Exploring Alternative Approaches to Valuing Physician Services

A report by staff from the University of Minnesota, Division of Health Policy and Management for the Medicare Payment Advisory Commission

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Executive Summary

Under Medicare's physician fee schedule payment system, payment rates are based on relative weights, called relative value units (RVUs). A variety of concerns have been expressed about this approach to setting physician fees. Given these concerns, and a health care reform environment that is encouraging new approaches to reimbursement, it is appropriate to re-examine private sector approaches to physician payment, and especially changes in those approaches, to help inform the Medicare Payment Advisory Commission's work in evaluating and improving Medicare's physician payment approach. The Commission contracted with the University of Minnesota to collect information regarding how physician compensation is set within provider organizations, and how health plans pay provider organizations for physician services, with special emphasis on innovative payment arrangements. A second objective was to assess the impact of market factors on physician payment arrangements.

Researchers conducted interviews with representatives of provider organizations nationwide to address the first objective. Regarding the second objective, they conducted interviews with representatives of health plan and provider organizations in the Twin Cities, where significant experimentation with new payment arrangements between health plans and provider organizations is taking place. Because the organizations in this study were not randomly selected, the payment methodologies and approaches described in this report do not necessarily reflect the relative prevalence of similar approaches across the United States. Researchers also interviewed officials from the Veterans Health Administration regarding how VHA compensates physicians (described in Appendix B).

In general, relatively little variation was found across provider organizations in the way they compensated physicians. The interviews also suggested that innovative payment arrangements between health plans and provider organizations were being discussed in many markets, and that experiments were underway in a subset of markets. However, market-wide transformation in payment arrangements between health plans and provider organizations is not yet occurring, with very few exceptions. One exception is the Twin Cities market, where all health plans have changed the way they purchase physician services in their contracts with large integrated delivery systems (IDSs), moving from traditional fee-for-service to "gain sharing" models. While the Twin Cities market appears to be unusual, the experimentation with new payment arrangements between plans and provider organizations across the country suggests that innovation can occur in a variety of settings, although it may develop at different speeds depending on market history and structure.

Findings from National Interviews

- The internal physician compensation approach used by provider organizations is based on productivity, as measured by work RVUs, combined with a target salary level established to reflect community norms, as determined through surveys.

- Most provider organizations do not connect use of ancillary services to physician compensation because this could create compensation inequities among physicians in different specialties.

- The dominant method used by health plans to pay provider organizations for physician services is fee-for-service.

- Provider organizations generally favor productivity-based physician compensation at present because it aligns well with the fee-for-service payment arrangements used by most health plans, as both reward volume of services provided.

- Within the same Integrated Delivery System (IDS) there can be a variety of different physician compensation approaches, including schemes that involve explicit cross-subsidies of physician incomes in different specialties. Some of this variation reflects historical arrangements, for example compensation arrangements that existed when medical groups were acquired by IDSs.

- Basing some part of compensation on quality-based metrics was common among medical groups and IDSs interviewed. However, the share of compensation based on physician performance on quality metrics was a relatively small proportion of total physician compensation within most provider organizations (less than 10%). Even so, some organizational leaders were opposed philosophically to tying compensation to individual physician performance on these metrics, while others did not believe rewards of this nature are an effective way to improve physician performance.

- At present, physician compensation in IDSs generally is not linked in a direct way to health plan payments, however, there are exceptions. For example, pure productivity approaches used in some medical groups do pass through changes in fees in health plan contracts directly to physician incomes.

- There is a wide range of small scale payment experiments between health plans and provider organizations underway or being planned. The motivation for these experiments is either stakeholder dissatisfaction with the behavioral incentives in fee for service payments or a desire on the part of provider organizations to gain experience in preparation for ACO arrangements that are expected to develop under health reform.

Findings from Twin Cities Interviews

- In the Twin Cities, the focus of the market analysis in this report, productivity-based payment is the dominant method of physician compensation within provider organizations, consistent with findings from the national interviews.

- All health plans and most IDSs in the Twin Cities are involved in shared savings arrangements; IDSs share in savings if expenditures are below negotiated targets and quality targets are met. One IDS reported that it receives the majority of its private sector revenues through shared savings arrangements.

- Negotiation of shared savings arrangements requires that plans and provider organizations share data openly and, given the present state of knowledge, be willing to adjust contractual provisions based on new information and to experiment with different models for attributing patients to providers.

- Market factors contributing to the widespread adoption of shared savings arrangements in the Twin Cities include a history of collaboration in quality improvement and measurement, the longstanding use of pay-for-performance incentives in contracts between plans and provider organizations, the presence of large IDSs that have the financial resources to engage in risk contracts, encouragement and support from the public sector, and an organized employer group.

- At this stage in their development, shared savings arrangements are supported by IDSs and health plans in the Twin Cities because of their potential community benefits, rather than as a possible source of competitive advantage for health plans or provider systems.

Exploring Alternative Approaches to Valuing Physician Services

Under Medicare's physician fee schedule payment system, payment rates are based on relative value units (RVUs), which account for the relative costliness of inputs used to provide physician services: physician work, practice expenses, and professional liability insurance (PLI) expenses. The RVUs for physician work are designed to reflect the relative levels of time, effort, and skill associated with providing each service. The RVUs for practice expense are based on the expenses physicians incur when they rent office space, buy supplies and equipment, and hire non-physician clinical and administrative staff.

Recently, concerns have been raised about how the Medicare physician fee schedule values physician work and practice expenses. Specifically, does it appropriately account for the value of different services relative to clinical outcomes? And, has it become too costly and complex for CMS to administer appropriately? Given these concerns, the Medicare Payment Advisory Commission (MedPAC) contracted with us to re-examine private sector approaches to physician compensation within provider organizations and the purchase of physician services by health plans. Based on stakeholder interviews, the report presents a snapshot of physician compensation methodologies and health plan payment approaches at a point in time, with a special focus on new, more innovative approaches to physician compensation and/or payment for physician services.

Project and Methods

As part of our interviews with these stakeholders, we asked about market factors and market opportunities that had affected their decisions regarding physician compensation and about contractual relationships between provider organizations and health plans. The knowledge and understanding of most respondents concerning market influences on physician compensation methods or contractual relationships being pursued by other community organizations was quite limited. Therefore, rather than assess the influence of market factors on the strategies pursued by each of these individual organizations, we selected one market to study in depth, where the influence of market factors did seem to be important -- the

Minneapolis-St. Paul area. Thus, the report is organized according to a "national sample" and a "market sample" of respondents.

Throughout the text, we use the generic term "provider organization" to refer to physician groups and health care delivery systems, and "health plans" to refer to private sector purchasing organizations that contract with provider organizations to purchase physician services. We conducted a total of 24 semi-structured individual or small group telephone interviews with 34 leaders of provider organizations and health plans between October 2010 and February 2011. Fifteen provider organizations, within which three health plans were included, were selected from across the United States; the remaining nine (provider organizations, health plans, and state agency) were chosen from the Twin Cities market. Additionally, we conducted three interviews with leaders from the Veterans Health Administration (VHA).

Across the combined national and market samples, respondents were drawn from multispecialty physician groups (n= 3), single specialty physician groups (n= 2), integrated health systems that include a health plan (n= 4), integrated health systems with no health plan (n= 11), health plans (n= 3), and a state agency (n= 1). Geographically, the 15 provider organizations included in the national sample were drawn from the following regions: East (n= 1), Midwest (n= 7), South (n= 3), and West (n= 4). Respondents (national and market) included organization executives holding positions of chief executive officer or equivalent title (n= 13), vice president (n= 8), chief medical officer (n= 4), chief financial officer (n= 2), chief human resource officer (n=1), director (n= 4), and other positions (n= 2).

Selection of provider organizations and interview respondents was informed by industry intelligence on physician compensation methodologies and contractual relationships between provider organizations and health plans, as well as key informant recommendations. Provider organizations in the national sample also were selected to maximize geographic representation (see Table 1 for a description of organizational participants in the study). MedPAC participated in the selection of provider organizations and in the selection of the Minneapolis-St. Paul area for intensive examination. Because the provider organizations in this study were not randomly selected, the physician compensation and health plan payment methodologies and approaches

described in this report do not necessarily reflect the relative prevalence of similar approaches across the United States.

The interview protocol (Appendix A) was developed in collaboration with MedPAC. A written consent form was distributed prior to each scheduled interview and reviewed verbally at the start of each interview; interviewees were assured that information provided would not identify them individually or organizationally. The interviews were generally 60 minutes in duration and were digitally audio-recorded and transcribed for analysis purposes. Respondents were given an opportunity to review and comment on the transcript produced from their respective interview to assure accuracy of the information provided. The study design, protocols, and consent form were approved by the University of Minnesota Institutional Review Board.

The report begins with a brief discussion of the current environment in the private sector regarding physician compensation approaches and contractual arrangements between health plans and provider organizations. The next section presents information collected from the "national sample," of provider organizations, followed by a section that summarizes responses from the "market sample" of respondents drawn from the Twin Cities area. Tables summarizing interview responses for each section are found at the end of the report, and quotes from interview respondents are embedded in the text of the report as appropriate to illustrate critical points made by more than one interviewee. A description of the Veterans Health Administration method for physician compensation is included in Appendix B, and appears with permission from the VHA.

Background

At the same time that physician fee setting by CMS is coming under increased scrutiny, provider organizations are exploring new methods for compensating physicians, and health plans and provider organizations are experimenting with new contractual approaches for purchasing physician services. With respect to compensating physicians, it is becoming increasingly common for provider organizations to use "blended" approaches in which base or target salaries (however determined) are augmented or modified by "incentive payments" for

physician performance on a variety of metrics related to quality and efficiency (Conrad and Christianson, 2004; Christianson, Leatherman, and Sutherland, 2008). The funds for these incentive payments may be so-called "new money" made available by payers to encourage performance improvement, or it may consist of some designated percentage of "organizational revenues" dispersed to high performing physicians or clinics according to predetermined rules.

With regard to provider organization/health plan contracts, while fee-for-service remains the dominant mode of payment, experimental arrangements involving "bundled" payments, sometimes called "episode based" payments, are being negotiated or piloted (Averill et al., 2010; Rosenthal, 208; Berenson and Rich, 2010; Mechanic and Altman, 2009; Goldsmith, 2010; Bach et al., 2011). Under these approaches, the "fee" for physician services encompasses a range of services deemed necessary, by evidence-based standards, to care for a patient's specific condition over a designated time period. The physician or physician practice assumes some risk that the care delivered to any particular patient could exceed the predetermined payment for the expected bundle of needed services.

More recently, spurred in part by dissatisfaction with existing arrangements and by the prospect of Accountable Care Organizations (ACOs) under health reform (Kertesz, 2010; Shortell, Casalino, and Fisher, 2010), "global" payment approaches are emerging in negotiations between health plans and provider organizations (Goldsmith, 2011; Chernew et al., 2011). The care provided under a global payment arrangement includes physician services, but the payer ordinarily would not reimburse physicians directly for this care. Instead, physicians would be reimbursed under contract with provider organizations, either as direct employees or as members of a closely-affiliated physician practice. Typically, global payment approaches contain an element of "gain-sharing" in which the payer and the health care organization share in any cost savings according to a predetermined formula. Overall, the traditional model of "physician as independent entrepreneur" is becoming less common, while the model of "physician as employee" of a provider organization is growing in importance, so that incentives in health plan contracts intended to influence the behavior of physicians are increasingly being "filtered" through an organizational compensation scheme.

In the national sample of provider organizations, we asked about internal approaches to physician compensation to provide perspective on this filtering process. We also asked respondents to describe innovative or "pilot" payment approaches in order to provide guidance to Medicare regarding possible changes in payment arrangements between health plans and provider organizations, and how the effect of these changes could vary by the structure and consolidation of provider organizations. We followed the same general approach in our market interviews, but placed greater emphasis on understanding shared savings arrangements and the motivation of provider organizations and health plans in pursuing such arrangements.

National Sample of Provider Organizations

In this section, we organize general findings from the interviews with the national sample of provider organizations around three topics: approaches to physician compensation within provider organizations; contractual arrangements between health plans and provider organizations for the purchase of physician services; and the presence of experimental, or innovative, payment arrangements between health plans and provider organizations.

Physician Compensation Arrangements within Provider Organizations

In Tables 2 and 3, we summarize the different approaches used by provider organizations in our national sample to determine physician compensation. As these data indicate the physician compensation strategies of single specialty groups and free-standing, multi-specialty groups differ somewhat, but not dramatically, from the strategies of IDSs.

Single- and Multi-Specialty Physician Groups

Physician compensation in single- and multi-specialty groups reflects some measure of productivity (usually work RVUs), with compensation targets typically determined as a percent of median compensation reported by the Medical Group Management Association or other external source. New physician members of a group are the exception; for a limited time (e.g. two years) they are paid solely based on a salary negotiated at the time they are hired. This allows new physicians to "get up to speed" with respect to RVU production.

Different groups specify different "levels" of physicians for the purpose of determining physician compensation. At one extreme, one multi-specialty group has only two levels:

associate and partner. In this group, partners are paid on a full productivity basis, with compensation based on the past six months of performance, while associates receive a "market-based" salary with a productivity "bonus." (The "market-based" portion reflects specialty and years in practice). The interview respondent from this group characterized the situation as, "Every individual partner has their own profit and loss statement if you will" that includes patient services revenue and credits for other income, called "outside income" (e.g. medical director stipends). Compensation is not necessarily tied to measures of quality or patient satisfaction. If it is, the percentage of compensation determined in this way is small (e.g. two percent or less of total physician compensation).

