



NORWOOD

A Tightrope Worth Walking: Provider Incentives in the Mid-Revenue Cycle



Use Incentives, But With Caution

Provider Incentives

Introduction

Success in Value-based Care requires
an “all-in” level of support
from everyone in your organization



Not just coding or CDI enthusiasm. More than support of the c-suite. Above all it requires provider buy-in. And a great way to get that is through the careful use of incentives.

This report examines the landscape of provider incentives.

It includes a brief review of:

Stark Law

red flags and compliance no-nos to
keep you on the right side of fines



It also offers

Best Practices

culled from case studies and partners that you
might find useful in your own organization.

Enjoy the Report!



Provider Incentives Are Ubiquitous

Provider incentives are common, particularly incentives tied to reimbursement
You shouldn't be scared of them.

Data from the 2024 Today's Hospitalist Compensation & Career Survey shows that 42% of hospitalists are paid a combination of salary and incentives, compared to about one-third paid a straight salary.

The same report also found that on average, hospitalists earn about \$43,000 of their pay from bonuses and incentives, representing some 14% of their total compensation.

Bottom Line:

Incentives should be part of your documentation and coding initiatives. With caveats and caution.

Incentives in CDI/coding contexts typically don't involve referrals, but if you do, you need to be aware of Stark Law.

Stark Law prohibits physicians from referring patients for certain designated health services (DHS) to entities with whom the physician has a financial relationship, unless an exception applies.

Stark Law was launched to curb fee-for-service excesses. In some corners its validity is being questioned, as it can seem

antiquated when applied to value-based, episodic care models (Beckers).

But it is still on the books, and penalties for violation are severe: denial of payment for designated health services provided through prohibited referrals, mandatory refund of improper payments, civil monetary penalties of up to \$15,000 per service, fines of up to \$100,000 for schemes designed to circumvent the law, and exclusion from Medicare and Medicaid participation (Beckers).



Hospitals can incentivize physicians for good documentation practices. If physicians are paid (stipends, bonuses, etc.), the incentive in question must be:

Consistent with Fair Market Value (FMV)

**Not tied to volume or value of referrals
(which would violate Stark Law / Anti-Kickback Statutes)**

Tied to documentation quality (not outcomes)

You can reward:



**Timely query
response rates**



**Completion
of records**



**Participation in
CDI programs**



**Accuracy and specificity
of documentation**

Key Point:

**The incentive must be tied to process and quality,
not financial impact.**

That last sentence is worth emphasis. Incentives can be warped, and often are, in the name of the dollar.

A 2022 study published by the Journal of the American Medical Association found that despite growth in value-based payment arrangements from payers, health systems currently incentivize physicians to maximize volume, thereby maximizing health system revenues (JAMA).

Kaiser Permanente recently had to pay a \$556M fine to settle False Claims Act allegations, allegedly incentivizing its providers to complete addendums for the purposes of adding risk adjustment codes up to a year or more after the patient was seen.

This practice was not implemented for accuracy or tying diagnoses to clinical care. Just straight reimbursement.

Obviously something to avoid and guard against.



Common Documentation Incentives

Now that we have regulations squared away, let's talk about effective ways to develop and leverage provider incentives.

Provider incentives can run from zero compensation (support and tools, for example), to fully capitated/full risk models in which an organization redesigns provider compensation based on value, with a risk-adjusted panel size established for every provider.

Following are some Commonly Employed Documentation Incentives

➤ **CDI Query Response Bonuses:**

Specific bonuses for answering CDI queries in a timely manner (e.g., within 48–72 hours), often tied to "housekeeping" or "threshold" metrics (7% to 13% of total pay). For example, Crouse Hospital rewards hospitalists who complete 90% of billing queries within 48 hours (Today's Hospitalist)

➤ **Quality & Risk-Adjustment Metrics:**

Incentives are linked to accurately documenting patient complexity to ensure appropriate reimbursement and quality reporting.

➤ **MIPS Compliance:**

Financial rewards are increasingly tied to performance under the Merit-Based Incentive Payment System (MIPS), where thorough documentation aids in capturing the necessary severity of illness.

