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Changing Incentives: physician compensation under health reform

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I. Introduction

Changes in reimbursement methodologies and the goals of health reform are beginning to shift the focus from volume based to value based healthcare. With new programs reimbursing hospitals and physicians based on the measurement of quality, organizations will need to drive this focus down to the day to day actions of its physicians. One mechanism to accomplish this is to modify the physician compensation structure. In contemplating changes, however, there are many factors to manage including identifying the right metrics, ensuring the support systems are sufficient to successfully implement any changes, and making certain that the incentives will result in desired behavior.

Many organizations have focused their recent compensation structures on incenting physicians around productivity given that current reimbursement structures pay on volume produced. But new reimbursement approaches under health reform are increasingly tying quality to payment. Progressive organizations that have embraced quality measurement are folding quality metrics into the compensation structure. This paper seeks to understand the impending changes in the marketplace and to identify the optimal ways to compensate physicians under quality based healthcare through a review of Centers for Medicare and Medicaid Services (CMS) regulations, an exploration of new approaches of select organizations, and research on the economics of incentives and human motivation. The names of the individuals and organizations interviewed for this paper have been changed.

II. The Changing Marketplace

While the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010 garnered significant attention, in actuality CMS has been investigating ways to tie reimbursement to value for years. Up until the last few years, many of the programs discussed and proposed by CMS were offered only through pilots. More recently, however, programs are shifting out of the pilot and honeymoon phases and into a stark reality of impending penalties and withholds of payment. At the same time of these reimbursement changes, the American economy has struggled to recover from a recession, placing a higher burden of the healthcare costs on the individual. These two substantial shifts in the marketplace are driving providers to reexamine the way they have traditionally done business. The following sections describe the quality programs proposed and implemented by CMS and investigate the impact individuals are having on the industry.

A. Physician Quality Reporting System

The Physician Quality Reporting System (PQRS) was established through the 2006 Tax Relief and Health Care Act (TRHCA)[1]. It includes an incentive payment for eligible providers who report on quality measures regarding services provided to Medicare beneficiaries. In 2011, the program included 131 individual quality measures eligible for claims-based reporting organized into 10 groups. Between 2011 and 2014, PQRS will pay eligible providers a percentage increase for all Medicare patients if the provider meets the reporting requirements. However, beginning in 2014, providers will face a decrease in reimbursement amounts if they fail to meet reporting requirements. CMS has

recently included an added benefit for providers that achieve a Maintenance of Certification (MoC), the penalties that are scheduled to start in 2014 will not apply to them.[2] The schedule for bonuses and penalties can be found in Appendix I.

B. EHR Meaningful Use

The American Recovery and Reinvestment Act of 2009 (ARRA) included incentives for healthcare providers to become meaningful users of healthcare information technology in order to improve the efficiency and effectiveness of care provided in the United States. In order to qualify, a physician or mid-level provider must quantitatively and qualitatively demonstrate that they are using certified EHR technology. There are three main components of Meaningful Use:

- "The use of a certified EHR in a meaningful manner, such as e-prescribing.
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
- The use of certified EHR technology to submit clinical quality and other measures."[3]

CMS will phase in Meaningful Use over a five year period. The first stage is set for 2011 and 2012 followed by Stage 2 implementation in 2013 and Stage 3 implementation in 2015. While Stage 1 has been defined, the details for Stages 2 and 3 are yet to be determined. Stage 1 is the baseline period in which standards for data collection and sharing are to be established. The requirements for Stage 1 are the following:

- "Eligible professionals have a total of 25 meaningful use objectives

    - To qualify for an incentive payment, 20 of these 25 objectives must be met.
        - There are 15 required core objectives.
        - The remaining 5 objectives may be chosen from the CMS list of 10 menu set objectives.
- For eligible hospitals and CAHs, there are a total of 24 meaningful use objectives.
    - To qualify for an incentive payment, 19 of these 24 objectives must be met.
        - There are 14 required core objectives.
        - The remaining 5 objectives may be chosen from the CMS list of 10 menu set objectives." [4]

C. Health Reform

Signed into law March 23, 2010, the PPACA is intended to reform the private health insurance market, provide better coverage for those with pre-existing conditions, improve the prescription drug coverage for Medicare patients, and extend the life of the Medicare trust fund. Of particular interest to healthcare providers are the provisions that will expand eligibility for Medicaid and the establishment of health insurance exchanges. The effect of the PPACA and these two provisions in particular will mean a significant increase in the number of patients covered by insurance. This influx of patients into the healthcare system will place an enormous strain on providers already stretched thin due to low supply. The shortage of primary care providers will be exacerbated by the projected increase in demand for services. In addition, the PPACA has paved the way for

a number of reimbursement programs including Shared Savings, Bundled Payments, Value Based Purchasing and other programs.

i. *Medicare Shared Savings*

The Medicare Shared Savings Program or Accountable Care Organization (ACO) is a legal entity that is recognized and authorized under applicable state law and comprised of an eligible group of participants to work together to manage and coordinate care for Medicare Fee-For-Service (FFS) beneficiaries.[5] In part, the ACO regulations encourage providers to embrace quality, preventative care, patient satisfaction, cost management, chronic disease management, and end-of-life care; all of which are utilization reducing activities. The regulations have been deemed by most provider organizations, including the American Hospital Association, to be overly prescriptive, too expensive, and too little reward for the investment made. Even though most organizations will not be pursuing the Medicare ACO designation as it is currently described, the general sentiment remains that hospitals and physicians must focus on providing value-based medicine. Organizations must be able to prove that they provide high quality (good outcomes, good patient satisfaction scores), low cost care.

ii. *Bundled Payment*[6]

Under the PPACA, the Secretary of Health and Human Services is required to establish a pilot program to pay providers for integrated care during an episode of care to a Medicare beneficiary around hospitalization. The pilot program is required to start by January 1, 2013 and last for a period of five years. The bundled payment approach is intended to pay providers one established amount for all healthcare services required to treat a given

condition or illness for a defined time period. The goal of this approach is to encourage better coordination of care between providers and eliminate or greatly reduce repetitive services. A bundled payment will eliminate reimbursement for each discrete service. It is at the discretion of the Secretary to extend the bundled payment program if the expansion is deemed to reduce spending without reducing quality of care or improve the quality of care without increasing spending in addition to other consideration.