> *About five years ago we started to do internal pay-for-performance measures …We decided to take a portion of the dollars from the pooled area of our compensation and apply those to several measures (process and clinical outcomes) that could be individually applied, and then that compensation amount would be given to the individuals if they met those goals. [The proportion is] somewhere in the range of about two percent.*

In this group, patient services revenue for specialists also incorporated profits from ancillary services, which were allocated back to the specialists. However, the treatment of ancillary revenues in this way creates some complications in determining compensation, as not all specialists have the same opportunities for generating these revenues. Other sources of funds (e.g. profits from capitated contracts) can be used to address inequities that might occur in this regard. Also, physicians who have reached their target compensation levels for a given time period, with a substantial portion of that compensation resulting from ancillary services, have little incentive to see more patients; that is, in the words of one respondent, to create the "traffic" that generates more revenue for the practice as a whole. Because of these kinds of complications, most physician groups in our sample did not tie physician compensation to ancillary revenues.

> *The challenge going forward is because many of our physicians have reached their lifestyle compensation numbers and 40 percent of their compensation is made up by ancillary services…some of them aren't producing the work RVUs that they should, and*

so in our opinion there is a lot of capacity on the work side which would further drive all of the other side that we're not getting from many of our physicians, because of the ancillary effect.

Overall, respondents noted that some form of productivity-based compensation using work RVUs serves single specialty and multi-specialty groups well in the current marketplace (even though it continually needs "tweaking," according to one respondent) where fee for service is the dominant approach used by health plans to purchase physician services. In "pure" productivity compensation approaches, such as the one described above, an individual physician's compensation is tied quite closely to fee schedules negotiated between provider organizations and health plans. If a group is able to negotiate higher fees in a particular specialty area, this leads directly to higher revenues generated by those specialists and consequently improved "profit-loss" statements for them as individuals. However, it should be noted that the percentage of compensation tied directly to productivity can vary. A different group reported that physician compensation consisted of 70 percent "shared compensation" and 25-30 percent based on the physician's own productivity. In this case, individual physician compensation would be tied less closely to negotiated fee schedules.

Integrated Delivery Systems

Integrated Delivery Systems (IDSs) often have multiple different types of relationships with affiliated physicians, ("We have five different methodologies that we currently use."), typically reflecting the compensation strategies used by physician practices before they were acquired by, or merged with, the IDS. As with physician groups, base salaries for IDS physicians are set to be competitive in the market and, for some specialties, the relevant market is believed to be the United States.

Our comp system, which is primarily individual performance-based; its framework is the marketplace…We like to be somewhere in the 65th, 70th percentile in terms of comp for our physicians. And then we look at conversion factors per RVU, and pay a segment of compensation as productivity based on conversion factor times RVU…We actually set salaries and they are in place for a year.

Information used for this purpose is gleaned from various proprietary market surveys. An IDS might set base salaries, for instance, to reflect median work RVUs for a specialty, with a conversion factor used to generate a competitive market level compensation amount.

> *We start with a principle which is market competitive compensation for market competitive work. So we use a number of surveys…a number of those types of surveys where we look at RVUs, so we use an RVU-based compensation system, and we look at kind of what the median compensation is for the median RVU…Obviously, if we're having difficult times recruiting, we may increase the RVU rate compared to what the median would say…but the idea is ultimately to get within that median range for median productivity.*

In a different example, an IDS bases 94 percent of a physician's compensation on an RVU-related productivity measure ("we use work RVUs as the indicator for productivity"), while in another IDS, 80 percent of an individual physician's compensation is tied to productivity, with the remainder linked to other incentives. In these two organizations, as in most other IDSs in our study, compensation is not affected by ancillary billings.

> *They do not (receive compensation for ancillaries) and that was a big change for the group that we brought in…and interestingly and somewhat sadly to me the number of ancillaries ordered dropped off pretty dramatically. But, no, you don't get ghost RVUs or credits. Actually they had a system, they had a very elaborate thing that Byzantine Empire administrators would have admired, the system that they had for any credits to our physicians for things like lab and imaging, but we actually did away with all of that.*

A third IDS reported setting specialty-specific salary scales based on market benchmarks, with each physician practice that is part of the IDS required to generate enough revenue to cover practice expenses. Any additional revenues are allocated to physicians using work RVU-related productivity measures. In specialties where physicians within the IDS have less control over the volume of the patients they see, the IDS may supplement their compensation beyond the revenues they generate.

IDSs in our study either did not include performance on quality-related metrics in their general physician compensation formulas (although some had done so in the past), or they

attached a very small weight to them. Some IDS respondents believed that tying physician compensation to quality metrics was not wise;

> *We have quality expectations which continue to grow in the importance they play, but they are not part of the compensation formula. They are part of the employment agreement…It is expected that you meet whatever quality criteria that we've laid out. We don't pay you for doing good quality, we expect you to do good quality care and if you don't, we have a number of conversations with you and then, if it doesn't work out, then you are invited to go look for work elsewhere.*

This group had experimented with using quality metrics in determining compensation but, based on this experience, decided that using the compensation system as a "management tool" was not a particularly effective way to modify behavior.

> *We were using compensation to manage people and that I don't think is where we want to be. The compensation system shouldn't be a management tool. It should reinforce some of the behavior you want, but it's not a management tool, and I think a lot of smaller groups and some big groups may use it as a tool, but we've grown in terms of our sophistication in regards to physician leadership, so our docs who are section chairs or division chairs are very skilled now in having those kinds of difficult conversations with physicians and so instead of using comp to modify behavior, we have conversations and we explain where we need to be.*

Health Plan Payments for Physician Services

Individual physician compensation within physician groups and IDSs generally is insulated from health plan payments for physician services, except in the cases noted above; that is, when physicians within practices operate as "mini-firms." More commonly, for physicians working within provider organizations, the organizations negotiate with health plans to determine the structure (fee-for-service, performance payments, and risk distribution) and amount of reimbursement for the services delivered by their employed or closely affiliated physicians. Currently, fee-for-service typically is the basis for health plan payments to provider organizations for physician services. As noted above, physicians employed by organizations are paid a salary, with the salary level determined primarily by market incomes for similar

physicians and also, in part, by their work RVU products, but typically not by the fee per unit of service negotiated with health plans or performance-based payments for meeting quality or service benchmarks received by the provider organization. Indirectly, of course, if the sum of revenues generated under these negotiated contracts is not sufficient to cover practice costs over time, physician salaries may be reduced; reductions also might be triggered if physician work effort, in aggregate, falls below expectations built into organizational budgets.

Within this context, provider organizations noted that the fee-for-service payment system that is favored (in their view) by health plans does have a significant impact on their organizational decisions about how to structure internal physician compensation arrangements. Specifically, one IDS respondent argued that the use of fee-for-service methodologies to purchase physician services essentially forces the organization to base physician compensation at least in part on measures of productivity in order to align incentives:

> *What I would really like to do is move to payment for outcomes, but none of the payers are willing to do that right now. I think…we're going to have to work through it for them to get comfortable and willing to try new things that don't reward volume of services.*

A multispecialty group practice respondent expressed a similar view: "Insurance plans in the marketplace are paying benchmarked to the Medicare fee schedule…If the market shifts to more risk sharing or incentive payments, the organization's compensation model would need to be changed to fit it."

Although many organizations use Medicare's work RVUs as a major component in their compensation schemes, they recognize the limitations of RVUs. An IDS respondent expressed the opinion that Medicare's "RVU system has some problems with undervaluing targeted services (e.g. primary care) and overpaying for certain procedures…Specialists still make much more than primary care providers" and "there is a lot more work to be done there if we're really serious about paying people in some sort of equitable fashion." Given these reservations, several respondents expressed the hope that Medicare will break out of its traditional fee-for-service payment system. For example, one respondent observed that "Assuming that a significant part of the payer community, and it's got to be the government payers, plus commercial, get into it [shared risk payment], it's going to change this market."

Experiments in Restructuring Purchase of Physician Services

In our national sample interviews, we learned of a number of collaborative efforts between health plans and provider organizations designed to test models for reforming and restructuring the way in which payment for physician services occurs (Table 4). In fact, most provider organization respondents were able to identify one or more efforts of this type, some of which have been in existence for several years. However, other efforts to restructure payment arrangements were still in the discussion phase at the time of our interviews, or were just beginning to be implemented. There appeared to be two different motivations for these efforts. First, health plans, provider organizations, or both, saw a need to escape the treadmill created by fee-for-service reimbursement. All parties recognized that this payment method encouraged more and more service utilization, without rewarding value, and that it discouraged provider organizations from implementing new treatment approaches that could benefit patients and reduce costs, but would at the same time penalize providers by reducing revenues.

> *I mean, today it's all about productivity. There's no incentive for physicians to necessarily do what's right for the patient. By not doing things they don't get paid. So when you're in a pure productivity model, your income is dependent on you doing things, not necessarily doing them well. If we move, in fact, toward a more value-based purchasing system of reimbursement, we need to get our physicians to start thinking that way. So by introducing elements of performance as part of their total compensation opportunity we are trying to refocus their attention on it's not all about quantity, quality does matter…The impetus is to try to position ourselves for the future.*

The second motivation clearly was health reform. There was a perception among respondents that a major goal articulated in health reform discussions--bending the cost curve, while at the same time enhancing quality --- would require new physician payment arrangements. The Accountable Care Organizations (ACOs) proposed under health reform, although their structure and operations were not yet clear in the minds of respondents, were seen as likely vehicles for testing new physician payment relationships involving Medicare and provider organizations (Table 5). Respondents believed that health plans would follow (if not

lead) this effort, and that it is to the provider organization's advantage to get "out front" by collaborating with plans in pilot projects. As one respondent said, "We're looking at it that way (ACO)… It's the first mover advantage. You can't just do this in six months and go from 'more is better' to thinking about how do we manage a population and how do we focus on value."

Some provider organizations view the experience they gained with past payment arrangements in contracts with managed care organizations as preparing them for adapting to new payment arrangements under health reform. In fact, one multi-specialty group has an existing global risk contract with a health plan that it believes has positioned it to be an effective ACO, in whatever form ACOs take. More often, provider organizations reported small scale, more recent efforts to gain experience with new payment arrangements. For instance, one single-specialty group reported working with a primary care physician group that had negotiated an "ACO arrangement" with a health plan, while a multi-specialty group said that it had negotiated a capitated contract with a health plan to provide professional services to its members. An IDS respondent described an ACO pilot program which was viewed by the organization as helping it in "…developing actual capabilities to provide seamless, coordinated care" and managing complex patients needing both primary and specialty care. This respondent viewed the organization's experience as positive to date, but doubted that the pilot will be expanded, or even be sustained, unless payment methodologies can be developed to support it more effectively. Another IDS respondent reported being in discussions with a health plan to "…develop an ACO-type contract based on shared savings for total cost of care."

In summary, our national sample interviews suggested that, for the most part, provider organizations (and the health plans that reimburse them for physician services) are involved at some level (planning, pilot, or full contract) in innovative payment arrangements that involve global or bundled payments for services (for example, a payment for all services for a total hip replacement including the physician component) and/or sharing of cost savings. However, these arrangements typically were not fully developed, nor did they appear to be ubiquitous in the communities where the organizations were located. For a small number of provider organizations in the national sample, there reportedly was a lack of internal consensus regarding the need to change. These organizations had a "wait and see" attitude regarding the

direction that health reform will take with respect to implementation of ACOs and support for pay-for-performance reimbursement schemes.

The Twin Cities Market

In conducting our interviews with provider organizations throughout the United States, we concluded that experimentation in new payment arrangements between provider organizations and health plans was common, but that these arrangements were small in scale and reflected primarily a desire on the part of provider organizations to gain experience in anticipation of possible future changes in Medicare policy. We identified one market where multiple stakeholders seemed to be engaged in physician payment innovation that was progressing beyond the experimental stage and where market factors were cited as playing an important role—Minneapolis-St. Paul, Minnesota (the "Twin Cities"). Because we conducted a relatively limited number of interviews with respondents in different communities, we cannot say that the Twin Cities is the only community where widespread innovation is underway. In fact, a systematic search across all metropolitan areas could uncover communitywide innovation in other markets as well.

To gather information about new payment arrangements between health plans and provider organizations in the Twin Cities, and the impact of market factors, we interviewed respondents from five IDSs, three health plans, and a Minnesota state government agency. We organize our discussion around five topics: market background; physician compensation approaches; changes in contractual arrangements between health plans and provider organizations; critical factors in implementing changes; and early results.

