Michael H. Bailit
Megan E. Burns
Mary Beth Dyer

implementing value-based physician compensation

advice from early adopters

Provider organizations exploring ways to alter physician compensation to create incentives for the delivery of value-oriented care can benefit from the insights of peers that have pioneered such efforts.

In our fee-for-service-dominated healthcare system, provider organizations have long used production-based compensation models to distribute funds internally to physicians. This payment approach creates incentives for physicians to focus on increased productivity and patient volume—in essence promoting a "do more" culture. However, with the proliferation of value-based payment (VBP) models across the healthcare system, provider organizations that receive payment under these models face a challenge in reconciling the external financial incentives of VBP models with internal, productivity-driven compensation approaches. Growing numbers of provider organizations are participating in a variety of VBP models that remove the link between payment and volume for at least some portions of revenue, while including monetary incentives for improved "value" as defined by payers.

As provider organizations seek to de-emphasize productivity and align physician compensation with evolving VBP incentives applied by payers, they can benefit from considering the early lessons learned and the metrics and approaches used by organizations that are on the front lines of such efforts. To obtain this information, we interviewed leaders from 20 provider organizations that linked some portion of their physician compensation in 2014 to performance measures other than productivity-based measures.[a]

a. Funding support to conduct this study was provided by the Commonwealth Fund. The provider organizations interviewed may not be representative of all organizations that have implemented innovative compensation models because we used a convenience sample methodology.

AT A GLANCE

Provider organizations that have experience in implementing value-based physician compensation can recommend the following best practices, among others:

- Clearly link changes in physician compensation to the broader strategic and financial objectives of the organization.
- Focus financial incentives on evidence-based measures that physicians find credible and achievable.
- Make sure everyone understands the incentive measures and compensation formulas before implementing changes.
- Provide complete data transparency for all aspects of performance.

Interviewed organizations ranged in number of employed physicians from 50 to 4,000 and in type of organization from health systems to community-based provider organizations to small, private physician groups. Many also had an established network of contracted physicians. During the interviews, we confirmed that these organizations—especially those in markets with higher use of VBP models (e.g., California, Massachusetts, and Minnesota)—are shifting their physician compensation models away from pure productivity measures to more closely align them with payments for reducing costs and improving care outcomes. Here, we present key findings and recommendations derived from these interviews.

The Motivation for Value-Oriented Compensation

We assumed that provider organizations would be motivated to align physician compensation with risk-based and other VBP contracts, now and over time, to ensure that individual providers' performance incentives would align with the external payment incentives. Although this assumption proved correct with respect to the organizations we interviewed, we found that changing compensation models to emphasize performance other than volume often was part of a broader strategy, vision, and viability plan.

Provider organizations in more developed markets were motivated by contractual performance requirements related to specific patient satisfaction or other measures. In contrast, organizations operating in markets with lower utilization of VBP felt the need to start making compensation changes early in anticipation of future payment model changes. Some organizations wanted to be ready to respond quickly to new VBP activity by payers and other purchasers, while others wanted to spur payers and purchasers to participate with them in VBP models.

Percentage of Compensation Tied to Value

Although there was consensus among the organizations interviewed that physician compensation should be more value-oriented, there was no clear consensus as to what percentage of compensation should be tied to value.

Some believed that as little as 2 percent of compensation would be sufficient, noting that many physicians can be motivated by small financial incentives. "Trivially small incentives can be effective if the change is consistent with the world view of the clinicians and their ethics," a leader at one organization said.

Other organizations suggested that at least 20 percent of physician compensation, and preferably more, must be linked to value-oriented performance to promote significant behavior changes and create cost-effective improvements in patient care.

In practice, the percentage of primary care physician compensation that was not paid as salary or based on productivity incentives ranged from 8.5 to 60 percent, with half of the sample at or above 20 percent. Organizations with higher levels of value-oriented compensation were in markets with higher levels of VBP and generally reported a longer duration of experience with value-oriented compensation approaches for employed primary care physicians. Most organizations viewed their value-oriented compensation models as dynamic, and some cautioned against allowing revenue-generating metrics for physicians to get too far out of sync with revenue-generating metrics for the system. For example, if physicians are paid on volume, and the system is managing to a budget, fee-for-service revenue generated by individual providers is an expense to the system, potentially causing the system to suffer financially.