According to the law, the bundled payment is required to be "comprehensive, covering the costs of applicable services and other appropriate services furnished to an individual during an episode of care… and made to the entity which is participating in the pilot program." A bundled payment is intended to cover applicable services such as acute care inpatient services, physicians' services delivered in and outside of the acute care setting, outpatient hospital services, and post-acute care. In addition to those applicable services, the bundled payment is required by law to include payment for care coordination, medication reconciliation, discharge planning, transitional care, and other patient-centered activities. The law stipulates that the bundled payment for the services may not exceed the amount that would be paid if the pilot program was not in place. In addition to detailing the requirements for selection criteria for the ten conditions to be included in the pilot program, the Secretary is expected to establish a set of quality measures to monitor performance.

iii. Value Based Purchasing Program[7]

Written into the PPACA, the Value Based Purchasing Program (VBPP or program) goes into effect in 2013. In the program, hospital payments will be tied to performance based on quality measures that are related to a defined list of cases. The list initially includes acute myocardial infarction, heart failure, pneumonia, surgeries, and healthcare associated infections. Hospitals that are able to exceed standards will receive an increase in their DRG payments for the subsequent performance period. Hospitals that fail to meet standards will have DRG payments reduced by up to 2 percent by 2017.

iv. Other Health Reform Reimbursement Initiatives

The federal government has also encouraged the development of other reimbursement changes tying quality to payment through the PPACA. Initiatives include a penalty for high rates of hospital-acquired conditions. Beginning in 2015, all data regarding hospital acquired conditions will be available to the public. Those hospitals in the top quartile for reported hospital acquired conditions will be subject to a 1 percent reduction in payments. Beginning in 2013, hospitals will also be subject to a readmission reduction program in which payments will be reduced for readmission to the facility within 30 days for heart attack, heart failure, and pneumonia. Four more conditions will be added to the program in 2015. As with the information on hospital acquired conditions, the readmission data will be available to the public.[8]

D. Individuals

The cost of health insurance is overwhelming the average American family. In five years, health insurance is projected to consume over one-third of the median family income.[9] A chart in Appendix II reflects this projected trend.

With the cost of health insurance rising, more small and mid-size companies are scaling back the amount of capital they contribute to employees' health insurance plans and / or offering high deductible health plans (HDHPs). HDHPs force employees to become more responsible for managing their healthcare consumption. As a result, individuals are beginning to act like consumers looking to price out the cost of healthcare services against the perceived quality. Individuals are looking for healthcare value.[10] This fundamental shift in approach to healthcare will force providers to prove they can offer high quality care by publishing rates and post performance on quality measures.

E. Legal Considerations

The initiatives under health reform, particularly the Shared Savings program, will require hospitals and physicians to construct new legal entities that can jointly contract for reimbursement. This will necessitate careful consideration of structures that ensure compliance with the Stark Law, Anti-Kickback Laws, IRS provisions, and the Federal Trade Commission's and states' antitrust laws. To make certain that the delivery system meets all of the necessary regulations, physicians and hospitals must establish good working relationships and develop trust among parties.

F. Making the Case for Physician Engagement

There is a fundamental shift under way in the healthcare industry. All of these initiatives pushed by the government, payers, and individuals (Meaningful Use, Value Based Purchasing, ACOs, Bundled Payments) are focusing hospitals and physicians on the cost and quality of care they provide. In order to maximize performance in today's healthcare market, it is critical that providers effectively operate within a team environment. In addition, healthcare regulations (Stark, Anti-Kickback, etc.) require hospitals and providers to construct legal entities that will enable all parties to receive and distribute reimbursement for the services they have provided. This is a vastly different approach for many providers who were trained to operate independently. Within the new structures, organizations will need to align incentives for all parties and drive incentives for value based care to the individuals on the front lines of providing care to patients.

III. Current Compensation Approaches

Each medical practice compensates its providers in its own unique way yet the general construct follows along parameters of a few approaches. There are several resources that help illustrate what those approaches are including Bruce Johnson's and Deborah Walker Keegan's *Physician Compensation Plans: State-of-the-Art Strategies*[11] and physician compensation surveys like the Medical Group Management Association's (MGMA) *Physician Compensation and Production Survey* (PCPS) and the American Medical Group Association's (AMGA) *Compensation and Financial Survey*. Johnson and Keegan's comprehensive analysis of physician compensation includes a matrix to help explain elements that may be used in developing compensation structures and how they compare to one another. The matrix is included in Appendix III.

The compensation matrix details nine separate elements to establishing compensation plans for physicians. They are ranked along two axes; team oriented versus individualistic plan, and revenue versus expenses. According to the authors, compensation plans that focus on revenue generation and incorporate it into the structure have a more positive cultural orientation. The individualistic plans assign revenue generation and expense management to the individual provider whereas the team oriented approaches attempt to hold all providers equally accountable for either revenues or expenses. For a brief description of each plan, please see Appendix III. As Johnson and Walker explain, no one structure will meet the needs of all practices. Compensation plans must evolve and reflect the culture and needs of the group.

Examining MGMA's PCPS over the past four years reveals some interesting trends about compensating physicians and mid-level providers. The compensation classifications included in the surveys are described as the following[12]:

1. Production less allocated overhead

   An allocated portion of practice expenses are subtracted from an individual provider's revenue to determine the compensation. This structure treats individuals as separate economic units within a group practice.

2. Production- based share of practice compensation pool

   The compensation pool is determined by subtracting practice expenses from practice revenues. The remaining net income is then divided among the providers based typically on individual production. This approach is more team-like in that it approaches the expenses as a cost of doing business incurred by all providers rather than assuming the expenses are individually driven.

3. 100 percent equal share of practice compensation pool

   This approach establishes the compensation pool based on what is left over after expenses are subtracted from practice revenues. The pool is divided equally among all providers.

4. Base plus incentive

   Providers receive a guaranteed amount of compensation plus an incentive that must be earned. Incentives can be based on individual production, unit or organizational performance, patient satisfaction, and other factors.