Market Background

The Twin Cities has a history of innovation, collaboration, and public sector and employer activism in health care. In the 1950's one of the nation's first consumer-owned health plans was established in the Twin Cities, followed by the first multi-hospital system in America. In 1991, a coalition of large employers (the Buyers Health Care Action Group, BHCAG) contracted with a large health plan and two multi-specialty clinics to provide a health care option tailored to their employees. This contract gave birth to the Institute for Clinical Systems

Integration (ICSI), which exists today under funding from local health plans. ICSI products include clinical guidelines and care improvement collaboratives that involve virtually all physician groups in the community. One respondent noted that, at least in part as a result of their experience with ICSI, health care organizations (providers and health plans) have a history of collaboration, rather than competition, in the area of quality improvement. At about the same time as ICSI's creation, the state legislature passed a health reform bill that supported and encouraged the development of Integrated Service Networks, envisioning that a limited number of these networks (consisting of physicians, hospitals, and a health plan function) would compete to provide services across the state. Most components of this legislation were subsequently repealed but, in combination with BHCAG's initiative, the legislation is believed to have been a major factor that contributed to a subsequent spate of mergers among providers, and between provider organizations and health plans. The Twin Cities market became even more consolidated than previously, and remains so today.

Later in the 1990's BHCAG established a different initiative built around direct contracting with provider organizations. Under this initiative, measures of costs and quality were published at provider organization level, and consumers were given incentives to choose organizations providing lower cost, higher quality care. (The control of this initiative was passed to a local health plan in 2000.) Shortly thereafter, the Minnesota Medical Foundation and local health plans formed Minnesota Community Measurement (MNCM) to track and publicly report quality measures for outpatient care (e.g. care for diabetes patients), first at the medical group level and currently at the physician clinic level. MNCM's leadership draws from provider organizations, health plans and a variety of other stakeholders, and the development of its measures is a collaborative activity. The number and types of MNCM's publicly reported performance measures have grown over time.

BHCAG now bases its participation in the national, employer-based "Bridges to Excellence" quality rewards program on MNCM performance measures, and all community health plans include the same MNCM measures in their physician pay-for-performance programs. Recent Minnesota state health reform legislation (2008) effectively institutionalized MNCM's role in collecting and reporting a single set of performance measures used by all

payers. The legislation also raised the issue of payment reform by convening provider organization and health plan representatives to explore the potential for pricing episode-based "bundles" of health care for some types of patients.

At present, there are three major commercial health plans in the Twin Cities, all with comparable enrollment. One of these plans also owns hospitals and a large medical group. The delivery side of the health care system is dominated by five IDSs that combine inpatient and outpatient facilities. These IDSs have different relationships with affiliated physicians, but the proportion of community physicians employed by Twin Cities' IDSs has grown substantially over the past five years. In addition, there are several large, single specialty groups that remain independent from the IDSs and enjoy dominant positions in their service markets.

In summary, the Twin Cities health care market has a history of horizontal and vertical consolidation that has resulted in large IDSs playing a major role in health care organization and delivery. The actions of the private sector payers and the state government have contributed to shaping this market at various points over the last two decades. There is a twenty year tradition of collaboration among stakeholders in quality improvement and quality measurement and reporting, and (more recently) among payers in harmonizing their pay for performance programs.

Physician Compensation Approaches

Physician compensation arrangements in Twin Cities' IDSs are quite similar to the arrangements in other parts of the country (see discussion above) in that they are based primarily on productivity (Tables 6 and 7). Two IDS respondents reported that about 94 percent of physician compensation reflected RVU based productivity: "…over the last three years we've had a three percent incentive for meeting access goals; and then about three percent for various educational activities. So for the most part, it's about 94 percent RVU-based work and six percent other." The IDSs use market surveys and internally-designed conversion rates to transform work RVUs into dollar amounts.

We looked at a bunch of the different survey tools and survey companies and we used primarily MGMA numbers in setting a work RVU-based compensation model. We do

have approximately 6% of that is then added on top, related at 5% quality, currently 1% to patient experience.

The rest of the payment is based on performance with respect to meeting various organizational goals. Each organization has overall physician compensation targets that are related to local and national compensation levels (e.g. market median, top of the market average, etc.), and these vary by specialty. A third IDS respondent stated that 5-10 percent of its physician compensation was based on meeting quality and other targets, while a respondent from a fourth IDS said the organization intended to increase the proportion of compensation related to quality and other measures to 30 percent.

We have set the goal that 30% of physician compensation will be based on patient satisfaction, quality outcomes and total cost of care. So that's a goal that we have set internally and one that we – and we're moving quickly towards that…

Similar to findings in the national sample of provider organizations, two primary sources of dissatisfaction with current productivity-based compensation schemes were mentioned. One concern was that a compensation strategy consisting of pay-for-performance payments layered on top of productivity-based compensation would not bring about needed system change. As one respondent noted, "The RVU system does not allow care organizations to focus on reducing total cost of care and keeping people out of the hospital." Also, finding the right balance between productivity incentives and patient outcome incentives in compensation schemes has been difficult, according to some respondents. Second, respondents did not believe that productivity-based physician compensation aligned physician incentives sufficiently with the type of payer/provider payment arrangements expected under health reform. "I think that providers will respond better and be able to improve more quickly when there is alignment across payers – whether that's health plans or government payers." However, one provider organization respondent reported that providers already were becoming more receptive to changes in compensation approaches.

I would say that the provider community in Minnesota, I think, is stepping up to the plate and embracing a future that is focused on outcomes and less focused on production – a production-based model. You know, sometimes we think about it as the providers'

economic model has been more revenue-based, so driving more services; and I think that there is a realization that that is not sustainable.

To this point, however, there has been relatively little change in physician compensation arrangements within provider organizations in response to these concerns. As one respondent observed, "Work RVUs are the least bad option we have available right now" to pay physicians. Rather than attempting wholesale changes to physician compensation within their organizations at this time, Twin Cities' IDSs are looking outward, devoting their efforts to restructuring payments in their contractual relations with health plans.

Changes in Health Plan and Provider Contractual Arrangements

As a percentage of dollars spent, the predominant method of reimbursements from health plans to provider organizations in the Twin Cities is fee-for-service. However, widespread experimentation with risk sharing contracts is occurring. At present, all health plans in the Twin Cities have negotiated various forms of "shared savings" contracts with almost all IDSs as well as some independent physician groups (Table 8). One IDS respondent said that the organization was currently participating in "total cost of care" contracts with all three major health plans in the Twin Cities. These contracts vary in detail, but usually focus on a calculated annual expected "total cost" of providing care for a set of patients attributed to the provider organization, based on historical patterns of patient use of services and cost in that population. Provider organizations receive a negotiated fee-for-service reimbursement for care provision throughout the year (often at a discount from the organization's previous fee-for-service rate). If at the end of the year the provider undercuts the expected total cost of care for its attributed patient population, any cost savings are shared between the health plan and provider organization at a pre-determined contractual rate. Another respondent noted that a different IDS has "…worked with all the commercial payers to be paid on a shared-savings method, which also includes a payment for clinical outcomes." The various shared savings contracts are quite similar in structure, but their details vary to accommodate provider concerns and capabilities.

We were working with the health plans and the payers to say, "Rather than paying us based on a discounted fee for service, could we begin to think about a new methodology where you would compensate us for the value we create? So, if you could continue to

pay us a discounted fee for service rate, because that is the system, but we'll take less of an increase in that discounted fee for service rate and let's put the difference into a pool which would be available if we could demonstrate that we can improve clinical outcomes and reduce the total cost of care." So all of our commercial payers have moved into the shared savings methodology where they are paying us based on the value, the outcomes and the value, that we create.

One plan described a specialist contract that had been in place for several years. Under this contract, a total cost of care target is negotiated that includes all services for a population and is risk-adjusted; if the contracted providers deliver care for a cost below the target, the savings are shared with the specialty group according to a predetermined formula. In some contracts, providers share in downside risk as well, but this is not typical. Another health plan described its contracts with providers as follows: the plan and IDS agree on a total cost of care for a year, with the IDS receiving half of the savings for "undercutting" this expected total cost. But, the IDS must meet quality and satisfaction measures to receive the "shared savings."

So somewhere between say 3 and 10% of the total value of a contract…we are talking about hundreds of millions of dollars with some of these contracts [that] would be at risk and you could earn it back by changing your total cost of care. None of the contracts is solely based on cost. They all have quality metrics too. So there are clinical performance measures and/or satisfaction measures that have to be lock step with the efficiency measures to get the payback.

An IDS described one contract with a health plan as a fee-for-service payment arrangement in which the IDS payment increases at a lesser rate than has historically been the case (e.g. 2-4 percent, as compared to 6-7 percent) in exchange for opportunities for additional compensation though shared savings. The IDS said that it initiated discussions with health plans to develop these contracts because a change in payment approach was needed to support the IDSs efforts to develop a stronger "population-based" focus for care delivery. Currently, 40 percent of the revenue for the IDS flows through some type of shared savings contract.

Most of what we are settling for now is around a 2, 3, 4 percent. But, we are creating the opportunities for additional compensation, additional revenue to the system, based upon

hitting those clinical outcomes and demonstrating that we can be competitive in the market…if we can empower the clinicians to create the model, use the model to drive the outcome, we will generate more revenue and then we are aligning [incentives], if you will, the compensation of those individual clinicians that are providing the value with the value, in a sense, that they create by working in a new care model.

A health plan respondent pointed out that some might view the types of shared savings arrangements described by respondents as similar to "the failed HMO approach." Consequently, the plan is "…trying to ensure that this is a different approach by separating 'insurance risk' from 'provider risk,'" with insurance risk (defined as anything outside of the provider's control) still being held by the plan. Provider risk was defined by the respondent as risk the provider organization assumes "…for providing appropriate care and for utilization."

Critical Factors in Implementing Changes

As respondents reflected on the process through which shared savings contracts were negotiated with health plans, they identified several critical factors. The first was a shared belief that the volume-driven approach to care delivery, as encouraged by existing payment arrangements, was not sustainable, nor should it be sustained. There was agreement that this payment arrangement, and the power-based negotiation process that it encouraged, did not serve patient interests or the public's interest well. That is, a market-wide consensus had developed over time that something needed to be done to change the payment system.

Second, respondents felt that the history of cooperation in the Twin Cities around quality improvement and performance measurement and reporting had laid the groundwork for a more cooperative, problem-solving approach to payment reform than might be possible in many other communities. One respondent observed that,

We're at a time when plans need to experiment with innovative methods and learn from each other. Providers are able to respond better when payment methods are aligned across payers. We don't necessarily see payment methods as an area where we compete. We're actually, you know, fairly open to the 'open source' concept when it comes to payment approaches, because to the extent that we [multiple payers in the

market] are aligned in the incentives that we are providing to providers, the faster they are going to improve.

An IDS respondent observed that, "Certainly payers and providers are all talking openly and collaborating on developing approaches to ACO," but also suggested that this could change if one organization found a superior solution (Table 9).

While these two factors clearly were important in preparing the way for new payment arrangements, there were several challenges that needed to be addressed. First, agreement on a method for attributing patients to IDSs needed to be reached, in the absence of a requirement that patients "enroll" with a provider organization. Health plan claims data were used for this purpose; a certain percentage of visits by a patient to a specific provider was required before responsibility for the patient was "assigned" to that provider. While the parties recognized that there is no perfect way to do this, they agreed to move ahead and to revisit the question as more experience was gained with the contract. Second, the parties to the negotiation had to agree to share their data, something that had not always been the case in the past. In general, they agreed that "data transparency" was necessary if a new payment arrangement was to be negotiated that was acceptable both to the provider organization and the health plan. Data sharing was needed to establish appropriate target amounts and to assess the potential for providers to create efficiencies in care delivery sufficient to generate shared savings.

And then we have a total cost of care measure, which is looking at all of the claims data because the payers are the ones that have the data related to the total cost of care. We did not have access to that information until probably about a year ago or 18 months ago, and they [all payers] agreed that they would make available the data so we can understand total cost of care and then use it to derive our attribution model…So the primary care physician now knows what the total cost of care is for their patients and the patient population.

Data transparency required trust on the part of the parties involved and, as one IDS respondent remarked, "It's interesting to watch because insurance companies and payers are learning along with us."

Early Results

Because the shared savings contracts are in their infancy, respondents were not able to provide quantitative evidence of their effectiveness. However, one health plan respondent said the plan had been unsure about whether IDSs actually would be able to lower costs and thereby qualify for shared savings. He reported that he was "…pleasantly surprised that providers have earned 50-100 percent of the available shared savings in the first two years of the contract."

A few respondents reported early evidence of behavioral changes that they attributed to shared savings contracts. For instance, the same respondent observed that

> *"When the plan shows providers the list of their attributed members and where the money for them is being spent, providers have an 'aha' moment…primary care providers are beginning to call the plan to try to get information about who the most efficient specialty care providers are. All of this is information we've had for years that we tried to administer and make relevant at the level of the health plan…all of a sudden it has some use…to physicians."*

A health plan respondent said that the plan is "…seeing and negotiating single digit fee and cost increases in the market, while similar plans in other markets are seeing much higher rates of increase."However, while observations like these are interesting, independent assessments of the impact of the shared savings models in the Twin Cities market are not yet available.

Conclusions

As Medicare considers possible changes to the way it pays for physicians' services, several findings from our interviews with a national sample of respondents from provider organizations and a market sample of respondents from provider organizations and health plans seem pertinent.

