usually they are not worried if it's more pay but usually if it's less there will be suspicion that something was done on purpose when in fact it could be done in error. If the physician can see what are the elements or weights given to various undesirable shifts or how RVUs are valued, the distrust is reduced. For bonuses, you may want to set aside some money for bonuses and devise a point system for divvying up the pool for whatever it is you want to incentivize and reward; you need a system to track the components for that kind of bonus pay. The other major component to an incentive payment system, besides the concept of fairness to the physician, whatever they mean by that, is when incentives are put on by management or aligned with the hospital, to either see more patients or see patients more productively."

Do you think incentives work?

"Yes, incentives do work; they work for some people, especially if it is a volume, production kind of thing. Some people simply cannot work in more than one gear, at more than one pace, and those people won't be very well incentivized by the system, but most people will respond to incentives. They have to be viewed as "fair" and in keeping with good clinical care but every group of people responds in some way to incentives.

A lot of groups don't know how to get started with an incentive payment system. Do you think RVUs are a good metric to use for incentive payments?

I think they are "a" metric and they're what's available and generally agreed upon, and you can pick apart any given one and say that it should be more or less for some reason, but it's kind of a standard we have, it's what the government recognizes, it's what every other medical specialty uses as a metric. The other thing that using RVUs does is incentivize documentation because you can't maximize your RVUs

without having the documentation to support it, so it provides a double-incentive, if more and better documentation matters; if that doesn't matter, then you can always do more documentation, more and more and it becomes a burden after a while, but if it becomes a reward for doing so, that becomes a double incentive. Again that's an alignment of incentives between physician groups and the hospital because unless the physician documents properly the hospital can't charge properly. One way to incentivize proper documentation is to provide regular down-coding reports for what percent of patient seen could have been at a higher level but weren't because the documentation wasn't adequate. In my personal situation, if my overall score is below a certain threshold, I don't qualify for pool bonus. Other key measurements for me are the length of time before a patient is seen, the down-coding percentage, the average for the site, and where I stand relative to other people."

How do you feel about that, being analyzed at everything you do?

"One thing that has shown to be an incentive, that physician responds to is when put up on a list where they stand relative to their peers; nobody wants to be an outlier in a bad sense. Seeing where you stand is useful and is also useful for directors when counseling various people because everyone always assumes that they are working harder than everyone else, they're seeing more difficult patients, and when they see real data that they can believe in, that can help change behavior or at least allow someone to believe that they are being fairly compensated. Software needs to constantly change to support what it is you're doing in response to what it is that is important at that time like should you put more into midnights or weekends or expand what we mean as a holiday day. As the group agrees to change definitions, the software needs to accommodate those changes. I think it can be a recruiting tool for a group to say that we have a sophisticated way to provide appropriate incentives and rewards that's transparent to the doctor who comes on board and we can change it as the situation changes and we do it systematically and we can change it as the payment system changes."

What do you have to say about the cost of an incentive payment system?

"Consider the cost of not having an incentive payment system. It's the cost of doing business, it's a recruiting tool to show fairness, a recruiting tool to show incentives, and it's an incentive for documentation, depending on how you use it, which goes to everybody's bottom line. It's a tool to recruit hospitals, to show alignment of incentives between physicians and the hospital. It's like having people have a pager and a cell phone, just the cost of doing business, you just have to make sure it meets your needs and is efficient. Somebody's got to do all that work in some way, so you can pay people to do it or have a computer program to do it, and in general, it's cheaper to have the computer program automate it once you go through the setup part, and the personnel cost will be less."

Do you think an incentive payment system can increase revenue?

"If they have the right incentives to do that, yes, it can, it has the potential to do that, sure, because they now have feedback, and they have real data as opposed to some hospitals that can't give you data, I think it has the potential to do that. I showed a colleague the difference between a 99285 and a 99284 based on one particular item of documentation and he was paid by RVUs and in mid-sentence, he changed his pattern and it was done! Incentives can be used to change documentation habits to increase revenue, sure. Do you think an incentive payment system can make a difference for a small group? Again, they have to do it somehow and if the hospital does the billing, they usually do it poorly. Any sized group can just look at the numbers of what it costs them now, and see the benefits."

About COREmatica:

COREmatica is the leading developer of compensation management software specializing in performance-based payroll for health care providers. Headquartered in Ann Arbor, Michigan, COREmatica works with hospitals and large health care provider groups to implement effective incentive-based compensation plans to drive productivity and keep costs aligned with revenue objectives. Our software product, COREmatica®, is used nationwide to calculate pay for thousands of clinicians in more than 25 states.

Founded in 2007, COREmatica is a Health IT company staffed by information technology experts with over 30+ years of experience developing software products for the healthcare industry. We are degreed professionals and have over 15 years of experience working with incentive-based pay. We take pride in helping our customers implement the best, most effective compensation plan for their clinicians. With COREmatica, you'll have a proven solution quicker than you can develop a custom solution, saving you time and money.

"If you can say it, we can pay it!"