5. Straight / guaranteed salary

   Under this approach, the provider's compensation is a fixed amount.

The results of the 2008 through 2011studies reveal shifting approaches to compensation methods used by medical groups. The top twenty specialties, based on the number of providers, were analyzed to isolate any trends in the way groups are paying their providers. Chart 1 in Appendix IV shows that compensation structures which are individually focused, such as the production less allocated overhead and production based share of practice compensation pool, are declining in popularity. Structures that guarantee at least a portion of the compensation are becoming more pervasive.

Interesting to note is that as these individually focused structures are declining in use, the number of hospital employed physicians is growing. The split between hospital employed physicians and non-hospital employed physicians among the survey respondents is moving closer to 50% each. Chart 2 in Appendix IV reflects this trend.

IV. Ensuring Incentives Will Work

As the research on current compensation methodologies for this paper reveals, there is no best in practice approach. Yet most, 79 percent of the PCPS respondents, include some way of encouraging a particular behavior that is important to the practice. Establishing a compensation structure for providers, either as an independent medical practice or as a hospital employed group, has posed challenges for years. Finding a structure that supports the strategic goals and culture of an organization requires group leaders to examine the use of group and individual incentives. Before determining the appropriate approach, however, it is critical to understand what incentives are and how they are intended to be used.

An incentive is defined as "something that incites, or tends to incite to action or greater effort, as a reward offered for increased productivity."[13] Incorporating incentives into compensation structures is a common practice across all industries. Unfortunately, incentives don't always work the way they are intended. If the target or threshold is deemed to be unattainable, they may not work at all. Many times incentives end up encouraging behavior that is detrimental to the organization and counter to the actual end goal.[14]

There are many examples of incentives that encourage and produce the desired behavior. A common practice in physician compensation structures is to include a productivity incentive. These incentives reward physicians with additional pay based on the level of Work RVUs produced, charges generated, or collections earned. Incentive examples from other industries include a bonus based on achieving stated profitability targets or stock options granted for proven performance.

However, incentives don't always work as intended. People find ways to manage the system to benefit themselves and their own needs. There are many examples of companies incenting production and protecting workers from the downside of producing too little, for example, Donald Roy's study on incentives[15]. Roy, a PhD student, worked in a piece-work shop to study the impact of incentives on individual behavior. What he found was that workers determined the production ranges in which they should operate to either get by without being fired or earn a bonus yet not increase management's expectations of them or co-workers. These workers were acting rationally based on the

economic incentives that were incorporated into their compensation structure.[16] Recent examples include Sears' introduction of a monetary incentive system in its Auto Centers which aimed to reward service members if the average revenue per customer visit increased. This approach encouraged Sears' employees to convince customers that additional work was vital to their cars' performance.[17] So while Sears achieved its end goal of increasing the average revenue per customer earned, it also negatively impacted its reputation by pushing repairs that weren't necessary.

Understanding incentives and their ability to influence behavior is a topic of great interest to economists and behavioral scientists alike. James Brickley, Clifford Smith, and Jerold Zimmerman, authors of *Managerial Economics and Organizational Architecture*, found that employees and owners have fundamentally different objectives but that incentives can work, and will not cause problems, when actions are contractible.[18] Further, these authors explain that in competitive labor markets, employees must be compensated for undertaking undesirable actions. Quite simply, employees should receive higher pay for taking on tasks that are deemed to be unappealing. Ideally, an employee would be able to purchase the rights to his or her total output in situations where the actions of the employee are unobservable. This approach allows both the benefits and costs of exerting effort to be internalized by the same person. According to Brickley, Smith, and Zimmerman, the best approach would then be to encourage ownership and decision-rights at the provider level.

Other researchers have found that economic incentives don't always increase volume or production if people feel that their moral sentiment is undermined. In another study on incentives and behavior, Samuel Bowles cites an example of experiments in which the level of blood donations decreased when donors were offered pay for their services. [19] The conclusion by the researchers is that the monetary reward for the blood donation caused donors to be uncomfortable with the perception of their underlying intent in giving blood. According to Mr. Bowles, "Incentives also run into trouble when they signal that the employer mistrusts the employee or is greedy." Further, "Fines or public rebukes that appeal to our moral sentiments by signaling social disapproval (think of littering) can be highly effective. But incentives go wrong when they offend or diminish our ethical sensibilities."[20]

It is possible, however, to appeal to the economic interest of an individual and still meet their moral standards. The critical component to being successful in structuring appealing compensation structures with incentives that work is to understand what motivates employees. The Belief System of Motivation and Performance (BSMP) is explained in Dr. Merwyn Hayes' and Dr. Thad Green's book, *The Belief System: the Secret to Motivation and Improved Performance* (BSMP). BSMP describes how people determine their level of effort and how well they will perform.[21] Drs. Green and Hayes suggest these decisions are determined through the following chain of events: effort leads to performance which leads to outcomes which results in satisfaction.[22] Appendix V provides an illustration of this chain of events and their relationship.

In BSMP, Belief 1 ties an employee's effort to his performance. It is important to understand whether the employee believes he/she can perform the task as expected. If not, there typically is an underlying problem of inadequate skills, unrealistic expectations, or inadequate resources. The second Belief focuses on whether the employee thinks the outcomes will be tied to his/her performance. Many times Belief 2 falters when employees feel that everyone is treated the same no matter what kind of job performance they have. In order for Belief 2 to hold, it is critical that employees and managers or owners define performance in the same manner. Finally, Belief 3 focuses on whether the outcomes will be satisfying to the employee. It is important for owners and managers to understand whether the work is meaningful to the employee and whether the employee wants the things that are being offered. Problems in Belief 3 usually stem from employees not receiving desired outcomes, receiving unwanted outcomes or having conflicting desires.

