

# Part I

## PHYSICIAN ISSUES

### Chapter 1

# Physician Compensation for Quality: Behind the Group's Green Door

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- § 1:1 Introduction
- § 1:2 Whither P4P?
- § 1:3 Physician compensation—In general
- § 1:4 —Compensation architectures
- § 1:5 —Productivity
- § 1:6 —P4P treatment
- § 1:7 —Non-clinical production
- § 1:8 A snapshot of today—In general
- § 1:9 —Relatively young or limited programs
- § 1:10 —Longer duration, broader metrics programs
- § 1:11 —The oldest, broadest programs
- § 1:12 —Common lessons learned
- § 1:13 Coming payment changes—In general
- § 1:14 —Primary care/medical home
- § 1:15 —More than primary care
- § 1:16 —The PROMETHEUS Payment® model
- § 1:17 —Implications
- § 1:18 The law—In general
- § 1:19 —The difference between profits and productivity bonuses
- § 1:20 —“Permissible safe harbored” formulae
- § 1:21 —Hospital and integrated system issues
- § 1:22 Employment contracts
- § 1:23 Conclusion

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## § 1:1 Introduction

The drumbeat for improved quality performance throughout the United States is louder. Pay-for-performance (P4P) programs are proliferating. From 2003 until today, the number of P4P programs has quadrupled and does not show signs of abating.<sup>1</sup> Public reporting linked to Medicare reimbursement now applies to both hospitals and physicians.<sup>2</sup> Public reporting of quality with no payment link has also burgeoned, in waves of transparency—including even institutions not only posting their quality results<sup>3</sup> but actually making public their JCAHO survey reports.<sup>4</sup> The goal of all of these initiatives is to stimulate quality improvement—whether by the persuasion of bonus payments, the blunt force of regulatory mandate, the market effect of competition based on quality, or the sheer moral power of doing the right thing. All reflect the belief that either more money for more quality will get better results, or comparative data will instigate change by virtue of competition for consumer-driven choices.

Despite all this ferment, there is astonishingly little information available about the extent to which physicians within their own groups, reward or motivate quality improvement through their own self-directed compensation models. If P4P for physicians is intended to change behavior, what happens to that money when it gets to the groups where the physicians practice? Do individual physicians reap the direct ben-

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### [Section 1:1]

<sup>1</sup>Robzniecks, “P4P programs quadruple,” *Modern Healthcare*, p. 10 (Sept. 3, 2007).

<sup>2</sup><http://www.cms.hhs.gov/QualityInitiativesGenInfo/>.

<sup>3</sup>Rowe, “The Great Disclosure Debate,” *Health Leaders*, pp. 43-44 (Oct. 2007); Aviles, “Transparency in Practice,” *Modern Healthcare*, p. 24 (Dec. 10, 2007).

<sup>4</sup>See “A Message From MGH President, Peter Slavin, M.D.” (April 20, 2007), at [http://.massgeneral.org/message\\_\\_april07.html](http://.massgeneral.org/message__april07.html).

enefit of their response to these programs? Could proactive compensation in groups propel quality further and faster? What are the countervailing goals of physician compensation models? What does the law say about how monies may be divided within groups and is that a boon or a barrier to this quality movement? What would be different given developing payment models? The murky corridors of physician group compensation practices in relationship to quality need illumination. This chapter sheds light on the answers to these questions.

### § 1:2 Whither P4P?

The advent of P4P has been well documented.<sup>1</sup> With the acknowledged failure of both capitation and fee-for-service to generate optimal quality, payors (and sometimes employers) have decided that making bonus payments to physicians for better results would improve their performance. Some programs pay on the basis of comparative performance within the “class” of participating physicians. Others pay based on a threshold of performance. Still others have moved from a bonus payment model to one which expressly characterizes the potential payment as a withhold.<sup>2</sup> All of them, whether sponsored by a health plan or an employer, give more money to groups or physicians whose performance is “better” as measured in widely variable metrics.

Is it working? So far that is hard to say, in part because, ironically, the sponsors of these programs have frequently not established any thresholds, benchmarks or metrics of their own to assess the impact of their new payment approach. P4P programs have been in vogue essentially since 2003-2004, although aspects of these programs were evident long before. In a study based on 1999 data, the Center for Studying Health System Change found that physicians were more likely then to face health plan quality incentives than

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#### [Section 1:2]

<sup>1</sup>Gosfield, “Contracting for Provider Quality: Then, Now and P4P,” Health Law Handbook, pp. 103-82 (Gosfield, ed. 2004).