First, any change in Medicare's basic RVU methodology, and especially in its determination of work RVUs, will have implications for the way in which provider organizations compensate employed (or partner) physicians, as all provider organizations used RVUs in their compensation schemes. However, changes in Medicare's RVU methodology will affect the level of physician salaries only indirectly. This is because provider organizations establish "market

based" salary targets for their physicians. Changes in Medicare's RVU methodology could affect, over time, median physician incomes by specialty in a geographic area, and therefore organizational salary "targets," but many other factors (e.g. physician supply) likely have more significant implications for physician median incomes. Interestingly, while provider organizations make use of the RVU methodology in their compensation schemes, they do so with little enthusiasm. Most would prefer to compensate physicians based on measures of quality of care, and "organizational value," but feel constrained by the fee-for-service payment approach used by health plans and Medicare; RVU-based compensation is seen as necessary to "align" physician incentives when fee-for-service is the dominant mode of purchasing physician services.

There is considerable interest among provider organizations in how Medicare will structure payments for physician services under ACOs. If Medicare initiates shared-savings arrangements with ACOs, provider organizations would view this as a potential opportunity to restructure physician compensation, reducing reliance on RVUs and tying physician compensation more closely to organizational performance on quality improvement and cost control. Provider organizations are conducting, or planning, relatively small scale experiments in "shared-savings" contracts with health plans as a way of preparing for this possibility. The Twin Cities market serves as an example of how payment for physician services can be transformed relatively quickly across a whole community when both provider organizations and health plans are committed to implementing shared-savings models. However, to date this has had little impact on physician compensation models within provider organizations in the Twin Cities. Provider organizations may be hesitant to change internal physician compensation methodologies until they have accumulated several years of experience under shared-savings contracts with health plans, or until Medicare has changed from an RVU-based, fee-for-service purchasing approach to shared-savings models with quality incentives.

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Table 1: Participating Organizations (National)

#	Organization Type	Service Area and Market Share	Physicians	Facilities and Relationships	Services
Physician Groups					
1	Multi-specialty Medical Group (Independent. For profit)	Midwest. 12 counties 40% market share.	215 employed physicians.	25 clinics.	Primary care, multi-specialty care (outpatient).
2	Single-specialty Medical Group (Subsidiary. Nonprofit)	Midwest. Large metropolitan area. 45-50% market share.	60 employed physicians.	6 clinics. Consulting relationships with 11 hospitals.	Single-specialty care (outpatient).
3	Multi-specialty Medical Group (Independent. For profit)	South. Small metropolitan area.	121 employed physicians.	10 clinics.	Multi-specialty care (outpatient).
4	Single-specialty Medical Group (Subsidiary. Nonprofit)	South. Large metropolitan area.	90 employed physicians, 17 affiliated physicians.	2 outpatient specialty care centers, specialty care research center. Inpatient care provided at integrated health system hospital. Subsidiary of integrated health system.	Single-specialty (inpatient and outpatient).
Integrated Delivery Systems					
5	Integrated Delivery System (Insurance and Delivery. Nonprofit)	Midwest. 19 counties in 4 states.	480 employed physicians, 320 affiliated physicians.	1 hospital, 52 clinics, multi-specialty medical group, medical and nursing schools, home care, health insurance plan. 2 affiliated hospitals, 4 affiliated nursing homes.	Hospital care, primary care, multi-specialty care (inpatient and outpatient), insurance.
6	Integrated Delivery System (Nonprofit)	Midwest. 4 states. 50-100% of market share, depending on region of service.	750 employed physicians, a few affiliated physicians.	15 hospitals (3 critical access), 62 clinics, research center.	Hospital care, primary care, multi-specialty care (inpatient and outpatient).
7	Integrated Delivery System (Nonprofit)	West. 1 state. 60% market share.	212 employed physicians, 800 affiliated physicians.	5 hospitals, 72 clinics. Partner and/or network relationships with 25 hospitals and 13 medical centers.	Hospital care, primary care, multi-specialty care (inpatient and outpatient).
8	Integrated Delivery System (Nonprofit)	Midwest. Large metropolitan area. 15% hospital/inpatient market share	3,600 employed physicians, 2,700 affiliated physicians.	10 hospitals, 90+ clinics and specialty centers, Home health, Hospice.	Hospital care, primary care, multi-specialty care (inpatient and outpatient).
9	Integrated Delivery System (Insurance and Delivery. Nonprofit)	West. 1 state.	12,500 employed or affiliated physicians.	21 hospitals, numerous clinics and specialty centers, 5 multi-specialty medical groups, 5 multi-specialty independent practice associations, 18 home health/hospice sites, 5 long-term care centers, 5 research institutes.	Hospital care, primary care, multi-specialty care (inpatient and outpatient), nursing and long term care; research, medical training, insurance.
10	Integrated Delivery System (Nonprofit)	West. Large metropolitan area.	500 employed physicians.	1 hospital, 8 clinics, nursing residence, research institute, training institute. Affiliated with 2 hospitals, health insurance/care coordination organization, and network of 10 clinics.	Hospital care, primary care, multi-specialty care (inpatient and outpatient), nursing care, research, medical training.

Table 1: Participating Organizations (National)

#	Organization Type	Service Area and Market Share	Physicians	Facilities and Relationships	Services
11	Integrated Delivery System (Insurance and Delivery. Nonprofit)	South. Medium metropolitan and rural areas. 65% inpatient market share. 60% outpatient market share.	395 employed physicians.	8 acute care hospitals, 6 outpatient care campuses, senior services (nursing, assisted living, and home care), health insurance company (offers commercial, third party administrator, Medicare and Medicaid HMO products). Medical group is a subsidiary corporation with 87 clinic locations.	Hospital care, primary care, multi-specialty care (inpatient and outpatient), nursing care, insurance.
12	Integrated Delivery System (Nonprofit)	West. Medium metropolitan area.	1,120 - 1,500 employed physicians.	Hospital, primary care, specialty care, health care administration. Contract with insurer/integrated health care organization to provide all professional services for the insured population.	Hospital care, primary care, multi-specialty care (inpatient and outpatient).
13	Integrated Delivery System (Insurance and Delivery. Nonprofit)	East. Medium metropolitan and rural areas. 50% hospital services market share, 40% physician services market share.	550 employed physicians.	7 hospitals (1 academic), 72 clinics, multispecialty medical group, residency programs, small Medicare Advantage plan. Medical school. Partnerships with other medical groups.	Hospital care, primary care, multi-specialty (inpatient and outpatient), research, medical training, insurance.
14	Integrated Delivery System (Nonprofit)	Midwest. Small metropolitan and rural areas, 33% general market share 66% hospital market share.	240 employed physicians, about 160 affiliated physicians.	4 hospitals, 26 clinics and specialty centers, 4 long-term care facilities (assisted living, home care, short stay care, retirement apartments, memory care, nursing home).	Hospital care, primary care, multi-specialty care (inpatient and outpatient), long term care.
15	Integrated Delivery System (Nonprofit)	Midwest. Medium metropolitan area. 580,000 members in health plan. Hospitals and physicians serve 750,000 to 1.2 million people.	530 employed physicians, 1,200 affiliated physicians	8 hospitals, 1 multispecialty medical group, health insurance plan.	Hospital care, Primary care, Multi-specialty care (inpatient and outpatient), Insurance.

Table 2: Current Physician Compensation Methods (National)

		Physician Reimbursement		Organizational Perspective	
#	**Org Type**	**Overview**	**Detail**	**Opportunities**	**Challenges**
Physician Groups					
1	Multi-specialty Medical Group	Productivity (financial), salary, capitation	'Partner' physicians: Productivity based on previous 6-month financial performance. A profit-and-loss balance is created for each individual physician, including; (a) patient services revenue which is 100% of billed charges for commercially-insured patients (or % as agreed upon with insurer), allowable charges for Medicare and Medicaid insured patients, and; (b) outside revenue (e.g. stipends). 'Associate' physicians: Market-based salary with productivity bonuses based on specialty, years of practice, and other physician characteristics. If a particular insurer utilizes quality incentive or other incentive payments (e.g. a PMPM fee for case management) these revenues are attributed to an individual physician as part of patient services revenue. Funds such as these that are not attributable to an individual physician are placed in a reserve fund that is distributed to physicians in differing specialties (e.g. primary care) as needed. About 15% of revenues also come from an HMO arrangement, wherein specialists are paid through capitation and primary care physicians are paid on a fee-for-service basis. Non-physician practitioners: Reimbursed on an hourly or salary basis. Any profit or loss accrued by a non-physician practitioner is attributed to the attendant physician.	System incentivizes physicians to be efficient and take good care of patients. Providers were initially uncertain about specialist capitation but have accepted it as part of the culture.	In some cases a large % of physician compensation is made up of ancillary services, so physicians aren't producing to capacity. Expense management is an ongoing struggle - need to provide better information to physicians on how they compare to their peers on expenses to help them decrease their own expenses.
2	Single-specialty Medical Group	Productivity (work RVU), shared compensation, salary, performance	'Non-shareholder' physicians: employee physicians reimbursed on a specialty-specific, market-based salary basis. Their salary is determined based on market surveys within their specialty area. 'Shareholder' physicians (who have been with the practice for more than 2 years): 70% shared compensation and 30% compensation based on work RVU productivity. About 2% of compensation is pay-for-performance. Non-physician practitioners: salaried, with contracts that stipulate they will participate in quality development programs (can receive raises based on participation). Ancillary services not tied to physician reimbursement. **Performance measures:** Quality: Benchmarks are set within measures and have to be met to receive a certain portion of compensation. Some measures were taken from national standards and some were developed internally. The compensation associated with a particular measure is weighted and those measures that have been successfully achieved by most providers are weighted less over time.	Inclusion of production-based component has increased overall practice productivity. Current variation between high and low producers is about 30%, where it was formerly 200%. System is viewed positively by potential physician recruits.	Difficult to incent physicians towards productivity given differences in practice sites. Increased specialization/tertiary care is reimbursed at a lower rate for RVUs than more commonly-used care. This creates a negative financial incentive for developing new service lines.
3	Multi-specialty Medical Group	Productivity (work RVU), salary	New employee physicians: reimbursed by salary. Associate physicians (2+ years): reimbursed on RVU productivity with benchmarking to national median RVU payments. Physicians are expected to meet certain levels of quality - there is no reward for doing so but punitive measures if they fail to do so. Physicians who do additional work (e.g. surgery, medical directorships) are paid these fees directly, outside of their clinic compensation. Ancillary profits go to offset overhead.	Because compensation is based on straight RVU production it is not affected by payer mix or changes in payer mix. Simple system is easy for providers to understand.	Work RVU reimbursement doesn't take into account practice differences and varying overhead costs.

Table 2: Current Physician Compensation Methods (National)

		Physician Reimbursement		Organizational Perspective	
#	**Org Type**	**Overview**	**Detail**	**Opportunities**	**Challenges**
4	Single-specialty Medical Group	Productivity (RVU), salary, performance	Physicians currently compensated "on a guarantee". Compensation model that soon will be in effect includes base salary, productivity, and performance bonuses. Base salary is comprised of 50% for taking full call, plus about 25% each for being a full time physician and for allowing the organization to set your schedule and assign you patients. Base salary contributes 40-50% of total reimbursement. The other 50-60% of total reimbursement is a combination of market- and specialty-based work RVU productivity and bonuses for 'good citizenship' and meeting individual physician goals. E&M office visits are compensated at a slightly higher level per-RVU to encourage physicians to bring in more patients. Individual subspecialties will have some control over allocating their resources (through a 'pool') if desired, as long as it is approved by leadership. Non-physician practitioners: salaried. Ancillary services are not tied to physician reimbursement.	Providers have had a positive reaction so far to the proposed plan.	Worried that it may create too much internal competition between individual physicians and subspecialties because of the focus on personal productivity.
Integrated Delivery Systems					
5	Integrated Delivery System	Salary	Physicians are employed and salaried by the health system. A general compensation range is generated from national averages by care type/specialty. Physicians are paid within that range, with increases in salary for special skills, experience, productivity, and provision of high-quality and/or efficient care. There is no formula for determining salary; it is decided case-by-case based on these and other factors and is revised annually. Upon hiring (or applying) the organization makes clear to physicians that a baseline of quality and service is required, and physicians will be expected to maintain this baseline in order to stay employed. Ancillary services not tied to physician reimbursement.	Method allows providers to stay focused on improving quality and delivery of health care. Method reinforces the organizations' commitment to high quality.	None mentioned.
6	Integrated Delivery System	Productivity (RVU), salary	Employed physicians: reimbursed by salary, RVU production, or a combination of the two. New hires are reimbursed on the higher of either a salary or RVU basis for the first 2 years. Physicians are paid the median rate (based on national surveys) for RVUs. If the organization is having difficulty recruiting, it may increase the RVU rate past the median, or pay a bonus. Physicians are expected to maintain an RVU rate at the 60th percentile or above the AMGA median for their specialty in their market. A base level of quality of care is expected as outlined in the employment contract, but does not affect compensation. Non-physician practitioners: Reimbursed similarly on a salary or combined salary-RVU system that varies by region. Ancillary services not tied to physician reimbursement.	Organization does not see the compensation method as being the main driver of quality - compensation should be used in partnership with management to change physician behavior. Providers are happy with the reimbursement method.	RVU system ignores financial issues that exist with caring for government insured or uninsured patients, discounts by commercial payers, and so on. Surveys that provide information on median reimbursement may not accurately reflect the payer mix of the market.
6	Integrated Delivery System	Productivity (work RVU), salary	Employed physicians: Guaranteed base salary plus additional work RVU productivity based reimbursement. New physicians: Base salary (market based, specialty specific). As a new physician's productivity increases over time, base salary is increased to be consistent with the physician's average productivity level. Amount of compensation varies by specialty, but the approach to calculation remains the same. Contractors are paid on a work RVU productivity basis. Ancillary services not tied to physician reimbursement.	Using work RVUs as the productivity indicator ensures no disincentives to providers seeing charity care patients, because they get the same credit for seeing any type of patients. Physicians are incented to work hard and are happy with the system.	Productivity based system doesn't reward physicians for outcomes. Organization would like to move toward rewarding outcomes, quality, and patient satisfaction in order to better serve patients, but feels like it can't do this without payers leading the way.