How then should medical practices pull these disparate statements regarding compensation structures and incentives together for their providers? First, it is important to understand the culture of the practice. The underlying culture (an individual practice or team based approach) will have a significant impact on determining the compensation structure including what incentive metrics to choose. Second, it is critical that targets are possible to reach or exceed with effort. Third, it is necessary that providers trust the ability of the practice to make the compensation structure work successfully. If a structure includes metrics that rely upon data capture and mining, the practice must have an infrastructure that will seamlessly support that effort including the reporting of the

outcomes. If employees do not trust the outcomes, the incentives will fail. Finally, it is critical that the medical group determine whether the outcomes or fairness of the compensation structure are satisfying to the providers. The providers must not feel an incentive unjustly rewards some behavior that is not valued over other, more meaningful efforts. A new compensation structure will not work if it does not achieve all four of these expectations.

V. New Approaches: Lessons from Today's Leaders

Eight individual interviews were conducted with industry leaders from hospital employed groups, independent practices, integrated medical groups, and attorneys from across the country. The organizations ranged in size from ten physicians to over 800 physicians. The following topics were discussed: current compensation methodologies, challenges facing the group today, and trends they see for the future. In addition, the leaders were asked to provide recommendations to medical practices contemplating changes to their compensation structures.

G. Hospital Employed Groups

Leaders of hospital employed groups face added challenges when determining appropriate compensation structures. The hospital must remain within regulatory guidelines including Stark, Anti-Kickback, and private inurement. The parent organization must also determine the extent to which it will subsidize the physician salaries. The willingness of the hospital to do so is often dictated by the strategic

imperative of having a given specialty within the community and the difficulty of recruiting. Even as hospitals are willing to subsidize, it is imperative that they manage a loss through appropriately structured incentives to encourage revenue generation and tight expense management.

i. Elm Hospital: employed group administrator

For Elm Hospital's employed group administrator in the metro-Atlanta area, the next few months and years will be challenging as they transition the physicians from one compensation structure to another. According to the administrator, "the physicians currently "rise and fall" on their own bottom line." The difficulty, however, is that as the hospital expands the number of physicians within the group, fewer physicians that are brought into the group can actually thrive under this approach. The Elm Hospital employed group is now looking at using a Work RVU based model that establishes a floor of production at the 25th percentile of the MGMA survey. The contemplated structure is not simply based on production, however. It also ties the physician compensation to expenses, to the extent that as expenses increase, the physicians are subject to earning less. The expenses allocated to the physicians include billing and collections, malpractice, and depreciation. In addition to the productivity and expense management expectations, the Elm Hospital employed group will also be subject to a quality incentive. Twenty percent of compensation will be withheld from total based on the individual physician's ability to meet targets in PQRS and patient satisfaction metrics.

This new structure will not be implemented all at once, though. This hospital employed group is rolling out changes one practice or service line at a time. The group has engaged

physicians through a Physician Committee which is comprised of physician leaders, nursing leaders and other department representatives. The most significant challenges are expected in implementing the compensation structure. Questions to consider are; how should the group equitably set the minimal target? How and what type of credit should be offered for providers who perform other duties? Should the organization capture the work effort of physicians to adequately compensate them under bundled payments? This transition is not expected to negatively impact the culture of the physician organization but other external challenges are expected to challenge the group as more independent providers in the Atlanta market shift to a concierge approach leaving hospital groups to manage a disproportionate share of under-insured patients.

In addition to restructuring compensation, the Elm Hospital physician group recently implemented the patient centered medical home in several of its practices. Physicians working in this business model are salaried because the reimbursement, as the administrator states, is "not there right now." This will be monitored and as reimbursement methods catch up, this organization will update the compensation structure for providers working the medical home model.

ii. *Birch Hospital: community hospital*

Birch Hospital, a community hospital located in rural Texas, is managing a growing employed physician group and has recently implemented a new compensation structure. The goal of the new structure, developed in by internal physician advisors and outside consulting support, is to reduce the administrative burden of compensation by placing all

physicians within the same structure. The new approach includes a base payment, a productivity incentive, and incentive payments intended to focus the employed physicians on the expense management of the practices and patient satisfaction. One of the largest challenges in developing the compensation structure was how to accommodate and reward the administrative work that some of the physicians were doing to support initiatives within the practices. After exploring several options, including an annual stipend, Birch Hospital decided to calculate and assign an "Administrative RVU" rate by specialty to any hour that designated physicians spent on supervision, meeting attendance, and other administrative duties. In order to meet regulatory requirements, the physicians are required to keep detailed records on their time spent and duties conducted.

H. Independent Medical Groups

According to one attorney interviewed, many of the private medical groups have not yet considered incorporating quality metrics into their compensation structure. Most structures continue to use productivity based incentives to motivate and reward physicians. However, some of the larger independent groups like Oak Practice, are investigating the use of quality data in their practice in some form or another.

Oak Practice is an independent provider group, comprised of anesthesiologists, radiologists, pathologists. It has instilled as part of its culture, a focus on quality. The Oak Practice has a system to capture data on the care it provides within its offices and hospitals. The process requires providers to complete data sheets on the care and process

in a given location, tailored to the individual specialties. This data is then aggregated at the group level but can be analyzed to the individual patient and provider level.

The information gathered on care has proven to be a differentiator for the group and helped it to expand its market reach. The quality data has also allowed the group to approach third party payers and negotiate better reimbursement rates. Releasing this information internally to providers has been very successful in changing behavior but it is not used in determining compensation levels. Oak Practice feels that the self-reported data provides an opportunity for self-reflection but nobody can risk-stratify (or apply the appropriate constellation of activities like lab and clinical testing used to determine a person's risk for suffering a particular condition and need–or lack thereof–for preventive intervention) the data. Tying self-reported data to the compensation structure would lead to significant discontent and unwanted incentives. Rather, the group ties components of the compensation structure to performance on key metrics that are extracted from hospital and practice information systems and reported to CMS.

I. Integrated Systems

Two integrated provider groups interviewed are also in the process of adjusting their compensation structures.

i. Pine Multi-Specialty Group: 50 providers

The first, Pine Multi-Specialty Group with approximately 50 providers and also insurance products, is undertaking a major initiative to standardize compensation approaches across three internal divisions that were the result of separate practices coming together under one parent organization. This group has organized themselves around Don Berwick's Triple Aim (please see Appendix VI for a detailed description of the Triple Aim): better care for individuals, better care for populations, and reducing per capita costs. It is important to the group to include a compensation component on performance around outcomes in order to better support its mission and vision.