<sup>2</sup>Lee, “Using Payment Incentives to Improve Care Delivery,” Commonwealth Fund (Aug. 30, 2007), at [http://commonwealthfund.org/innovations/innovations\\_show.htm?doc\\_od=520326](http://commonwealthfund.org/innovations/innovations_show.htm?doc_od=520326).

incentives that limited utilization.<sup>3</sup> Even so, such incentives were far more prevalent in group/staff-model HMOs, which profiled their physicians in accordance with not only productivity, but also patient satisfaction and/or quality. Of course, the dilemma in casting these arrangements as what we understand today as P4P, turns on the fact that the respondent physicians and the HMOs where they practiced were far more integrated than is the case in the broad physician population across the country.

Data on results of more modern versions of P4P are neither robust nor compelling. A 2007 assessment of P4P among 10 commercial health insurers—8 regional plans and 2 national plans—found that physician-focused P4P was far more evolved than hospital P4P. Still, among those 10 plans, almost 60 indicators of physician performance were being used; and of the plans surveyed, no two rewarded providers the same way for performance. All administered their programs differently as well.<sup>4</sup> Generally the researchers found that the dollar amounts available for payment could not be said to change provider behavior significantly; yet, the same study reported that few plans have established tracking methods to determine whether their efforts are working at all.

The inherent design of the programs has been criticized.<sup>5</sup> They almost all reward affirmative acts—actually doing something that can be counted or measured—rather than addressing overuse by paying extra to *not* do something. They are very heavily focused around primary and chronic care, although some programs do reward specialists. In the Bridges to Excellence Spine Care program, physicians are paid for not providing unnecessary procedures.<sup>6</sup>

Still, there seems to be a perceived inevitability in the relentless pace of P4P program implementations. Payors de-

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<sup>3</sup>Stoddard, Grossman and Rudell, “Physicians More Likely to Face Quality Incentives than Incentives That May Restrain Care,” Issue Brief No. 48 (Jan 2002), at <http://hschange.org/CONTENT/396/?topic=topic02>.

<sup>4</sup>“Keeping Score,” PriceWaterhouseCoopers Health Research Institute (2007).

<sup>5</sup>Gosfield, “P4P: Transitional At Best,” Managed Care (Jan. 2005), at [http://www.managedcaremag.com/archives/0501/0501.p4p\\_gosfield.html](http://www.managedcaremag.com/archives/0501/0501.p4p_gosfield.html).

<sup>6</sup><http://www.bridgestoexcellence.org/assets/Documents/BTEsSpineCareLinkOverview1.pdf>.

scribe them as essential.<sup>7</sup> Physicians are resigned to their presence;<sup>8</sup> and are even generally supportive of incentives for quality “if the measures are accurate.”<sup>9</sup> But only 30 percent of physician respondents in the same recent study agreed, on any level, that P4P measures today are accurate. The vast majority of general internists surveyed (85 percent) believe the current measures associated with P4P are not appropriately adjusted for clinical severity or socio-economic status.

In California, after the first year of the highly touted multi-plan Integrated Healthcare Association (IHA) P4P initiative, researchers found that in one PPO, most physicians had no idea any payment had been made to their groups based on their performance; more than half were not even aware of the program’s existence; and none indicated its presence had made any difference whatsoever in their treatment of patients.<sup>10</sup> The physicians reported that the primary motivators in their practice were, above all, improving their patients’ health, followed by money and respect. They cited as challenges to their ability to render optimal care: (1) cost/insurance concerns (including documentation demands as well as actually getting paid for services); (2) loss of time; and (3) administrative program demands. Asked why Americans only get 55 percent of what science says they should, half (52 percent) blamed patient compliance, another significant portion (44 percent) cited lack of time, followed by insufficient insurance coverage (35 percent) and physician failures (36 percent).

On the other side of the country in Massachusetts, another 2007 study surveyed physician group leaders in a setting where 89 percent of the groups were subject to a P4P

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<sup>7</sup>“Keeping Score,” Price Waterhouse Coopers Health Research Institute (2007).

<sup>8</sup>DeFrancesco, “Pay for performance: We’ll be better off,” *Journal of Family Practice*, Vol. 18, No. 12 (Dec. 2006), at <http://www.jfponline.com/Pages.asp?AID=4608>.

<sup>9</sup>Casalino, Alexander, Jin and Konetzka, “General Internists’ View on Pay for Performance and Public Reporting of Quality Scores: A National Survey,” *Health Affairs*, 26:2, pp. 492-99 (Mar./Apr. 2007).