Table 2: Current Physician Compensation Methods (National)

		Physician Reimbursement		Organizational Perspective	
#	**Org Type**	**Overview**	**Detail**	**Opportunities**	**Challenges**
8	Integrated Delivery System	Productivity (work RVU), performance, capitation	Physicians paid differently based on medical group membership and specialty. Medical group 1: Reimbursed by work RVU productivity with multiplier ensuring physicians market based payment for their level of productivity. Additional incentive of about $5,000 annually tied to service and patient satisfaction scores. Ancillary services not tied to physician reimbursement. Medical group 2: 75% RVU productivity, 25% capitation. Revenue from ancillaries is shared evenly across the group. Medical group 3: Pay for Performance, with about $5,000 additional incentive if targets in a clinical integration program are reached. 70% of P4P is based on individual or small practice performance, and 30% is based on the medical group overall performance. Primary care physicians: Capitated reimbursement. **Performance measures:** Pay-for-performance program tracks outcomes of certain grouped diseases in electronic registry. Those involved with treating the patient are 'accountable' for the results.	The pay-for-performance method improves alignment between multiple specialties to manage chronic conditions and to improve performance through peer pressure. The reimbursement method is generally accepted by physicians.	Capitation for primary care physicians doesn't adequately reimburse for productivity.
9	Integrated Delivery System	Productivity (RVU), salary	Physician reimbursement determined by each medical group or IPA. The system pays each medical group an annually agreed-upon amount which varies based on budgeted professional revenues, patient volume, and performance. Each medical group pays an annualized amount back to the network for use of buildings/utilities, technicians, nurses, and midlevels. Most medical groups pay their physicians based on work RVU productivity (varies by specialty and meets market benchmarks). Most physicians in the groups are hired for the first 2-3 years in the group and work on a minimum salary basis. Once they become full medical group members they move to production-based compensation. Non-physician providers: Employed by the system and reimbursed by market value salary. Ancillary services not tied to physician reimbursement.	Not mentioned.	Not mentioned.
10	Integrated Delivery System	Productivity (RVU), performance	Physician reimbursement is 80% market- and specialty- based work RVU productivity and 20% additional incentives. Additional incentives are provided for teaching, research, academic pursuits, involvement in organizational planning and governance, and working on initiatives to increase patient satisfaction and decrease waste. Non-physician providers: Reimbursed on a specialty-specific salary basis.	Not mentioned.	Not mentioned.
11	Integrated Delivery System	Productivity (RVU)	Each physician practice is responsible for generating revenue to cover practice-related expenses. Net revenue is then divided among physicians in the practice, typically based on work RVU productivity. Once a physician covers her portion of allocated expenses, she receives the remainder of the RVU based compensation. For specialties that have little control over volume of patients or payer mix, the system supplements their compensation above what they bring in through direct professional revenue. Non-physician providers: Reimbursed by market-based salary. Some are eligible for base salary plus productivity bonus, the same as physicians. Ancillary services not tied to physician reimbursement.	Adds value for physicians to be part of integrated system. Centralizing administrative operations allows the group to be more cost-effective than private practice.	Specialties that have little control over volume of patients or payer mix have difficulty remaining profitable, so the organization subsidizes their reimbursement.

Table 2: Current Physician Compensation Methods (National)

		Physician Reimbursement		Organizational Perspective	
#	Org Type	Overview	Detail	Opportunities	Challenges
12	Integrated Delivery System	Salary, performance	Specialty-specific salary scale based on market benchmark and adjustments for benefit program. Total compensation, including salary and benefits, is at or better than market average. Each scale has a number of 'tenure steps', varying from 3 to 7, which correlate to an increase in salary. Physicians are paid a monthly salary based on hourly work (FTE is 36 hours). Physicians who work below 36 hours receive a prorated salary based on FTE rate. Physicians who work above 36 hours can receive additional compensation through a 'work unit system' that pays additional base compensation, as defined by specialty-specific scales, for additional hours worked. Additional incentive compensation is paid at the end of the year if quality and service targets are met (4-6% of total compensation). Incentives are the same dollar value across specialties, but vary between 'senior status' physicians, normal physicians, and administrative staff physicians, and vary based on FTE status. The contracting health plan pays an overall bonus to the organization for meeting targets, which the organization then distributes. Ancillary services are not tied to physician reimbursement. Non-physician providers are compensated directly through the contracting health plan. **Performance measures** - Quality and Patient Satisfaction/Service: Incentive compensation paid at the end of the year if quality and service targets are met. Targets are set yearly. Quality is measured using HEDIS measures (including breast cancer, preventive screening, hospital composite, controlling high blood pressure and diabetes, appropriate drug use, etc). Service is measured using patient satisfaction surveys and measures of access to health care.	Within the organization, physicians can see any other physician's quality performance. This successfully motivates physicians to improve their quality of care.	Not mentioned.
13	Integrated Delivery System	Salary, Performance	Specialty physicians: Total compensation combines market- and specialty-based salary (80%) and performance incentives (20%). No relationship between ancillary services and physician compensation. Primary care physicians: Base salary plus performance incentive. 90% of base salary is RVU productivity and 10% is panel size. Base salary is determined by historical productivity plus primary care panel size. Historical productivity sets the next year's base productivity calculation. Scorecard/performance incentive is a set amount, about $25,000. Primary care does not have a productivity/RVU bonus. Non-physician practitioners: Base salary plus 5% bonus opportunity linked to the scorecard of supervising physician. **Performance measures -** Organization uses a 'balanced scorecard' which is developed for every clinic, department, section, and physician. The scorecard is used to determine 20% (for specialists) 10% (for primary care) or 5% (for midlevels) of base salary incentive payment. Scorecards include elements of quality of care, patient experience/satisfaction, efficiency and cost of care (decreasing supply chain utilization, avoidable admissions), research and education, and productivity (by work RVUs). They also include links to care utilization and implementation of medical homes. Each physician has an individual productivity target based on time allocation between clinical, teaching, research, and administration. Regardless of specialty, for each RVU above the individual target, a physician receives a bonus of $35. Productivity/RVU conversion factor is the same for all physicians, regardless of specialty. Total compensation per RVU does vary across specialty, because RVU bonus is a part of the balanced scorecard bonus, which is based on a percentage of specialty-specific salary. To get a productivity bonus, physician has to meet a threshold on the balanced scorecard of at least 65%. If a physician has a significant productivity bonus for a few years running, base salary is adjusted to raise productivity target.	Organization is positive about core structure and approach, which focuses on 'the full balance' of care including quality, efficiency, cost of care, patient satisfaction, and teamwork. It took awhile for physicians to get used to the idea of goals and objectives, and the imperfections of measurement. Now physicians are reacting positively to the reimbursement method.	The organization is experiencing challenges with electronic databases and attribution of a patient to one primary care physician's panel. It didn't know the extent to which this would be a problem and is now trying to better manage flux in primary care patient populations.

Table 2: Current Physician Compensation Methods (National)

		Physician Reimbursement		Organizational Perspective	
#	**Org Type**	**Overview**	**Detail**	**Opportunities**	**Challenges**
14	Integrated Delivery System	Productivity (RVU, pooled), Performance	Work RVUs are tracked for each individual physician. A specialty-based conversion factor is applied to the RVUs by a consulting organization (based on salary surveys). After conversion, the total pool of RVU-based compensation is given to each department for that departments' individual physicians. Departments then decide how to distribute that pool. In some cases it is 100% individual productivity, and in others it is 50% individual productivity and 50% shared across the board. Physicians can receive an individual bonus payment based on elements of finance, quality as measured by patient satisfaction, and citizenship (participation in department meetings, quality improvement initiatives, etc.) **Performance measures -** Board of directors sets patient satisfaction targets yearly. If these are met, physicians and employees receive bonus payments. If not, the physician does not receive the bonus (all or none measure).	Patient satisfaction bonus has been helpful in creating a culture of cooperation within the organization. Retaining some element of RVU based pay allows the organization to reward providers for doing extra work and allows it to provide flexible schedules that providers appreciate. Method allows physicians to be flexible in number of hours/FTE worked.	Not mentioned.
15	Integrated Delivery System	Productivity (work RVU and financial), salary, performance	5 different reimbursement models based on former independent physician group models. 1. Pediatrics: guaranteed compensation, must meet productivity and quality standards. 2. Multi-specialty: revenue minus expenses. 3. Multi-specialty: work RVU based productivity. 4. Main medical group: Must fulfill criteria for quality, patient satisfaction, contribution to the group, productivity (hours per week dedicated to patient care), and work RVU productivity (must meet national mean of work RVUs). Once a physician reaches the national mean for work RVUs (the 87th percentile), any additional RVUs earned are paid at decremental reimbursement rates. Model does not apply to physicians spending 20% or more of their time on research or administration. These physicians are reimbursed based on national norms. Performance measures - Quality, Patient Satisfaction, Group Contribution, Productivity: Physicians are not reimbursed directly based on these measures but are expected to meet measures to remain in the physician group. Physicians who do not meet minimum standards are given 3 quarters to improve their performance before they are asked to leave. Measures are often department-specific. Quality measures are drawn from measures used in national pay-for-performance methods.	Method allows physicians to focus on care quality, patient satisfaction, and research rather than just producing. Method creates a more meaningful work environment and 'an extraordinary place to be cared for'.	Varying cultures and histories of physicians and newly-integrated physician groups makes changing reimbursement methods difficult.

Table 3: Changing Physician Compensation Methods (National)

#	Org Type	Changing Reimbursement Methods	Challenges and Reactions to New Method
Physician Groups			
1	Multi-specialty Medical Group	No recent or planned changes.	N/A
2	Single-specialty Medical Group	No recent or planned changes.	N/A
3	Multi-specialty Medical Group	No recent or planned changes.	N/A
4	Single-specialty Medical Group	In the process of implementing a reimbursement method (Table 2) which is a hybrid of productivity, salary, and performance.	Providers have had a positive reaction so far to the proposed plan.
Integrated Delivery Systems			
5	Integrated Delivery System	Will change to a method that supports moving toward ACO preparedness and managing population health. New method will look at overall efficiency and quality in determining salaries annually. This method is currently in discussion and preliminary stages of financial and compensation planning at the department level.	Not mentioned.
6	Integrated Delivery System	No recent or planned changes.	N/A
7	Integrated Delivery System	Plans change to a method that moves toward improving and managing population health. It will be a 'pay-for-outcomes' model which supports a transition towards bundled payments and incentives for reducing costs, avoiding preventable readmissions, using evidence-based practice and improving patient satisfaction. This method is currently in discussion.	Not mentioned.
8	Integrated Delivery System	Plans change to a method that encourages primary care physicians to provide more coordinated care. This method would move primary care physicians currently in HMO capitation from current capitated status to fee-for-service care, reimbursing physicians for extra services given to patients where a capitated model does not. This method is currently in discussion.	Not mentioned.
9	Integrated Delivery System	Will change to a method that supports a value-based and team-based approach to compensation. New method will be a hybrid of production and salary models which include incentives around patient satisfaction and efficiency of care. This method is currently in discussion and is being implemented variably across medical groups in the system.	Physicians have some mistrust of quality measures and methods of attribution and sampling, but they do want to 'do the right thing'. Challenges in development and implementation include finding accurate and trusted quality metrics developing infrastructure to collect, analyze, and report on quality data. The EHR currently in use does not support these data needs. Physician acceptance of a new method seems to be driven by practice culture, where older medical groups with consistent internal culture are more amenable to change than younger, less well-established groups.
10	Integrated Delivery System	No recent or planned changes.	N/A

Table 3: Changing Physician Compensation Methods (National)