In order to determine the best approach for the medical practice, the Pine Group has engaged physician leaders in the discussions around compensation structures. The physician-led committee is comprised of representatives from different sites, specialties, and ages. The committee had to initially identify the overarching principles for the structure and determine what the committee and a compensation system could realistically achieve.

This Pine Group has considered several approaches for the future along the same general compensation design of a salary plus incentive. One model discussed includes a salary based on market rates plus a quality bonus comprised of service, health outcomes, and the cost of care metrics. The second model under consideration would employ a gradual transition of the current productivity component to a quality one. The second approach attempts to manage the physicians' fear of the unfamiliar compensation structure. A third possibility is to incorporate team based metrics rather than rewarding individual performance. This approach would require a structural shift for all members of the care team.

Several challenges in moving to a new compensation structure are forefront for this physician compensation committee. One challenge for the Pine group, according to their Vice President for Quality, is reducing the "noise." Many of the providers within the group participate in numerous payer initiatives. This leads to various reporting requirements and a significant amount of data collected. All of this data pushed to and pulled from the physicians can be very confusing and overwhelming. Ideally, this organization will end up with a compensation structure that is able to focus the providers on the key metrics that are important to the group and that drive value based medicine. Rather than looking outward for determination of the metrics and targets, this group is planning to set its own standards. They want to reduce the number of metrics that the providers need to manage and tie those directly to the organization's strategic goals.

The second major challenge for the Pine group is accommodating individual providers' practice styles. The move towards standardization and care pathways can be a lengthy one requiring significant changes to the way some providers practice medicine. Finding the appropriate pace at which the organization is driving change and transitioning to a new model is critical in retaining valued providers.

ii. Maple Health: national integrated health system

Maple Health, an integrated health system with a national presence manages its operations through eight distinct units. Each of these groups approaches compensation very differently. Some of them have moved away from incentive based pay while others compensate physicians purely on incentives. However, all groups rely heavily on an integrated information technology system. A robust EMR and practice management system are critical to Maple Health in order to gain and maintain the trust of the providers. Without trust in the numbers and data, the compensation structure would not work.

According to one Maple Health leader, this health system attracts a certain type of physician; one that wants to focus on practicing medicine without having to deal with running their own business. He states, "The doctors are looking to be paid a fair wage without "the headache" of the administrative requirements in a physician practice." In addition, the pension package offered by the system is extremely attractive.

The executive medical director of one of Maple Health's divisions, Alpine, describes managing the compensation system as keeping an eye on three structures, "last year's, this year's, and next year's." Alpine can never be complacent with the compensation structure it has in place as it will need constant attention to ensure that the metrics and approach continue to meet the needs of the organization. This division renews its contracts with physicians each year and wrap into the contracts quality metrics that must be met. This approach to the compensation structure allows Alpine to implement changes at various speeds and gauge reactions to the changes as they go.

The Alpine division includes incentives at both the population level and individual performance level. At the population level, all shareholders will share equally in the allocated payment if targets are hit in the group's overall performance in managing the health of its patient base. The corridor type payment requires the group to meet specified thresholds which are based on past internal performance and stretch goals which are based on external benchmarks.

Over the past three years, the division has introduced a variable compensation component to the physicians which focuses on individual performance. This component is not a withhold; the physicians only participate on the upside. However, their salaries do not increase as much as they used to on an annual basis because the division is allocating more money to the variable compensation pool. The goal of variable compensation is to incent efficiency within the practice and to increase the number of consults or new patients. Once the plan is fully implemented within the next two years, the division will

have a compensation structure that includes measures on population health and 15 percent allocated to variable pay that is divided 5 percent each on practice management, service management, and quality metrics.

As the division contemplates and reviews these changes, it is led by a committee comprised of the CFO, physician leaders, and compensation experts. While the organization still believes in the principle of being mostly salaried, it does recognize the importance of incenting individual performance. However, according to the Medical Director, it does not want to "recreate the treadmill" of solely an individual focus.

This structure depends heavily on data and measurement. Accurate and timely information is absolutely critical to the process and to establishing trust within the organization. Having qualified and capable people to manage the information is of utmost importance.

VI. Compensation Methodologies for the Future

While the limited survey conducted for this paper did not uncover any fundamentally new approaches to physician compensation, there are significant changes occurring within the existing frameworks. More groups appear to be investigating ways to allocate some portion of pay to group performance and ability to meet quality targets.

As the examination of the last four years of MGMA compensation surveys revealed, there has been a slight increase in the percentage of organizations relying on a pure salary

approach. However, the more significant increases have been in the utilization of base plus bonus and the equal share of a compensation pool. Both of these methodologies can be used to promote a more team focused culture. Increasingly the bonuses are being tied to team performance and quality metrics rather than on volume-focused metrics like gross charges, Work RVUs, or collections.

Each practice will continue to select the metrics it prefers to have tied to incentive compensation, if any, yet research for this paper indicates that the measures will tend to be tied to health outcomes, patient satisfaction, service, and quality. Some organizations will rely on external benchmarks to set standards while others will establish internal thresholds that must be met in order to qualify for a bonus payment. Regardless of how benchmarks and thresholds are established, physician practices will require robust practice management systems and electronic health records to support data capture and measurement efforts.

Analysis and research for this paper suggest that integrated physician groups will allocate some level of compensation to a performance pool which will be shared equally by providers when the collective group meets targets. Approaches such as the one employed by Maple Health will likely be replicated as organizations attempt to find ways to incent providers on keeping population health goals in mind. At the same time, it is important not to place too much weight on the population health goals as individual physicians are far removed from being able to directly move the practice's performance on these measures.

Withholds and bonuses will continue to be used within physician organizations. As with defining the right metrics, the appropriate approach will be determined by the group. Withholds may be appropriate when a group wants to mimic a Medicare reimbursement program that utilizes this methodology, such as the Bundled Payment program. It also connotes a more punitive methodology or culture within the organization. Physicians may feel that the portion that is withheld is actually their earned money and end up resenting the need to earn it again. A bonus, on the other hand, allows participants to share in an upside and can provide encouragement. However, it is critical that targets are seen to be attainable. Some organizations apply tiers or corridors to bonus structures that establish various thresholds providers must meet in order to qualify for a bonus. As production increases and the next tier or corridor is achieved, the provider is pushed into a higher earning bracket.