<sup>10</sup>Teleki, Damber, Pham and Berry, “Will Financial Incentives Stimulate Quality Improvement? Reactions From Frontline Physicians,” *American Journal of Medical Quality*, 21, p. 367 (2006).

incentive.<sup>11</sup> Those additional payments represented between 1 percent and 10 percent of their total revenue (mean 2.2 percent of total revenue). The researchers found a positive correlation between P4P incentives tied to a Healthcare Effectiveness Data and Information Set (HEDIS) measure and the implementation of quality improvement (QI) initiatives to target it. But, adopting an initiative targeting a measure is at least one step removed from actual improved performance. The implementation of specific QI interventions was tied to the perceived clinical importance of the measure, the cost and effectiveness of available quality improvement initiatives, the group's operating margin and the plan's payor mix and market share. Almost all the physicians (91 percent) reported that for any P4P program to have much effect, it must represent 5 percent or more of revenue to motivate changed behavior.

A more recent study of the evolution of P4P returned to its early adopters for evaluation of developments.<sup>12</sup> The authors found that among early adopters, P4P has taken root and is reaching out to new provider types. Most plans studied, though, have added to pure quality metrics, additional measures of cost efficiency and information technology. This finding is echoed in the changes occurring in the IHA program which acknowledges employer dissatisfaction that P4P is not saving money,<sup>13</sup> so efficiency measures are being added to assure appropriate care is delivered. Most programs have increased the number of measures. The majority have augmented the pool of money available to pay rewards. More than half have begun to risk adjust their scoring. Still there is no strong evidence of impact. The study subjects cited three major challenges to building and maintaining effective P4P programs: "(1) overcoming physician resistance; (2) determining the necessary size of incentive pools to capture

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<sup>11</sup>Mehrotra, Pearson, Coltin, Kleinman, Singer, Rabson and Schneider, "The Response of Physician Groups to P4P Incentives," *American Journal of Managed Care*, Vol. 13, No. 5, pp. 249-55 (May 2007).

<sup>12</sup>Rosenthal, London, Hewitt, Sony and Epstein "Climbing up the Pay-for-Performance Learning Guide: Where Are the Early Adopters Now?" *Health Affairs*: 26:6; 1-9 (Nov./Dec. 2007).

<sup>13</sup>Terry, "Is P4P Getting Tougher?," *Medical Economics* (July 20, 2007), at <http://www.memag.com/memag/conent/printConentPopup.jsp?id=440879>.

providers' attention; and (3) finding the resources necessary to continue funding the programs.”<sup>14</sup>

So, we have evidence of equivocal impact of P4P programs in a context within which quality performance undeniably still lags. Among the critical factors to improve quality, it would seem essential to look at how physicians are paid as individuals and whether their individual compensation enhances, facilitates, reflects or contradicts external payment incentives. If P4P is not improving quality, can internal compensation jumpstart better quality results? Is the reason P4P is not working in part because internal incentives are discordant with its goals? If “aligned incentives” have been the holy grail of health plan payment, consistent physician group internal compensation incentives would seem to be critical to optimize the potential for improving the health care delivered to Americans. To understand the complexities of where compensation for quality fits in this complex network of plan-provider-purchaser-consumer-patient-relationships, it is important to understand basic principles of traditional physician compensation.

### § 1:3 Physician compensation—In general

The evolution of compensation models and principles begins with the classic business of a solo practicing physician. Whether one physician and one support person or one physician supported by a very sophisticated array of ancillary personnel, systems and equipment, or, in a few widely reported stories, one physician alone without any staff,<sup>1</sup> the financial reality of solo practice is no different from any other small business held as a sole proprietor. Revenue is used to pay overhead and expenses, and the rest is either paid out

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<sup>14</sup>Rosenthal, London, Hewitt, Sony and Epstein “Climbing up the Pay-for-Performance Learning Guide: Where Are the Early Adopters Now?” *Health Affairs*: 26:6; 1-9 (Nov./Dec. 2007).

#### [Section 1:3]

<sup>1</sup>Moore, “Going Solo: Making the Leap,” *Family Practice Management* (Feb. 2002), at <http://www.aafp.org/fpm/20020200/29goin.html>; Moore, “Going Solo: One Doc, One Room, One Year Later,” *Family Practice Management* (Mar. 2002), at <http://www.aafp.org/fpm/20020300/25goin.html>; Guglielmo, “What’s a micropractice?,” *Medical Economics* (Dec. 1, 2006), at <http://www.modernmedicine.com/modernmedicine/article/articleDetail.jsp?id=387511>.

as compensation or a portion is retained as reserves. In general principle then, increased prices, lowered expenses, better efficiency and more and sustained customers add to the profit margin and therefore, personal compensation.