#	Org Type	Changing Reimbursement Methods	Challenges and Reactions to New Method
11	Integrated Delivery System	Will change to a method which includes 3 components; salary, productivity, and performance. Salary: Specialty-specific base salary which is market competitive based on national surveys. To earn base salary the physician needs to be productive within a specialty-specific range of work RVUs. Productivity: If a physician produces above the upper limit of the designated RVU range, will earn additional compensation for those RVUs. If produces below the lower limit of the range, base salary would be adjusted downward. Performance: Incentives including 4 categories of goals: individual responsibility/accountability (including patient experience measures, specialty-specific clinical quality; system alignment (participation in system-wide initiatives, including medical home, chronic disease management, and advanced care planning initiatives); and financial stewardship (physicians know budget targets, and work to manage expenses and provide adequate levels of serves to meet budget targets). Incentive is based on a percentage of base salary and is currently set at 10% but will grow over time. Non-physician practitioners will be paid in the same way as physicians. The model is currently being piloted with some specialties, and will be fully implemented in early 2012.	Reimbursement method has been well received, and refocuses physicians on "taking care of patients and doing the best possible job" which physicians respond positively to. A challenge is to mitigate the impact of the new plan on high-production physicians in the medical group. The goal is to narrow the gap between low and high producers, without disincentivizing being a high producer.
12	Integrated Delivery System	Will change to a method to reward physicians who welcome larger patient panels and who provide high levels of quality and service. This method will include a standard annual salary base plus additional available reimbursement based on balanced scorecard reports. The balanced scorecard includes measures of productivity (work RVUs, 55% of scorecard reimbursement), service (access and patient satisfaction, 15% of scorecard reimbursement), and quality (HEDIS measures 30% of scorecard reimbursement). For areas where data collection on work RVUs is difficult a set allotment per shift of 'virtual RVUs' was produced. Total RVUs (work + virtual) are reported at 12-month rolling average for an individual. Scorecard reimbursement is attributed to individual physicians except in a few departments (e.g. pathology) who receive group scorecard reimbursement. Physicians who do well on the scorecard receive up to 120% of normal FTE salary. This method is currently in implementation in primary care, allergy, ophthalmology, and optometry specialties. Other departments will start being paid for scorecard results starting in mid-2011.	Some physicians are enthusiastic about the new direction, others see it as a complete reversal of organizational philosophy which may no longer be a match for how they want in practice. Lower performing physicians understand that they have higher-performing peers, even though their base compensation was not affected. The organization has seen some improvement in terms of service. It would like to have made the scorecard a bigger element of total compensation, but doesn't feel it currently has the overall revenue and economic strength to do so.
13	Integrated Delivery System	Organization is in the process of implementing a reimbursement method as described in Table 2, which is a hybrid of salary and performance.	Not mentioned.
14	Integrated Delivery System	No recent or planned changes.	N/A
15	Integrated Delivery System	Organization is in the process of converting all reimbursement methods to main reimbursement method. In this method physicians must fulfill criteria for quality, patient satisfaction, contribution to the group, productivity (hours per week dedicated to patient care), and work RVU productivity (must meet national mean of work RVUs). Once a physician reaches the national mean for work RVUs, any additional RVUs earned are paid at decremental reimbursement rates. Model does not apply to physicians spending 20% or more of their time on research or administration. These physicians are reimbursed based on national norms. Performance measures - Quality, Patient Satisfaction, Group Contribution, Productivity: Physicians are not reimbursed directly based on these measures but are expected to meet measures to remain in the physician group. Physicians are given 3 quarters to improve their performance before they are asked to leave. Measures are often department-specific. Quality measures are drawn from measures used in national pay-for-performance methods.	Varying cultures and histories of physicians and newly-integrated physician groups makes changing reimbursement methods difficult.

Table 4: Innovative Health Plan/Provider Payment Arrangements (National)

		Innovative Health Insurance Plan Payment	
#	**Org Type**	**Overview**	**Detail**
Physician Groups			
1	Multi-specialty Medical Group	Case management, Performance bonus, Capitation	Government Insurers: Medicaid pays on FFS basis, with the addition of a small PMPM payment to primary care physicians for case management services. Physicians are also eligible for bonuses annually based on overall panel performance. The organization passes these bonus payments directly on to the physician. Commercial Insurers: Organization functions as franchise of a health insurance plan which covers approximately 1/4 of the health plan's members in an HMO arrangement. 1/2 of the members covered in the HMO are full risk - the health plan receives the member premium, takes a percentage for administration, and makes 90% of the gross premium available to the organization to care for the members. Within this arrangement a partner hospital is paid an inpatient capitation based on the percentage of the gross premium, outpatient services are FFS with a not-to-exceed cap by service, primary care is FFS, specialists are capitated, and pharmacy, home care, reinsurance, and DME are paid as needed. Out-of-network hospitals are paid on a per diem cap basis.
2	Single-specialty Medical Group	ACO	Commercial Insurers: Organization is involved in developing an ACO concept with 2 integrated health care systems in the market, utilizing a shared savings model. Payers have made commitments to agree to a payment methodology that would pay 50% of any savings the ACO can generate back to the ACO. Initial phase of pilot will be fee-for-service with financial rewards for achieving quality targets.
3	Multi-specialty Medical Group		None.
4	Single-specialty Medical Group	ACO	Commercial Insurers: Organization is participating in a commercially-paid ACO delivery model with a primary care physician group. The ACO covers about 10,000 members in a capitated model. It is also working on developing a similar model with another payer.
Integrated Delivery Systems			
5	Integrated Delivery System		None.
6	Integrated Delivery System	Performance bonus, Shared savings	Commercial Insurers: Under an agreement with a major payer organization can earn up to $5 million over two years for meeting quality targets. It is participating in gainsharing for Medicare Advantage with another payer. Both types of payment accrue to the organization and not directly to providers.
7	Integrated Delivery System	Shared savings	Commercial Insurers: Organization conducted a pilot with a payer including shared savings for moving patients from brand name to generic drugs and pay-for-performance incentives.
8	Integrated Delivery System	ACO (capitation, shared savings)	Commercial Insurers: Organization is developing a 3-year shared savings pilot with a large health insurer that will allow it to focus on developing infrastructure for ACO-like population-based service. The contract will include risk-adjusted global capitation for HMO patients (20% of business with this payer) and shared savings for attributable PPO patients (80% of business with this payer). For the PPO patients, the organization still will be paid on FFS basis, but will receive shared savings. Shared savings will be based on the organization's performance relative to the rest of the market. It will receive any savings under market cost. In the first year of the contract any shared savings will be used by the organization for investments in infrastructure to develop medical homes and case management. In later years, the organization plans to distribute shared savings compensation quarterly to physicians.
9	Integrated Delivery System	Performance bonus, Risk sharing	Government Insurers: The state payer conducts a P4P initiative which provides an incentive for groups to perform highly on patient satisfaction and other quality measures. Any incentive received in this way is passed through the system to the medical group, and the medical group decides how to distribute the funds among physicians. Commercial Insurers: Organization participates in some managed care arrangements which include risk sharing for physicians or shared between hospitals and physicians.
10	Integrated Delivery System		None.
11	Integrated Delivery System	Pay for performance	Commercial Insurers: 2 of the organization's payers have a pay-for-performance incentive. Payment amounts to less than 3% of total revenues from those plans.

Table 4: Innovative Health Plan/Provider Payment Arrangements (National)

		Innovative Health Insurance Plan Payment	
#	**Org Type**	**Overview**	**Detail**
12	Integrated Delivery System	Capitation	Commercial Insurers: Organization contracts with a single payer, and is paid a capitated amount to provide professional services for that plan's members. In some cases, it contracts with an outside group to provide the services, but is always at risk for providing the service.
13	Integrated Delivery System	ACO, Pay for performance	Commercial Insurers: The organization is participating in an ACO pilot program. It would like to continue treating patients this way, but there is not sufficient financial support for the organization to implement a full ACO on its own. The organization is hoping to soon develop a 'single payer partnership' with a small commercial insurer, where value-based payment would occur for all insured populations (Medicare, Medicaid, and commercial).
14	Integrated Delivery System	Medical home, ACO (shared savings)	Government Insurers: Participating in state medical home effort spurred by state health reform, which pays PMPM for care coordination. Commercial Insurers: in discussion with a major commercial payer to develop an ACO-type contract based on shared savings for total cost of care. Targets would be established for improvement of total cost of care, and any savings associated with this improvement would be shared by the payer and the health care organization. Because any reward will be received at the system level, under this contract the organization will likely continue its current physician reimbursement method.
15	Integrated Delivery System	Medical home	Commercial Insurers: Organization is paid by the major insurer in the state for certified medical home services. Fee schedule payment is increased for medical home services.

Table 5: Provider Organization Views on Accountable Care Organizations (National)

#	Org Type	Organizational Preparedness for ACO	Additional Comments
Physician Groups			
1	Multi-specialty Medical Group	Organization feels well situated to take on risk based on its history in HMO arrangements. Organization would prefer to act as an ACO for less complicated populations. It would also require that there be sufficient population membership in the ACO to be able to accept risk, and that it would be able to control the movement of members in order to manage care.	Organization predicts that smaller hospitals and specialty groups will be pushed out of participating by larger, more well-connected networks that already have more infrastructure and networks in place for ACO-type care delivery.
2	Single-specialty Medical Group	Organization is prepared to participate in bundled payment arrangements. It thinks that ACO contracts will need to be based on identifiable carve-outs (e.g. a specific chronic disease).	Organization thinks that an ACO model would rely on patient compliance, but has seen no mechanism that would compel a patient to comply.
3	Multi-specialty Medical Group	Organization would need to change its reimbursement method away from RVU-based productivity in the event of participating in any risk contracts or ACO-type arrangements.	None.
4	Single-specialty Medical Group	Organization is preparing to operate under any new payment mechanisms, and is working on an ACO pilot and evaluating bundled payment options in anticipation of ACO implementation.	Organization believes that payment models which pay physicians and hospitals together should be used, and that payment should drive health care system integration.
Integrated Delivery Systems			
5	Integrated Delivery System	Organization is prepared to be competitive in a bundled payment environment based on an established integrated system network and strong physician leadership. It thinks that its current physician reimbursement plan can be applied to ACO-type arrangements.	Organization thinks that the health system needs to move towards paying for outcomes and population health.
6	Integrated Delivery System	The organization is ready to decrease focus on productivity and increase focus on population health.	None.
7	Integrated Delivery System	The organization would be interested in participating in or developing an ACO and feels ACOs will be useful for increasing incentives for population health improvement.	Organization thinks that health care business should be split into 3 segments to be paid in differing ways. 1. Diagnostic services; paid FFS. 2. Interventional (e.g. surgery); paid a capitated fee for conducting the service and all related care. 3. Disease management; paid a PMPM global payment with incentives for health outcomes and quality and infrastructure/care coordination payment.
8	Integrated Delivery System	Organization is working on developing small-scale ACO arrangements in order to prepare for larger-scale ACO implementation following health care reform.	Organization thinks that ACO strategies spearheaded by governmental payers will drive commercial payers, which creates the potential to change the market to focus on managing a population and delivering value. ACOs also will encourage currently independent physicians to join larger health systems in order to remain financially viable. Hospitals will be challenged to deal with what will become excess capacity under ACO arrangements.
9	Integrated Delivery System	Not mentioned	Any type of ACO, bundled, risk-sharing, or global payments need to be aligned with market changes by geographic region, and need to be standard across at least Medicare parts A and B. ACO regulations will need to construct appropriate cost, risk, and value-based adjustments to ensure that high quality groups are not penalized. ACO-type arrangements will need to accurately pay for population management to keep health care organizations financially viable. Organizations with primarily FFS payment will have a difficult time transitioning to risk sharing.

Table 5: Provider Organization Views on Accountable Care Organizations (National)

#	Org Type	Organizational Preparedness for ACO	Additional Comments
10	Integrated Delivery System	Organization is currently prepared to take on risk because it is a well-integrated system. It considers itself to be an unofficial ACO, and is interested in developing formal ACO capacity as soon as possible. The organization feels that their current focus on reducing costs and improving efficiency is penalized under current payment arrangements, and would be better aligned to ACO-type arrangements.	Organization believes that ACOs are what health care organizations should be - accountable to patients, and constantly working to provide better-quality, lower-cost, more patient-centered care.
11	Integrated Delivery System	Since ACOs are still undefined, organization is focusing on alignment between physician community and the broader organization, as well as clinical integration and improving patient experience and care quality in a cost effective way. Internal initiatives include medical home, chronic disease management, and advanced care planning initiatives to build on opportunities to provide better care/improve quality of life and minimize costs.	Organization believes that a movement towards payment for performance is a good idea.
12	Integrated Delivery System	None.	None.
13	Integrated Delivery System	The organization's current physician reimbursement method will work in a more risk-based care model, because it balances base and at-risk bonus reimbursement, and it has increased clinical and fiscal integration as a group and as a system. Organization is prepared and positioned to implement an ACO like arrangement, but cannot successfully do so until more payers are focused on paying for improved value.	Any approach to value purchasing in health care will require clinical and fiscal integration amongst doctors and between doctors and hospitals. Value-based purchasing or ACO arrangements will contribute to improvement in health care system.
14	Integrated Delivery System	Organization is well prepared to start accepting more risk because they have established relationships that span the continuum of care. This established network is more able to take care of patients globally and reduce inpatient cost of care. Organization anticipates accepting more financial risk from payers in the future.	Any model that would evolve into an ACO would involve increased use of physician extenders/midlevels to provide care coordination and similar services. Risk sharing/total cost of care payment may be the best model to align incentives to reduce global spending.
15	Integrated Delivery System	Organization is working towards being able to offer bundled payments to health plans.	None.