VII. Recommendations

There is no single correct approach to a physician compensation structure. Each methodology has its own strengths and weaknesses. For many organizations, the process by which a compensation structure is developed is just as important as the end result as it offers an opportunity to engage the physicians on important strategic and operational decisions for the practice. Research and interviews suggest the following considerations in developing a compensation structure:

- Know your organization's mission, vision and values. These all contribute to your organization's culture which will significantly influence which approaches will work best in the practice;

- Develop a collaborative process to review and update the compensation structure including the participation of physician leaders;
- Understand your practice's capabilities and limitations in information technology;
- If a quality metric is important to the practice, measure it and report it to the practitioners, even if it is not formally tied to the compensation structure. However, now is the time to begin introducing quality metrics into the compensation structure;
- Be mindful of the physicians' ability to affect change on a quality measure. Providers are less able to move population health than they are able to discuss the merits of the recommended health screenings with their patients.
- Keep the structure simple and meaningful. Too many metrics and compensation pools diffuse the incentive. Physicians need to clearly understand how a change in their behavior will be rewarded;
- Review the structure and its effectiveness on a regular basis. With all the market changes, organizations will need to be nimble, flexible, and creative.

VIII. Further Study

There are a number of areas that require further study to develop a more thorough understanding of how to incentivize and reward physicians. The expectations and desires of newly trained physicians are very different than those physicians who are reaching the end of their careers. Most physicians coming out of residency programs lately are looking for some type of employment arrangement whether with a large group, hospital, or integrated health system. They state a desire for a more balanced approach to life and

many do not feel the entrepreneurial pull that their older colleagues felt when that generation entered into medicine. Additional research may prove helpful in understanding what structures best motivate this age group of physicians.
Further, it may prove beneficial to study organizational differences in compensation design. For example, do rural hospitals and physician groups rely on one methodology more than another? If so, why is that and are they effective? Are market leaders drawn to a particular compensation structure over others?

Finally, as organizations think about incorporating patient satisfaction measures into the compensation structure along with quality metrics, it is important to remember that providers are not the only people in the practice that can impact a patient's perspective. To what extent is it important to align incentive pay for the support staff in order to drive and achieve process change?

IX. Conclusions

Many organizations are taking advantage of the upheaval in the marketplace to reexamine their physician compensation structure. As the support for quality measurement and cost efficiency in healthcare grows and reimbursement becomes increasingly tied to value, the need to create compensation structures to incent and reward groups and individuals around value based medicine will also grow. Medical groups should use this time to educate their physicians about the reimbursement changes in the industry, how those new reimbursement programs will impact their individual and group practice of medicine, and how to best affect behavior through a compensation structure. If systems and data

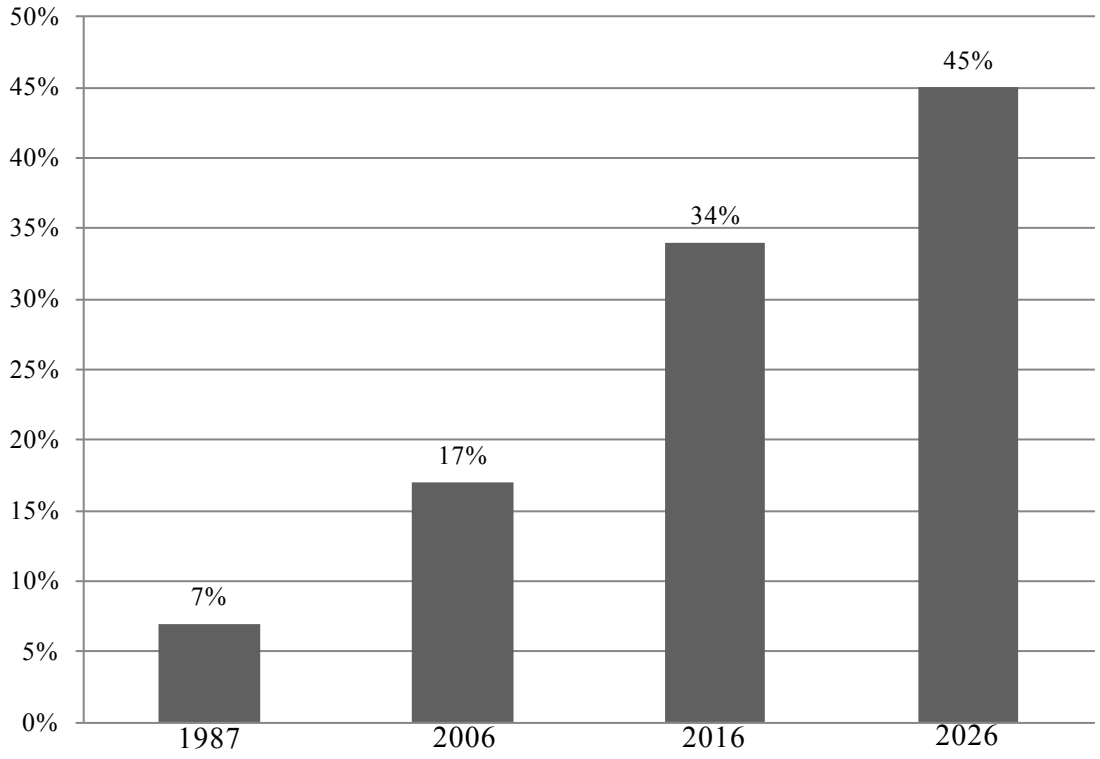
capture processes are not already in place, medical groups should strive to implement them immediately to begin introducing quality measures to providers. Providers are at the edge of a major shift in the marketplace from volume based to value based medicine. Compensation structures will need to shift, too.