The source of revenues—whether fee-for-service or capitation—creates a very direct incentive regarding management of resources. In fee-for-service, the more the physician does, the more revenues. Higher revenues, however, do not necessarily translate into higher profits unless the other factors besides price and volume are managed effectively. In capitation, because there is a finite pool of dollars per patient, the less one does for the patients, the lower the expenses and, theoretically, the more revenue is available to distribute as profit compensation to the solo physician. Where a single practice has payors which offer both models, the direct impact of the incentives is blunted.

In groups, the same principles exist, but they become more complex where management of expenses includes fixed and variable overhead, which itself varies in terms of to whom the expenses are attributable. Group efficiency in care delivery becomes more complex to manage as the group becomes larger and there are more people and systems to take into account. Multiple specialties complicate all the formulae.

The art of using physician compensation plans in groups to accomplish specific goals is one to which groups have devoted quite variable attention. In addition to the financial goals of any compensation scheme, however, compensation formulas, above all, will either create a culture or reflect a culture within the group. For example, an extremely egalitarian organization with a strong team ethic will pay physicians equal shares of the revenues received. While this is relatively manageable in single specialty groups, the variability in the way specialist services are reimbursed automatically creates issues which must be confronted in a multi-specialty context. Resource utilization also varies by specialty as do resource needs. Physicians who spend most of their time at the hospital represent a significantly different resource consumption profile from physicians whose practices are purely office based. Diagnostic or technology-demanding specialties have very different expense needs from cognitive, visit-heavy specialties. How a group allocates revenues and expenses, defines, quantifies and rewards “pro-

ductivity” and explicitly designs its system to balance the business model on the multiple axes of profit, culture and outcomes for patients is an increasingly difficult challenge.

#### **§ 1:4 Physician compensation—Compensation architectures**

The variables in physician compensation schemes are considerable. Explicitly shared values may be at work. “We are egalitarian and support a team approach through our compensation.” Or, “we value individual performance above all and those who contribute the most should receive the most.” They also reflect real business concerns. “Are we about maximizing revenues per physician or do we reserve for capital expenditures, like an electronic health record? Do we want to reserve revenues to recruit new physicians or other clinical personnel and build our future?” The decisions reflected in compensation can reflect short term challenges or long term cultural statements. In many groups, the design of the compensation models may reflect no explicit decision making at all and may simply have evolved as the group grew.

An interesting analysis of physician compensation plan strategies has been authored by Bruce Johnson and Deborah Walker Keegan of the Medical Group Management Association (MGMA). They have analyzed five “team-oriented” compensation “architectures,” five individualistic architectures and another eight which they place in the “middle ground.” All of the variables turn on the treatment of revenues and expenses.

Their cultural distinction between team-oriented and individualistic plans reflect fairly traditional views of the economic value that the physicians bring to the group. Team-oriented plans, they claim, recognize the reality of a single economic unit and group practice; promote a collaborative work ethic; permit production orientation; are simple and straightforward; can be linked to market levels of compensa-

tion; and include clear messages regarding performance expectations.<sup>1</sup>

While one might quibble about some of their characterizations, their analysis does permit the gradation of the implications of compensation plans along a continuum. The disadvantages of the team-oriented plans, according to them, are that they are more difficult to sustain with large variations in production and work levels among physicians. They do not capture direct responsibility for cost and/or resource utilization; they permit some physicians to shirk responsibility absent a strong group culture or explicit performance expectations; and they may not provide decent reward for working harder.

At the other end of the continuum, not surprisingly, individualistic plans focus on the performance of the individual as a largely separate profit and loss center. These are far more “eat what you kill” formulae which direct the rewards to individual efforts. They multiply the issues in the classic solo practice. The advantages, cited by Johnson and Walker, are that they promote a sense of individual responsibility; they are arguably easy to administer; they also include a clear message regarding expectations; and they are consistent with an intuitive view of how income is both generated and logically applied. In other words, they treat the individual physician as if he was an economic unit on his own, with far less emphasis on cross-subsidization across specialties. The disadvantages of individualistic models are that they might undermine the group practice perspective, are likely to generate the same behaviors that are problematic in the external productivity models (*e.g.*, stimulating over utilization as fee-for-service does) and can lead to tensions with regard to expense allocations.