Table 6: Physician Compensation Methods (Market)

		Provider Payment to Physicians		Organizational Perspective	
#	**Org Type**	**Detail**	**Overview**	**Opportunities**	**Challenges**
Integrated Delivery Systems					
1	Integrated Delivery System	Productivity (RVU), Performance	Physicians: 94% RVU-based productivity. Use regional market surveys to determine rates per work RVU, plus variation by specialty and local marketplace adjustments in a few specialties (e.g. GI, oncology, and rheumatology). 3% incentive for meeting access goals, 3% for educational activities. Payment is not connected to ancillary services. Contracted physicians paid for "fair market value of services". ER physicians receive some incentives around outpatient experience and quality. Non-physician practitioners: Reimbursed by specialty: in primary care and behavioral health, primarily RVU productivity based; in specialty care, primarily salary based.	None mentioned.	To succeed in shared savings approach, the organization must (1) synchronize payment model with shared savings approach; (2) deepen primary care/medical home model to create a "disciplined approach to risk application linked with case management"; (3) synchronize physician compensation, particularly primary care, with shared savings approach.
2	Integrated Delivery System	Productivity (RVU), Performance	For outpatient/primary care: 94% of total comp is based on productivity as measured by specialty-specific work RVU. A 6% pay for performance bonus is added. For hospitalists and emergency room physicians there are 3 components to total compensation: base salary, productivity (based on specialty-specific work RVU), and 6% pay for performance. Other specialists are paid 100% productivity based on specialty-specific work RVUs. Organization uses national surveys to be sure RVUs are rewarded appropriately at market level. **Performance:** Pay for performance measurement includes: clinical quality (outcomes measures including MNCM), patient experience (patient surveys), employee engagement (employee surveys), and operating efficiency. Individual measures are specialty-specific. P4P goals are set at a group level.	Pay for performance incentive has improved quality of care in the organization and patient satisfaction and engagement.	Organization has an ongoing debate about whether it works better to reward high quality financially or to expect it as a level of professionalism and improve it through performance management.
3	Integrated Delivery System	Productivity (RVU), Performance	Production based on RVU. Opportunity for additional compensation of up to $15,000 per physician for meeting quality targets and financial targets (depending on specialty this is 5-10% of total compensation). **Performance:** Quality measures differ by payer, but include MNCM measures and payer-specific outcome measures.	None mentioned.	None mentioned.
4	Integrated Delivery System	Productivity (RVU), Performance	Production based on work RVU at market median. Supplementary quality and service payments. Midlevels are paid either on salary or production basis.	None mentioned.	This model will not work well in a population health management focused system.
5	Integrated Delivery System	Productivity (RVU)	Production based on work RVU at market median. Pool of RVU-based reimbursement distributed to departments, which distribute those dollars at their discretion. Some departments distribute evenly among physicians, some base distribution on the amount of call physicians take, and some also distribute based on rudimentary performance measures and/or performance review from department chief. Ancillary services are not tied to physician reimbursement.	Physicians believe the current method is fair.	None mentioned.

Table 6: Physician Compensation Methods (Market)

		Provider Payment to Physicians		Organizational Perspective	
#	**Org Type**	**Detail**	**Overview**	**Opportunities**	**Challenges**
Health Insurance Plans					
6	Health Insurance Plan (Insurance and Delivery)	Productivity (RVU), Performance	Physicians: Combination of productivity-based payment and outcomes-based payment. Non-physician practitioners: Reimbursed on salary basis. **Performance:** Quality measures (MNCM and HEDIS quality measures, in addition to self-developed quality measures), patient experience (patient surveys), total cost of care.	Physician reimbursement and provider compensation methods support 'Triple Aim' outcomes of improved quality and patient experience and lower costs.	Quality measures aren't as well-developed for specialty care as they are for primary care, which is a challenge. Want to continue rewarding for productivity, however the organization feels that RVUs and RBRVS undervalue primary care and overvalue specialty services. Difficult to balance aligning payment levels for specialty and primary care and still remain competitive in the marketplace for recruitment.
7	Health Insurance Plan	N/A	N/A	N/A	N/A
8	Health Insurance Plan	N/A	N/A	N/A	N/A

Table 7: Changing Physician Compensation and Methods (Market)

#	Org Type	Changing Reimbursement Methods	Challenges and Reactions to New Method
Integrated Delivery Systems			
1	Integrated Delivery System	Current method will change to one focused on reducing the total cost of care by improving quality. The method will redefine productivity for primary care based on risk adjusted panel size. It will include larger physician payment incentives around quality, patient experience, cost/resource use, and citizenship. Primary care will be the only service line that has a significant increase in its total compensation. For specialists, payment will continue to be RVU based but will be 80-85% RVU based and 15% based on rewards for quality, cost/resource use, and patient experience. This method will be implemented in early 2012.	Not mentioned.
2	Integrated Delivery System	Recently expanded outpatient/primary care payment method (94% RVU, 6% pay for performance) to employed hospital-based physicians.	N/A
3	Integrated Delivery System	Current method will change to focus on population management, team-based care, and improved outcomes, and align with shared savings arrangements with payers. The method will pay primary care physicians based on quality outcomes, patient experience, total cost of care for patient panel, increase in panel size and panel management. Salaries will be guaranteed for a certain period of time to allow physicians to adjust and develop needed capabilities. Estimated increase in total compensation per physician through the new model is 4%, to just above market median compensation. Shared Savings: a portion of shared savings goes to reimburse the providers enrolled in the program. Do not yet know what criteria will be used to distribute funds. Each practice will receive some portion of the pool and decide how to distribute it to physicians. Distribution probably will be 60% to primary care and 40% to specialists. This reimbursement method is being piloted, and if successful will be used for employed primary care physicians.	In the pilot, costs of care within clinics are going up, but total costs of care are decreasing. Physicians are excited about the new approach. Physicians engaged quickly with the idea of providing care to produce better value for the patient. The organization is not seeing dramatic shifts in production. Instead, the locus of production is changing from the individual physician to the team.
4	Integrated Delivery System	Current method may change to align with population management approaches that payers are beginning to focus on. New methods may change from RVU productivity to panel-size based reimbursement for primary care physicians, and may build in process measures. Methods are currently under discussion.	Organization doesn't want to move too fast on changes to reimbursement because it may lose credibility with physicians. Organization is still working through how to reorganize care operationally to focus on care teams and care management. It doesn't want to finalize a reimbursement plan until it knows how the new care system will function. New system will require data entry, tracking, and analysis systems not yet in place.
5	Integrated Delivery System	Current method may change to focus on global production targets and improve incentives for providing high quality care and increasing patient satisfaction. New methods may include global production targets, incentives for high quality care, patient satisfaction, care management, and avoiding unnecessary costs. Methods also will move current incentives from department level to individual physician level. Methods are currently under discussion.	Organization needs to develop performance tracking and reporting systems to support this type of reimbursement. New reimbursement methods and management of physician performance will require greater infrastructure and cost than in the past.
Health Insurance Plans			
6	Health Insurance Plan (Insurance and Delivery)	Current method may change to reimbursement with a greater focus on outcomes. The method would increase the % that contracted and employed providers are paid based on quality, satisfaction, and efficiency measures. Method is currently under discussion.	Not mentioned.
7	Health Insurance Plan	N/A	N/A
8	Health Insurance Plan	N/A	N/A

Table 8: New Health Plan/Provider Organization Payment Arrangements (Market)

		Description		Organizational Perspective	
#	Org Type	Detail	Overview	Opportunities	Challenges
Integrated Delivery Systems					
1	Integrated Delivery System	Shared savings, Global payment, ACO	Working on developing shared savings arrangements with commercial insurance carriers. Planned experiments vary by health plan. One is PMPM global payment, one is shared savings based on organizational rate of change compared to marketplace rate of change, and one is shared savings based on current organizational rate of change compared to previous. Currently have the equivalent of an ACO model with one insurer, which includes about 4,000 patients.	None mentioned.	To succeed, the organization must (1) synchronize payment model with shared savings approach; (2) deepen primary care/medical home model to create a "disciplined approach to risk application linked with case management"; (3) synchronize physician compensation, particularly primary care, with shared savings approach.
2	Integrated Delivery System	Total cost of care, Shared savings	Organization is currently in 3 total cost of care contracts with 3 of the major private payers in the market and is working on gathering and analyzing the data needed to direct the effort, as well as working on how to tackle the overall approach. Contracts include a decrease in fee-for-service rate over time, where the difference is pooled and paid to the organization if it meets clinical outcomes and cost of care goals. Also includes shared savings/gainsharing arrangements.	None mentioned.	None mentioned.
3	Integrated Delivery System	Shared savings	Organization has worked with all its commercial payers to be paid based on a shared savings method, which also includes payment for clinical outcomes. Fee for service payment to the organization is increasing at a lesser rate (2-4% increase per year rather than 6-7% increase per year) in exchange for the opportunities for additional compensation. The organization is exposed to no downside risk other than this. Decreases in total cost of care are benchmarked against market total cost and the organization's historical total cost. Patients are attributed to providers if a provider has 50% or more of the patients their visits for the year.	Shared savings payment is aligned with system redesign to focus on population-based care.	When the system was redesigned with a population-based focus, the outside payment needed to be aligned with this. Organization undertook conversations with payers to develop shared savings contracts to support it.
4	Integrated Delivery System	N/A	No innovative/pilot methods in use.	N/A	N/A
5	Integrated Delivery System	Productivity, Performance	Organization has contract with its main payer to provide service to patients (hospital, specialty, and primary care) and manage clinics. The payer currently pays the organization based on productivity, with some incentives at the department or practice level for accurate coding, closing encounters, and quality of care in ambulatory care. Organization must meet targets for these to be paid. These are paid to the department and do not yet figure directly into physician reimbursement.	None mentioned.	None mentioned.
Health Insurance Plans					
6	Health Insurance Plan (Insurance and Delivery)	Productivity (RVU), Performance, Shared Savings	Productivity and Performance: For health plan contracted providers (varies by individual contract), 95% of payment is based on RBRVS productivity. 5% uses withholds and bonuses to compensate physicians based on internally-measured quality, experience, and cost-effectiveness outcomes. Began using this approach 13 years ago in primary care. The approach was extended to specialists 10 years ago. Shared Savings: Organization creates a total cost of care target which includes all	Physician reimbursement and provider compensation methods support 'Triple Aim'	Quality measures aren't as well-developed for specialty care as they are for primary care, which is a challenge. Want to continue rewarding for productivity, however the organization feels

Table 8: New Health Plan/Provider Organization Payment Arrangements (Market)

		Description		Organizational Perspective	
#	Org Type	Detail	Overview	Opportunities	Challenges
			services on a PMPM basis for a population (including hospital physician, ancillary, and pharmacy services) and is risk-adjusted. If contracted providers beat the target, the savings are shared with them. Depending on the individual contract, some contracted providers share only upside risk, and some share upside and downside risk. Performance: Quality measures (MNCM and HEDIS quality measures, in addition to self-developed quality measures), patient experience (patient surveys), total cost of care. Health plan provides public reporting on relative quality, satisfaction, and cost-effectiveness measures to members, trying to create "financial incentives for members to choose higher performing providers" by pointing out that they will have lower co-pays and deductibles with high-performance providers.	outcomes of improved quality and patient experience and lowered costs.	that RVUs and RBRVS undervalue primary care and overvalue specialty services. Difficult to balance aligning payment levels for specialty and primary care and still remain competitive in the marketplace for recruitment.
7	Health Insurance Plan	Productivity (RVU), Performance, Pilot (Medical Homes, Shared Savings)	The majority of provider payment is productivity based, using work RVUs for primary and specialty care providers and DRGs for hospitals. Payment schedules vary by type of health care provider/system. Providers negotiate with the plan to determine their conversion factors. Depending on the organization and specific contract between the plan and organization, a certain % of payment may be tied to P4P, Medical Homes, or Total Cost of Care. Pay-for-performance: P4P program for primary care providers was implemented 9 years ago and is being drawn down as the plan focuses on other kinds of contracts. At its peak, 5-7% of their reimbursement was P4P, and it is currently 1-2%. This was a bonus on top of normal payment. Medical Homes: Began paying for medical homes 4 years ago. Payments are negotiated with the contracting provider group based on PMPM historical costs to the plan for disease management services and needs of provider group. Providers are paid using a range of approaches, from a PMPM fee to a 6-month per member fee to conduct care management and medical home services. About 80% of physicians working with the health plan participate. Medical home reimbursement is 5-10% of their total compensation. Total Cost of Care/Shared Savings: Total cost of care approaches are designed in negotiations between plan and individual health care providers. Plan and providers go through mutual data examination and modeling of expected total cost of care. An agreed upon total cost of care is determined for a period (year). Provider then receives up to 50% of the savings generated from undercutting the expected total cost. Providers have to also meet quality and satisfaction measures to get the shared savings reimbursement. Reimbursement is from 3-10% of total reimbursement to these providers. Currently providers only have upside risk. Evolution of the model is occurring fairly constantly as providers learn more about what they can do and how, and renegotiate contracts accordingly. Organizations with such contracts range from large integrated systems to small (15-person) provider groups. Attribution is claims-based, where a certain % of visits must be to one provider for the member to be attributed to that practice. Attribution method is revised and re-tested over time to ensure continued validity. Performance: Organization uses MNCM and internally-developed quality measures.	Total Cost of Care/Shared Savings: Plan wasn't sure that health care organizations would be able to lower cost of care and meet quality targets. However providers have earned 50-100% of the available shared savings reward in the first 2 years of the arrangement.	Total Cost of Care/Shared Savings: This approach may be viewed as very similar to the failed HMO approach. The plan is trying to ensure that this is a different approach by separating 'insurance risk' from 'provider risk'. 'Insurance risk' is still held by the plan, and is risk for 'acts of god' or anything outside of provider control. 'Provider risk' is risk the providers assume for providing appropriate care and utilization.
8	Health Insurance Plan	Productivity, Performance, Shared savings	Current Methods: 2 contracting modes, standard and negotiated. Of total dollars spent, 62% goes to integrated health systems, 38% to smaller groups. Standard contracts are made with small physician groups, and use a standard fee schedule. Standard fee schedule is based on market fee levels/community norms, existing	Providers like seeing good comparative data about their	Current percentage of pay for performance used is not enough to change provider behavior. Organization needs to continue

Table 8: New Health Plan/Provider Organization Payment Arrangements (Market)

		Description		Organizational Perspective	
#	Org Type	Detail	Overview	Opportunities	Challenges
			payment level, and discount level. Negotiated contracts are made with integrated care systems. Negotiated overall rate of increase is based on market fee levels/community norms, existing payment level, and discount level. Contracts average 1-2 years in length. May include small pay-for-performance payment. Use Medicaid and Medicare fee schedules when setting payment for government programs, and internally derived fee schedules for commercial programs. New Methods: 3-year contracts. 3 elements: 1. Standard fee schedule with a decreased rate of guaranteed increase in fees over time. 2. Quality incentives where care system must meet or exceed a benchmark to receive payment. 3.Total cost of care: if total cost of care per attributed patient decreases over time, care system can receive payment. Proportion of payment for each element changes over time so that payment for fee schedule decreases while payment for decreases in total cost of care increases. For total cost of care, attribution is retrospective, based on 51% or more of E&M services, and patients will be attributed yearly. Risk-adjusted total cost of care is calculated for Minnesota patients, and care system's non-risk-adjusted total cost must be below this threshold. One contract uses a combination of community benchmarking and benchmarking based on past total cost within the health system. May build in incentives specific to the provider organization. Currently includes only commercially insured population. Organization began first such contract in 2010 and will begin more in 2011.	performance which they cannot get themselves. Providers are eager to start moving toward ACO types of contracting.	to build and refine analytic capabilities for measurement and reporting to support ACO contracting.