Appendix I: Physician Quality Reporting System

	2011	2012	2013	2014	2015	2016
Physician Quality Reporting Initiative (PQRI)	Potential **1.0% bonus** on total allowable charges	Potential **0.5% bonus** on total allowable charges	Potential **0.5% bonus** on total allowable charges	Fee schedule **reduced** by **1.5%** if quality data reporting is not satisfactory	Fee schedule **reduced** by **1.5%** if quality data reporting is not satisfactory	Fee schedule **reduced** by **2.0%** if quality data reporting is not satisfactory
with CoM	Potential **1.0% bonus** on total allowable charges	Potential **0.5% bonus** on total allowable charges	Potential **0.5% bonus** on total allowable charges	n/a	n/a	n/a

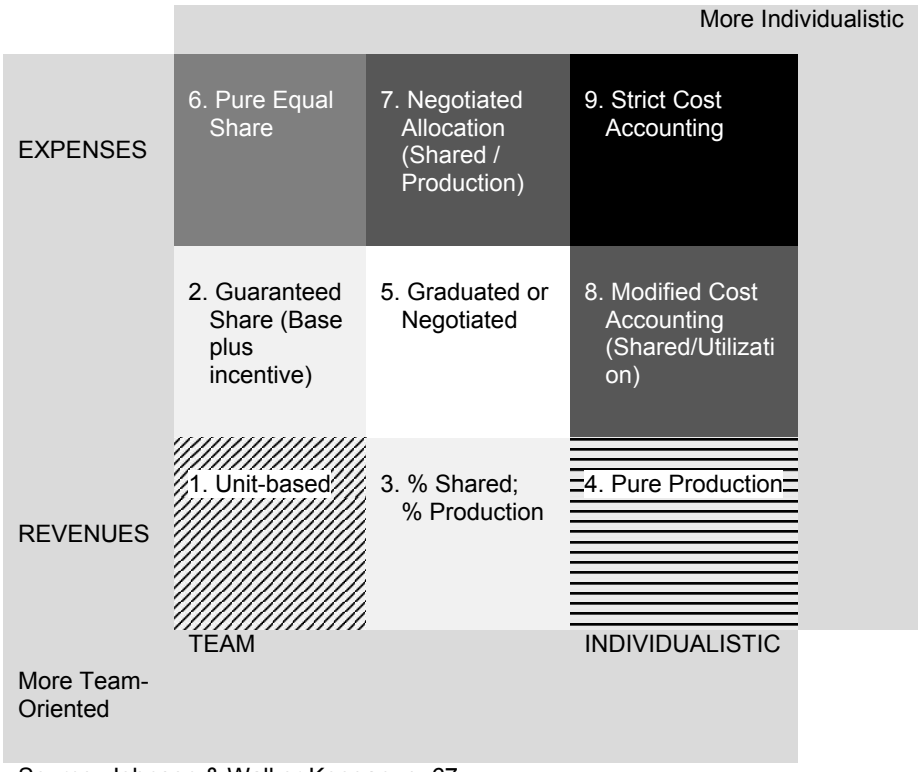
Source: Research and analysis by Susan Stowell, Principal, Stroudwater Associates, with data released by Centers for Medicare & Medicaid Services: Physician Quality Reporting System.

Appendix II: Health Insurance as a Percent of Median Family Income



Source: Nichols, PhD, Len, "Making REAL Health Reform Work" (2011). Department of Family & Community Medicine Lectures, Presentations, Workshops. Paper 4. http://jdc.jefferson.edu/fmlectures/4

Appendix III: Compensation Elements Matrix from Physician Compensation Plans



Source: Johnson & Walker Keegan, p. 67

1. Unit-based: These structures have a high team focus and do not contemplate expenses into the model. Examples of the unit-based approach include a straight salary, 100% equal share or compensation per unit of work (such as Work RVUs, percentage of gross charges or net collections, etc.), or hourly rates.

2. Guaranteed Share: These base plus incentive approaches are less team oriented than unit-based models and offer a guaranteed portion plus some type of incentive.

3. Percent Shared; Percent Production: In these structures, the practice continues to cover all expenses without specific allocation to individuals. The income, however, is split between a shared component and an individual component. There are many different ways to configure the exact split and allocation of income.

4. Pure Production: This model is solely focused on the individual performance of the providers within the practice. Common measurement approaches include net collections, Work RVUs, panel size, and encounters.

5. Graduated or Negotiated: This approach applies an increasing monetary value to the measurement tool. For example, if a practice is using gross charges, they would

increase the percentage allocated to the physician's compensation as he or she reaches specified thresholds of performance.

6. Pure Equal Share: Under this model, providers within the practice share the expenses equally.

7. Negotiated Allocation: Groups using this element distribute expenses by combining some allocation of equal share with a production based allocation.

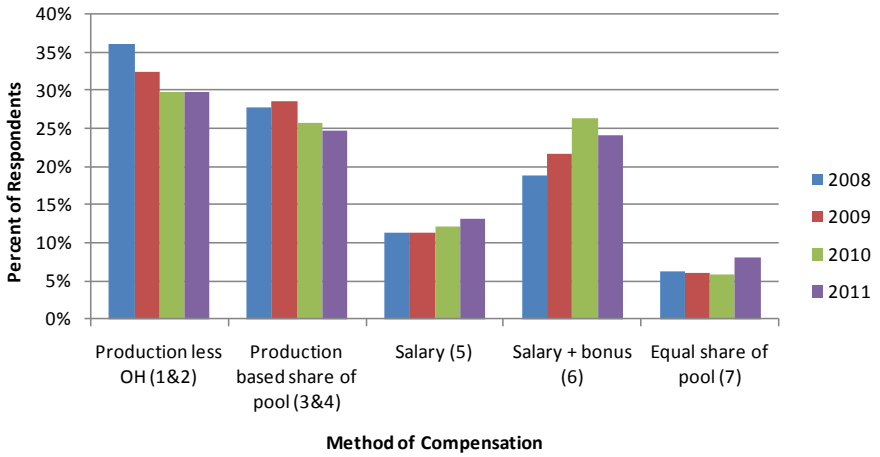
8. Modified Cost Accounting: Compensation structures that use modified cost accounting to manage expenses. The expense allocation is completed by categorizing some expenses as shared and others subject to utilization by the provider.

9. Strict Cost Accounting: This approach to expense management is the most individualistic of all methods. Expenses are allocated solely based on utilization.