The major differences among their architectures lie on the expense dimension, once the individual’s revenue has been captured. All assume deducting some expense calculation from revenue representing “pure production.” Their range of pathways include calculating expenses by: (1) strict cost accounting based on utilization; (2) modified cost accounting

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**[Section 1:4]**

<sup>1</sup>Johnson and Walker, “Physician Compensation Plans,” Medical Group Management Association, pp. 64-101 (2007).

expense allocation shared among the physicians based on utilization; (3) negotiated expense allocation (*e.g.*, revenues allocated based on production combined with equal 50 percent share and 50 percent production based expense allocation); (4) equal share expense allocation; and (5) negotiated or graduated expense allocation. But all models which do not compensate all physicians equally per force have to confront “productivity.”

### § 1:5 Physician compensation—Productivity

The most obvious measure of physician work value might be gross charges. However, not only is this measure most significant in a fee-for-service environment, where each specific activity generates additional dollars, charges, of course, are rarely actually paid by any payor. Therefore net collections (dollars actually received) are a more typical measure of productivity. However, in practices with mixed revenue streams, where there are some payors like Medicaid which pay vastly below the general market, charges are sometimes used to capture the actual work the physicians are doing, so as to not disadvantage the physicians in the group who treat more of the patients with under-compensating payor sources. When those patients are spread equally across the practice this is less of a problem.

Work relative value units (WRVUs) are still another quantifiable measure of physician work and effort, as are individual encounters. In mixed specialty practices, the work RVUs can capture the complexity of the services rendered for procedural based practices, whereas the number of encounters is the measure of volume for the non-proceduralist. This distinction, however, can lead to the same complaint that physicians have had generally about the inability to quantify effectively the capture of cognitive services versus the purportedly “overpaid” procedural services. As a result, increasingly, compensation formulas in multi-specialty groups are shifting dollars from the specialists to the primary care physicians to maintain better equity.

Finally, most traditional compensation models are oriented to reflect fee-for-service medicine. In capitation, revenues and collections have very little to do with physician work efforts, so panel size or panel size equivalences (the number of patients selecting the physician) are another way of measur-

ing production. However, many practices use encounters plus panel size or ignore panel size since within the group—panel size itself reflects no work effort requirement on the part of the physician. The traditional models also have not done much to take into account time expenditures, efficiency of care delivery or quality or appropriateness of care.

### § 1:6 Physician compensation—P4P treatment

P4P dollars are an add on to the basic reimbursement structure. Where physicians are paid capitation, the P4P dollars often are paid as an enhancement on the per member per month (PM/PM) capitation rate. In the first generation of the IHA program in California that addition varied among payors from \$0.20 PM/PM to \$2 PM/PM. Other programs, like Bridges to Excellence, pay a fixed amount a year (*e.g.*, \$100 on the diabetes program) for each patient in the physician's panel with the condition at issue. Three approaches to allocating revenues from P4P programs have been cited:<sup>1</sup>

- (1) Direct treatment gives the dollars generated under the P4P program directly to the physician whose scores produce the revenues. This, of course, assumes that the attribution is clear. Where P4P is paid to groups as a whole, determining which physician was responsible for the P4P dollars becomes more difficult.
- (2) Indirect treatment can arise in several ways so that, for example, if a practice credits physicians for net collections from professional services by applying a ratio of net collections to total net collections, then the same percentages apply to all of the P4P dollars received by the practice allocating to an individual physician his ratio. Another indirect treatment method involves a separate incentive pool for the P4P funds. Those dollars that are generated by P4P may actually be allocated to reflect other goals of the group. A third indirect compensation model would take those funds and apply them to practice operating expenses thereby reducing the expense allocations to the individual

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#### [Section 1:6]

<sup>1</sup>Johnson and Walker, "Physician Compensation Plans," Medical Group Management Association, pp. 64-101 (2007).

physicians or spending those dollars on implementing an electronic health record or disease registries or hiring more personnel to fulfill the goals of the practice overall.

- (3) Johnson and Walker have identified yet a third category of P4P treatment which they describe as “integrative treatment” within the context of a larger program of clinical integration. However, they offer no data or examples so the analysis is essentially speculative.