EXAMPLES OF PRIMARY CARE PHYSICIAN COMPENSATION MODELS

Variables	Provider Organization No. 1	Provider Organization No. 2	Provider Organization No. 3
Organizational Details			
Type of Provider	Integrated safety-net provider of primary and specialty care	Provider network affiliated with large integrated delivery system	A multispecialty group with two-thirds of revenue from capitation
Employed Physicians	450	500	180
Value-Based Payment (VBP) Models as % of Revenue	45%	80-85%	66%
Compensation Details			
RVU/Productivity*	80% (in the form of RVU-benchmarked salary)	40%	55%
Value-Oriented Performance	20% (based on withholds that must be earned back by the physician)	60%	45%
Value-Oriented Performance Details			
Quality	10%	40%	20%
Patient Satisfaction/Access	10%	10%	
Efficiency		10%	15%
Network Management		N/A	N/A
Citizenship		N/A	5%
Seniority	N/A	N/A	5%
Bonus Opportunity	Yes, based on productivity and system performance on VBP models.	Yes, based on system performance on VBP models. The formula used for bonus distribution reflects primary care physician performance on quality (25%), patient satisfaction (25%), and total cost of care (50%).	Yes, based on medical group performance on VBP models.

* RVU = relative value unit

Performance Measure Domains

Generally, innovative provider organizations linked six different domains of performance measures to compensation in some manner:

> Clinical quality/patient safety
> Patient satisfaction
> Access to care
> Efficiency
> Use of health IT
> Citizenship (e.g., physician engagement through participation in committees or meetings related to the operation or governance of the hospital or medical group)

Within this broad context, however, the actual mix of domains and measures varied substantially among organizations.

Clinical quality, patient safety, and patient satisfaction measures used in primary care physician compensation models often were drawn from standardized benchmarks, including

those reported by Medicare and used in commercial insurer contracts. Conversely, the access to care, efficiency, and citizenship domains often constituted "homegrown" measures.

For example, a few provider organizations adjusted primary care physician compensation based on risk-adjusted panel size. Those organizations viewed the panel size incentive as a means of encouraging and rewarding providers for engaging with patients in alternative ways, such as via email or with advanced practice clinicians.

Examples of Value-Oriented Compensation

The exhibit on page 43 highlights examples of primary care physician compensation models and their components used by three different types of organizations operating in markets with a relatively long history of experimentation with VBP models. These compensation models are complex and involve not only the base payment to physicians but also the potential for bonuses. The organizations using these three compensation approaches have reduced the link between compensation and volume to a greater extent than has any other organization in the interview group.

For the first organization, quality measures used for individual physician compensation mirror those in the organization's risk-based contracts, which are subject to change year-over-year. Primary care physicians have the potential to earn 50 percent of the withheld compensation by performing well on quality measures, and the remaining 50 percent based on a combination of patient experience-of-care measures and measures that are important to managing total medical expenses, such as specific network management protocols for enrolling high-risk patients in a care coordination program.

Of the interviewees, the second organization in the exhibit has the largest percentage of primary care physician base compensation that is not linked to productivity (60 percent). Physicians also receive a bonus—based on the organization's earned shared savings with Medicare and through a commercial payer's alternative payment model—that is distributed based on a formula different from that used to determine base compensation. For primary care physicians, 50 percent of the bonus allocation is based on total-cost-of-care measures that mirror the measures used by health plans. The remaining 50 percent is based equally on patient experience and quality measures.

The third organization shown receives a lump-sum payment from a management services organization (MSO), informed by productivity assumptions, and then divvies up that payment to compensate individual physicians within the group as described in the exhibit. This organization also adjusts compensation to account for unique situations. For example, the organization had lower productivity expectations for a small number of primary care physicians who were involved in a patient-centered medical home program to account for these physicians' temporarily decreased productivity.