Table 9: Views on Accountable Care Organizations (Market)

#	Org Type	Organizational Preparedness for ACO	Additional Comments
Integrated Delivery Systems			
1	Integrated Delivery System	Organization is actively moving towards developing ACO capabilities, with a goal of being ready for ACOs and/or global payment in 3 years.	Organization thinks that improved risk adjustment and attribution approaches are needed in a move towards ACOs. Organization also needs a 'critical mass' of payers to pay for total cost in order to move to ACO arrangements.
2	Integrated Delivery System	Organization is beginning to think about how it would operate in 'an ACO world'. It is not sure if it currently has structure or patient population necessary to absorb risk. It also doesn't know which other organizations to affiliate with in order to develop a larger network. It would not want to partner with financially fragile organizations in a risk-sharing scenario.	None.
3	Integrated Delivery System	Organization is working on developing ACO networks and capabilities, and sees a shared savings payment approach as a step towards developing these capabilities, with a goal of being able to take on risk in 2-3 years.	None.
4	Integrated Delivery System	Organization has no specific plans for ACO development. It is monitoring other's projects to learn from their approaches to ACO.	None.
5	Integrated Delivery System	Organization is working on projects and policy development to support vulnerable populations they serve during the development of ACOs.	None.
Health Plan			
6	Health Insurance Plan (Insurance and Delivery)	Organization feels well prepared for ACO arrangements due to current organizational alignment between delivery and payment.	Market is fairly consolidated already, but ACO development will likely drive more consolidation as smaller provider groups align with larger systems.
7	Health Insurance Plan	Organization is moving toward total cost of care approaches as a means of providing more efficient care while retaining high quality. Organization sees this as preparation for ACOs.	As ACOs begin to develop, provider organizations are living in 2 different payment worlds, where the majority of reimbursement is still FFS but some is quality and efficiency based. Providers are taking a financial risk by becoming more efficient.
8	Health Insurance Plan	Organization would like to move past lower-level reform efforts (e.g. medical homes) and toward paying for ACOs.	Organization thinks that attribution will work by patients electing to be attributed to a given provider.

APPENDIX A. INTERVIEW PROTOCOL

I. Organization Background: Organizational Approach to Valuing Physician Services

1. Describe your organization in terms of size, estimate of market share, number of units/ practices, physicians, owned ancillary services, etc.
   - In general, how would you describe your approach to determining physician compensation?
2. Tell us what methods your organization uses to determine compensation for physician services? Do these methods vary by specialty? If so, describe differences.
   - In your organization who is involved in determining these methods? What approval process, if any, is there before these methods are used? Are these approaches reviewed on a regular basis? If so, by whom?
   - Tell us about physician employment contracts used by your organization. Do these agreements include clauses that relate to protections from changes in third party payments or are there risk bearing expectations in these contracts? Explain.
   - How do changes in payers' reimbursement strategy affect your organization's physician compensation strategy? Describe. Is it important to your organization that you coordinate compensation plan design with payer reimbursement changes? If a particular contract differentially affects a particular specialty, would that affect compensation for that specialty? Explain.

II. Methods and Data Use

1. In physician compensation planning, for the methods you use that do not rely solely on RVUs or charges, tell us what are the components or elements, e.g., measures of productivity, quality, satisfaction, team performance, etcetera that factor into each.
   - How, why, and when were these methods developed?
   - Are any of the elements of the methods weighted? If yes, how/ on what basis?
   - What are the sources of data you use for the elements that make up these methods? Are these data used for other purposes? If yes, explain.
   - Walk us through how the method works for (ask respondent to select primary care and specialty case examples). Are there exceptions made for specific case situations? If yes, how are decisions about exceptions made?

- Tell us about the methods you use for compensating non-physician practitioners (e.g., NPs, PAs)? If a medical group: Does the physician compensation plan include margins on ancillary services?

2. In your opinion, how well have these methods served your organization's physician compensation plan needs?
   - Have there been any problems or pitfalls to the methods you are using?
   - Will your organization's physician compensation plan for the future require adopting a different strategy? Explain. Different strategy for physician recruitment? Explain.
3. What are the advantages of your approach to these compensation methods over a system whereby you would use RVUs or charges? What are the disadvantages?

III. Physician Reaction to Methods in Use

1. In general how have physicians responded to these methods?
   - Are there differences in response by specialty? Other factors?
2. To what extent are physicians involved in determining the methods for compensation? In determining what elements the methods use? Data collection and use for these methods? How specific elements are weighted? Other aspects?

IV. Market Background: Approaches to Valuing Physician Services and Perceptions of Market Power and Dynamics

1. For the local market your organization operates in, can you provide an overview for how the various players (meaning payers, plans, health systems, and large provider groups) approach determining compensation for physician services, especially those approaches that go beyond solely using RVUs or charges?
   - Have these approaches changed over the last five to ten years? If so, how?
2. How are you affected by market trends in the area of physician compensation planning?
   - Have market trends ever caused you to modify your approach to determining physician compensation? If yes, explain.
3. Do you see current trends in your market that may drive change in how compensation for physician services is determined?
   - In your opinion, what are the major market forces that drive these decisions in your market?
   - Has the balance of power between insurers and providers, with respect to these market forces, changed in this market? If so, how?

- How would you characterize your market in terms of the range of prices for physician services (higher-moderate-lower) than average? What do you base that on?
- In general, in the future what different strategies might you expect payers, plans, health systems, and provider groups to use in this market in developing their approaches to physician compensation?
- How do you think this market compares with others in the country?

4. Do you believe that in the future, another third party, such as an ACO, Accountable Care Organization, will play a role between the payer and your organization that affects payment methods for physician services? If so, for which payers? What are the potential implications of these arrangements? What are the pros and cons of these third party arrangements for organizations like yours?

V. Closing

Is there anything else that comes to mind that we have not asked or anything else you would like to tell us about payment methods for physician compensation?

APPENDIX B. VHA APPROACH TO VALUING PHYSICIAN SERVICES

The Medicare Payment Advisory Commission asked the investigators to interview respondents from the United States Veterans Health Administration (VHA) about physician compensation within the VHA system. We interviewed three executives from the Central Office and regional level, the Veterans Integrated Service Network, about budgeting decisions and methods for determining physician compensation. Because the VHA is a unique part of the U.S. health care system, and therefore readily identifiable, we sought and received permission from the VHA to identify it in this report.

VHA Background

In 2009, according to statistics from the U.S. Department of Veterans Affairs (2010), the VHA "provided health care for nearly 6 million Veterans at more than 1,400 sites throughout the country…VHA employs a staff of 255,000 and maintains affiliations with 107 academic health systems….there are now more than one million ambulatory care encounters each week" in the VHA. In 1995, VHA reorganized its centralized structure and management into 22 (now 21) geographic regional networks called Veterans Integrated Service Networks (VISNs). This structure ensures regional accountability and decision making for daily operations of hospitals, community-based outpatient clinics (CBOCs), nursing homes, and Vet Centers in each of the regions. Many of the decisions concerning resource allocation based on pre-determined budgets and methods for physician compensation are made at the regional level and the facility level within each region.

VHA Physician Compensation Arrangements

In brief, the process of resource allocation for the VHA begins with an annual formulation of its budget, based for the most part on an actuarial projection model that calculates expected veteran demand for health care services at an area level. The aggregation of these projections ultimately becomes the basis for the VHA's request of the U.S. Congress for appropriations. As one respondent described, "Once Congress appropriates that…we then have to allocate that out to the VISNs." This allocation process is done according to guidelines established in the Veterans Equitable Resource Allocation (VERA) System (U.S. Department of Veterans Affairs, 2010). The VHA employs most of the physicians it needs in its health system and also contracts with physicians in certain specialties which are relatively scarce or which are in short supply in the service area of a given medical facility. It is through VERA that determinations of resource allocation for VISNs are made, including expense budget allowances related to physician compensation methods for employed physicians and financial resources for contract physicians. However, VERA does not provide specific guidance on methods for physician compensation determination. These decisions are based on market comparisons, Federal legal limits, HR

compensation and policy, and VISN level local determinants. VERA, in essence, serves as a capitation model for resource allocation for all expenses related to caring for a given population of veterans within a prescribed geographic service area.

At the VISN and facility level, according to a respondent, "The determination for physician and dentist compensation is premised on the three components of total pay: base pay, market pay and performance pay." VISN and facility level recommendations on compensation for individual providers are made by a compensation panel of physicians and dentists. These panels utilize established pay tables to determine an individual physician's or dentist's base and market pay. The pay tables (as established by *Public Law 108-445*) contain minimum and maximum compensation levels for a given specialty/assignment and level of responsibility. The majority of physician pay panel compensation decisions are made at the facility level. VISN level physician pay panels are used less frequently for the recruitment of senior physician positions such as the facility Chief of Staff, or a physician with a VISN level assignment. Both VISN and facility level pay panels recommend physician annual salary to include base plus market pay. A number of benchmarking tools are used to evaluate market pay, including Association of American Medical Colleges (AAMC) survey data, Hospital & Healthcare Compensation Service (HHCS) survey data, Sullivan & Cotter survey data, VA salary comparative data, and others. Performance pay, which is determined by each physician's supervisor, is a small portion of overall physician compensation and is added on to the base plus market pay. For locally-contracted physician services contracts, the medical centers have compensation guidelines to follow, but generally make market based decisions; they are not necessarily mandated to use the CMS fee schedule in their determinations, but they do use that information to assist in competitive market decisions.

Methods Used to Determine Physician Compensation

In response to our request for information, the VHA provided more detail on the legally defined components for market pay determinations as used by VISNs, which includes the following description of methods:

> *Public Law 108-445 delineates the components that must be considered for market pay determination. The pay of VHA physicians and dentists consists of three elements: base and longevity pay, market pay, and performance pay.*
>
> - ***Base Pay.*** *The rate of pay fixed by law or administrative action for the position held by an employee before any deductions and exclusive of additional pay of any kind (e.g., market pay, performance pay, recruitment incentive etc.) as prescribed under 38 U.S.C. 7431.*

- ***Longevity Step***. *Increase is the advancement to the next higher step of the grade based upon completing the required waiting period of two years (104 weeks) of creditable service.*
- ***Market Pay.*** *A component of basic pay intended to reflect the recruitment and retention needs for the specialty or assignment of a particular VHA physician or dentist.*
- ***Performance Pay***. *A component of compensation paid to recognize the achievement of specific goals and performance objectives prescribed on a fiscal year basis by an appropriate management official. Performance pay is paid as a lump sum.*

Performance pay is paid at the end of the fiscal year based on the evaluation of attainment of specific preset goals and metrics, and is maximized at an amount that is no greater than 7.5% of annual pay, not to exceed $ 15,000. Establishing the performance goals is left to the supervisor in conjunction with the individual physician in the form of an annual performance contract. These goals are adjusted annually and are tied to the priorities for each specific facility and individual department and may include measures of, for example, productivity, volume, quality, adherence to process of care guidelines, patient experience, or other metrics. In determining performance, the metrics are generally equally weighted. According to a respondent, Public Law 108-445 "has been a real step forward for the VA. It has been used over the last four to five years and has helped us establish equality so that we are more competitive with the private sector." However, in some cases, an additional "recruitment bonus" or "retention bonus" such as with rare medical specialties or with physician shortages are used as augmentation compensation. These can be renewed annually after re-justification of continued need.

Any impact of health reform on the VHA specific to physician compensation determination has yet to be determined. A VHA Health Care Reform Work Group has been charged with this task. A respondent commented, "We are anticipating lots of changes [to health reform] but we're still in the study mode."