➤ **Value-Based Care (VBC) Targets:**

Incentives that directly link physician income to the financial health of the organization, driven by accurate coding of acuity to impact payor reimbursements. For example, physicians are held accountable for HCC capture by having 4% of their compensation withheld and later earned backbased upon their performance against VBC targets.

The Medicare Shared Savings Programs (MSSP) has provider incentives baked in. Providers who can keep costs low relative to complexity can receive bonuses from their ACO.



Under MSSP, providers are rewarded based on Total Cost Of Care (TCOC) compared to a benchmark. Spend less → shared savings.

And also on quality performance, including measures like readmissions, outcomes, and patient experience.

CMS allows ACOs to share savings with participating providers based on predefined methodologies.

These can include quality performance, cost management, patient outcomes, and care coordination activities.

One organization described in the Today's Hospitalist article linked below offers its providers an interesting, tiered compensation model we found worth sharing.

This includes a basic Threshold Category for answering their CDI queries or chart completion, which earns them a bonus of approximately 7% of total compensation.

The next level up is Target Category, accessed when hospitalists consistently perform within one standard deviation from the group median. Hitting this target triggers a 10% bonus.

Hospitals that Safely Offer Incentives

Follow this Formula

➤ Incentivize behavior, not dollars. For example:

- % of queries answered within X days
- Participation in CDI education
- Documentation completeness scores

➤ Blind financial impact. Place reimbursement in a separate box from accuracy:

- Physicians are not shown the revenue effect of their responses
- No reporting like "Dr. X generated \$300K in MCC capture"

➤ Use balanced scorecards. Include:

- Quality metrics
- Compliance adherence
- Documentation timeliness



Best Practices

To sum up, we recommend the following three best practices to stay on the right side of effectiveness and compliance.

1

Follow Governing Frameworks

The big four are ACDIS/AHIMA Query Guidelines, Stark Law, Anti-Kickback Statute, and the False Claims Act (FCA).

- **ACDIS/AHIMA Guidelines** are the operational backbone. Queries must be non-leading, including clinically reasonable options, and above all encourage providers to use their clinical decision making.
- **Stark Law** prohibits compensation tied to referrals. Incentives must be fair market value.
- **The Anti-Kickback Statute** is a broader intent-based law. If incentives are seen as inducing behavior that increases reimbursement, your risk correspondingly increases.
- **The FCA** is the enforcement hammer. Make sure you have clinical support and avoid upcoding.

Incentivize Use and Accuracy, Not Reimbursement

2

Physicians should be encouraged to answer and provide specificity—never to give a specific answer.

For example, if your hospital wants to encourage use of best practice alerts in Epic, ensure providers can opt out of addressing conditions when appropriate or not clinically relevant.

Give your providers a pass for when they don't know (note that ignoring prompts 80-100% of the time is a problem—you probably haven't introduced the tool

Ensure that your policies and procedures include provider expectations for point of care tools. For example, your policies should address what conditions providers are expected to address during visits, and what percentage.

Incentives should consider both what is addressed, and what providers reject from addressing. If a provider rejects a condition, weight that just as heavily as a condition that improves a RAF score, since both indicate effective use.





Educate to Eliminate the Need for Incentives

The greatest physician incentive is not without, but within. The flame of knowledge.

Physicians are lifelong learners who never left the classroom. Once they learn the true value of documentation specificity, tying diagnosis to medical decision making, and understand the why behind it all at a deep level, they will have their truest incentive.

But other incentives surely help.

Partner for Success

Thinking about implementing a NEW Provider Incentive Program, or need an unbiased third-party opinion on an existing framework?

We'd love to help. Reach out anytime at

consulting@norwood.com

for a zero-pressure conversation.

References & Resources

- Becker's ASC Review. Is Stark law 'antiquated' in the new age of medicine?: <https://www.beckersasc.com/asc-coding-billing-and-collections/is-stark-law-antiquated-in-the-new-age-of-medicine/>
- Journal of the AMA, "Physician Compensation Arrangements and Financial Performance Incentives in US Health Systems": <https://pmc.ncbi.nlm.nih.gov/articles/PMC8903115/>
- Today's Hospitalist, "Hospitalist compensation incentives: bonuses and risk": <https://todayshospitalist.com/hospitalist-pay-incentives-performance-bonuses/>



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