Developing New Compensation Models

Although the most innovative organizations used a variety of value-oriented measures and formulas in their physician compensation models, all 20 organizations showed similarities in how they approached redesigning physician compensation. The interviews disclosed that altering the foundation of physician compensation is a time-consuming change management process, often occurring over two to four years. Before altering compensation, a number of organizations tested and adjusted their value-oriented compensation measures during a transition or "shadow" period of six months to a year. Some guaranteed that the targeted physicians would not lose income

in the first year of new compensation arrangements. A few noted that physicians adjusted to the new arrangements more rapidly than anticipated, with the result that total physician compensation at the end of the first payment period was somewhat higher than budgeted.

The Role of Nonfinancial and Intrinsic Motivation

The effects of physician compensation on clinical and cost outcomes are complex and involve many psychological and economic factors. We found strong support in the literature for the idea that many factors motivate behavior and that people react differently to the same set of incentives.[b] And this idea was corroborated in some of our interviews, where we also found differing levels of support for using compensation as the primary lever for motivating higher-value care. Many organizations acknowledge that extrinsic motivation (i.e., external reward), such as that created by compensation models, is not what drives most primary care physicians to practice medicine or to deliver high-quality, efficient care. Rather, many physicians are driven by intrinsic motivation, such as an internal drive and belief system to provide the highest-quality care for patients.

As noted by best-selling author Daniel H. Pink, performance motivation involves more complex human psychological factors such as autonomy, mastery, and purpose.[c] As a result, physicians may perform more effectively in an organization where the culture and leadership foster common values. Pink suggests that, in accordance with motivation theory, extrinsic motivators such as financial incentives can actually backfire and create a decline in performance.

A few of the organizations we interviewed share this viewpoint. These organizations reported the need for a variety of complementary incentives and supports to encourage and enable physicians to improve care delivery, of which alternative compensation approaches are but one example. A nonfinancial technique used by many organizations to influence provider behavior involves giving feedback on performance in the form of peer assessments or peer comparisons or—more generally—in performance assessments. In general, results of our interviews support published findings that the right kind of feedback, performed by the right authority figure, can improve performance.[d]

Advice on Value-Oriented Physician Compensation

Experienced organizations offered the following advice for others seeking to establish or expand value-oriented physician compensation approaches.

Focus initially on compensation of primary care physicians. Most physicians paid under some form of value-oriented arrangements are primary care physicians. Changing the compensation of specialists is more difficult, and therefore is less common, because measures to effectively link payment incentives for specialists to performance are limited and require more substantial data

b. See Harlow, H.F., Harlow, M.K., Meyer, D.R., "Learning Motivated by a Manipulation Drive," *Journal of Experimental Psychology*, April 1950; Nantha, Y.S., "Intrinsic Motivation: How Can It Play a Pivotal Role in Changing Clinician Behavior?" *Journal of Health, Organisation and Management,* March 22, 2013; and Ratanawongsa, N., Howell, E.E., Wright, S.M., "What Motivates Physicians Throughout Their Careers in Medicine?" *Comprehensive Theory*, Winter 2006.

c. Pink, D.H., *Drive: the Surprising Truth About What Motivates Us*, New York: Riverhead Books, 2009.

d. Veloski, J., Boex, J.R., Grasberger, M.J., Evans, A., Wolfson, D.B., "Systematic Review of the Literature on Assessment, Feedback and Physician's Clinical Performance: BEME Guide No 7," *Medical Teacher*, March 2006; Deci, E.L., Koestner, R., Ryan, R.M., "Extrinsic Rewards and Intrinsic Motivation in Education: Reconsidered Once Again," *Review of Educational Research*, Spring 2001; and Balas E.A., Boren, S.A., Brown, G.D., Ewigman, B.G., Mitchell, J.A., Perkoff, G.T., "Effect of Physician Profiling on Utilization," *Journal of General Internal Medicine,* October 1996.

resources than are required to track the performance of primary care physicians. Changing primary care physician compensation not only allows for better alignment of incentives to support overall organizational goals for transforming the delivery system, but also can provide a basis for promoting e-visits and telemedicine and helping physicians improve practice efficiency though better panel management. An important benefit of moving away from payment based on productivity as measured by office visits is that it helps primary care physicians get off the "hamster wheel" of tightly scheduled visits and enables them to play a stronger role in prevention and care coordination.