Source: Johnson, Bruce and Deborah Walker Keegan. *Physician Compensation Plans: State-of-the-Art Strategies.* Canada: Medical Group Management Association, 2006, pages 83 – 100.

Appendix IV: MGMA PCPS Results

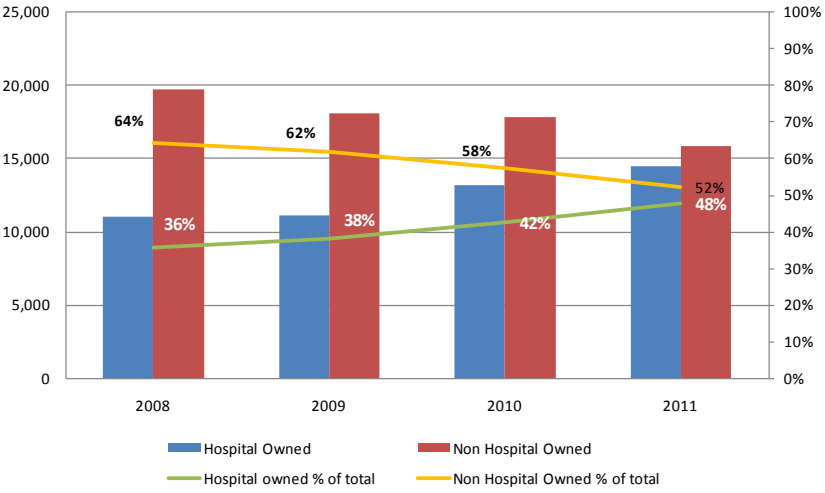
Chart 1: Physician Compensation by Method and Year



Source: Research and analysis by Susan Stowell, Principal, Stroudwater Associates, with data released by Medical Group Management Association. *Physician Compensation and Production Survey: 2011 Report Based on 2010 Data*. MGMA, 2011.

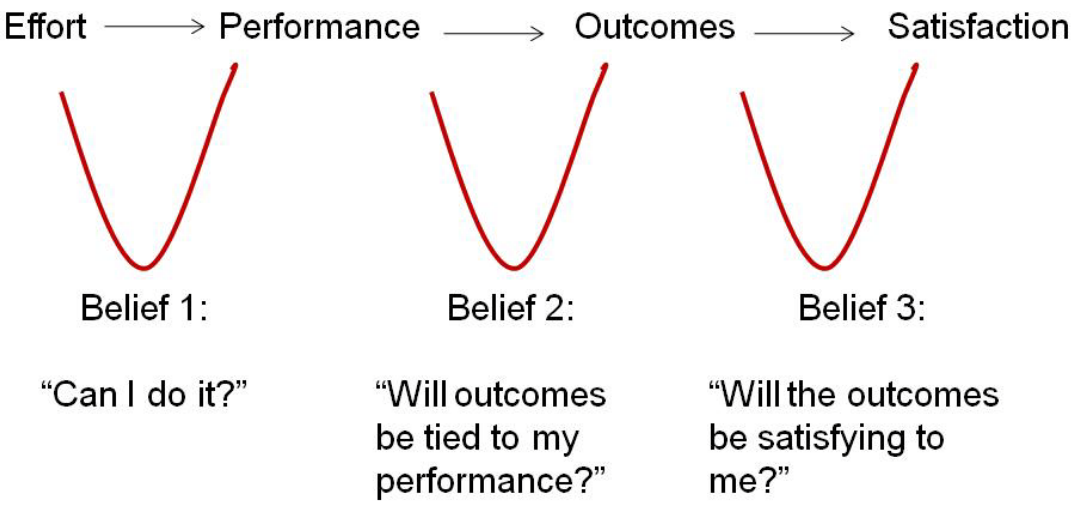
The survey allows respondents to categorize their production less overhead plan into two buckets: 100% or 1-99%. It applies this same differentiation to production-based share of the compensation pool. For purposes of this analysis, the production less overhead categories were grouped together and the production-based share of pool categories were grouped together.

Chart 2: Physician Ownership by Year



Source: Research and analysis by Susan Stowell, Principal, Stroudwater Associates, with data released by Medical Group Management Association. *Physician Compensation and Production Survey: 2011 Report Based on 2010 Data*. MGMA, 2011.

Appendix V: The Belief System



Source: Thad Green, Merwyn Hayes. *The Belief System: the Secret to Motivation and Improved Performance*. Winston-Salem, NC: Beechwood Press, 2003, p.18

Appendix VI: Triple Aim

Don Berwick, the current chief of CMS, has made the pursuit of the Triple Aim a priority under his leadership. These goals include:

1. Better care for individuals, described by the six aims for the health care system described by the Institute of Medicine's 2001 report, Crossing the Quality Chasm: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.
2. Better health for populations, through attacking upstream causes of ill health, such as poor nutrition, physical inactivity, and substance abuse.
3. Reducing per-capita costs.

Achieving these goals will require fundamental, systemic change of the system.

Source: Donald M. Berwick, Thomas W. Nolan and John Whittington. *The Triple Aim: Care, Health, And Cost*. Health Affairs, 27, no. 3 (2008): 759-769. http://content.healthaffairs.org/content/27/3/759.abstract

I. Notes

[1] Initially named the Physician Quality Reporting Initiative; renamed the Physician Quality Reporting System in 2011.
[2] (Centers for Medicare & Medicaid Services 2011)
[3] (Centers for Medicare & Medicaid Services 2011)
[4] (Centers for Medicare & Medicaid Services 2011)
[5] (Centers for Medicare & Medicaid Services 2011)
[6] (HealthReformGPS 2010)
[7] (U.S. Department of Health and Human Services 2011)
[8] (Foster August 2010)
[9] (Nichols 2011)
[10] (Altman 2010)
[11] (Johnson 2006)
[12] (Medical Group Management Association 2011, 318)
[13] (Dictionary Reference 2011)
[14] (Martin 2004)
[15] (Roy, Quote Restriction and Goldbricking in a Machine Shop 1952)
[16] (Martin 2004, 6)
[17] (Martin 2004, 5)
[18] (Brickley 2004)
[19] (Bowles 2009)
[20] (Bowles 2009)
[21] (Green 2003, 6)
[22] (Green 2003, 7)

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