Clearly link changes in physician compensation to the provider organization's broader strategic and financial objectives. To be successful, organizations require strong clinical leadership and clear communication regarding why changes in physician compensation are necessary. The physicians must be educated on how the changes in their compensation align with the organization's risk-based and other value-oriented contracts, now and over time, and, in turn, with the organization's overall financial performance and strategic objectives. The sheer number of external metrics used in payment arrangements can be an obstacle in promoting such understanding among physicians: The organizations we interviewed reported difficulty in directly aligning measures for individual physician compensation with external incentives, in part due to the multiplicity of external metrics.

Focus financial incentives on evidence-based measures that physicians find credible and achievable. Incentives supported by reliable, timely data at the individual provider level are essential to support desired behavior and system changes. Measures should be limited in number and, where possible, standardized. It is important not to underestimate the challenges of collecting, analyzing, and reporting the required data for physician compensation changes.

Make sure everyone understands the measures and how compensation formulas will be applied before implementing the changes. Time will be required to educate physicians about the data and documentation needed to perform well. To ease anxiety over the potential impact of compensation changes, organizations should implement a preliminary observational or "shadow" period to give the physicians and organizational administrators time to become informed and make modifications before the changes are finalized and put into effect.

Avoid having too much lag time between the measurement period and payment of performance incentives. Research and experience show that the less time that passes before an individual receives an incentive related to the targeted behavior, the more likely the incentive will be to promote behavior change. Ideally, provider organizations should have mechanisms by which value-oriented compensation payments occur within one or two quarters of the time period in which the physician's performance is being measured. The payment should not occur any longer than one year from the performance period being measured.

Provide complete data transparency for all aspects of performance. Even though it can be difficult to do initially, each physician should be provided with regular feedback on his or her performance—in terms of quality, efficiency, productivity, and payment—in an easily accessible format. Monthly electronic reporting is best. It is important not to discount the power of regular, unblinded peer profiling on targeted performance measures and productivity, as a means of motivating performance improvement. Organizations that wish to

move to transparent data can start slowly by sharing data on performance metrics that are most relevant or that present the greatest opportunity for improvement with individual providers and invite feedback and questions. Then, over time, as physicians become comfortable with viewing transparent data, the data are shared across more areas of the organization. Organizations also should consider how to provide feedback and support on performance improvement in the form of peer assessments and advice.

Develop a multiyear approach to test the thresholds of value-oriented compensation needed to achieve desired results. Organizations should develop and refine physician compensation arrangements iteratively with input from administrative and physician leaders to allow for annual or semiannual adjustments. The percentage of compensation linked to the targeted performance should be commensurate with the behavioral and systemic changes being sought—and it should start at no less than 5 percent. Consideration should be given to increasing the percentage of compensation linked to value-oriented measures over time, to acclimate physicians and administrators to the new approach and to increasingly align with the higher levels of value-based payment that the organization anticipates or intends to pursue over time.

The Right Mix

In the words of one physician commentator, "Linking physician compensation to quality is akin to the quest for baby bear's porridge in trying to get it just right."[e] Although opinions differ on the minimum percentage of value-oriented compensation that is needed or desired, there is consensus that provider organizations should not maintain a purely production-based compensation approach in markets where use of alternative payment models is increasing. The need to break the link between primary care physician compensation and pure RVU-based productivity measures to achieve higher overall performance is particularly acute in markets with a higher prevalence of alternative payment models that include downside risk.

The focus on how intrinsic incentives for physicians and provider organizations can contribute to successful payment and delivery system reform appears to be increasing, underscoring the need for provider organizations to adopt a variety of nonfinancial incentives and supports to promote improved care delivery among physicians. Balancing extrinsic and intrinsic motivational strategies for physicians and other staff should be a point of increasing emphasis in workforce performance improvement strategies. ■

e. Ogrod, E. S., "Perspective: Compensation and Quality: A Physician's View," *Health Affairs, May/June* 1997.

About the authors

Michael H. Bailit, MBA,
is president, Bailit Health, Needham, Mass. (mbailit@bailit-health.com).

Megan E. Burns, MPP,
is a senior consultant, Bailit Health, Needham, Mass. (mburns@bailit-health.com).

Mary Beth Dyer, MPP,
is a senior consultant, Bailit Health, Needham, Mass. (mbdyer@bailit-health.com).