### **§ 1:7 Physician compensation—Non-clinical production**

In any group practice, there are significant non-clinical physician activities which bring value to the practice such as: (1) administration to improve operations; (2) education or outreach which add to the prestige of the group; (3) medical staff leadership at the hospital to facilitate a harmonious, quality-oriented place to bring patients and work; and (4) developing new “product lines”—the equivalent of research and development in a manufacturing company and more. Clinical productivity can be captured with the financial models above. However, for purposes of bonus compensation or of general expectations to qualify for base salary and continued employment, other factors may well be taken into account in compensation. Their inclusion is critical in many compensation models if those functions are to be performed by physicians, particularly where clinical productivity is an otherwise significant driver, because if non-clinical work is not compensated, physicians who do that work are at financial disadvantage for doing so. These can include the extent of the performance of administrative roles within the group as well as in relation to the hospital or health plan.

Quality performance measured by compliance with clinical practice guidelines, contributions to P4P payments, performing in accordance with HEDIS or other measures which plans use to evaluate the group have been occasionally reported as activities compensated outside of clinical productivity. Efficiency, when measured, typically is calculated from the perspective of wait time, availability of appointments, and smooth operation in the office. Team orientation can also be measured in the use of non-physician practitioners, interpersonal effectiveness, participation in

inter-disciplinary meetings and the like. For faculty practice plans, teaching activities and research also are relevant factors to take into account. A wide variety of non-objective performance criteria are emerging in this far more complex environment seeking to motivate new and different behaviors from physicians.<sup>1</sup>

As the world of traditional fee-for-service medicine is evolving to the new environment of transparency, quality measurement, tiering of provider networks and insurance payment connected with quality and efficiency, what data are there about how physician groups are responding or moving proactively in their own compensation systems?

### § 1:8 A snapshot of today—In general

There is almost no published information about either how physician groups compensate their individual doctors for quality performance, or even whether they use compensation incentives to improve quality, especially with monies received from pay for performance programs. Some, like the Permanente Medical Group, believe that all care should be provided by teams and therefore, that accountability should be measured at the team level, so rewarding individual physicians for quality performance is at odds with that philosophy.<sup>1</sup> Still other groups have taken their P4P revenues and plowed them back into further support for infrastructure development, rather than for physician compensation.<sup>2</sup>

Because of the limited information available about what is happening in today's world behind the green door of physician group practices, I launched an informal inquiry among chief executive officers of major physician practices whom I knew. One of them believed that what I was seeking was likely to be of such interest to others, that he put me in touch with the American Medical Group Association (AMGA), whose CEO, Donald W. Fisher Ph.D., agreed to send out, on

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#### [Section 1:7]

<sup>1</sup>See Johnson and Walker, "Physician Compensation Plans," Medical Group Management Association, pp. 198-207 (2007).

#### [Section 1:8]

<sup>1</sup>Francis Crosson, M.D., "Personal communication" (Aug. 7, 2007).

<sup>2</sup>Early Duluth Clinic responses to P4P payments, as reported in survey communication.

my behalf, a very brief seven question survey I authored. Of the 345 CEOs among their groups, I received responses from 11, 9 of which actually offered substantive information. This was in addition to interviews I had conducted with representatives of Geisinger, Partners in Boston, Healthcare Partners Medical Group in Los Angeles, and Harvard Vanguard Medical Group in Boston before the questionnaire was sent. All tolled, there is data here from 14 groups.

The groups providing information were from all across the country and ranged in size from the smallest two at 67 and 70 physicians, through multiple groups of more than 200 to the largest with 900 participating physicians, not all of whom are employees. The respondent groups' average size of more than 300 physicians, characterizes these as some of the largest, oldest, and most organized medical groups in the country. That said, it is amazing how little has been reported, despite unquestionably fast burgeoning interest, in using individual compensation as part of the tactics to achieve overall quality performance improvement.

Groups were asked seven questions in an e-mail: (1) Describe the settings within which the incentives are used (*e.g.*, multi-specialty, primary only, etc.); (2) How long have they been in place?; (3) Did you change from something else?; (4) How did you arrive at the metrics and system now in place?; (5) What has been the effect?; (6) What lessons have been learned?; and (7) Can I attribute results to your group? They were also asked to provide any written descriptions of what they were doing. The latter ranged from the only published article available<sup>3</sup> (Geisinger), to the actual documents used within the group to describe the compensation approach (Healthcare Partners—LA), to results of a not-yet-published study sponsored by the Commonwealth Fund regarding P4P in physician groups (Health Partners Medical Group—Minneapolis); to a PowerPoint description (Everett Clinic), to examples of quality metric grids (Billings Clinic); to discursive descriptions of their programs (IHA—Michigan); to simple answers to the questions (Duluth Clinic, Allina Clinic, Camino Medical Group, Sutter Medical Group, PriMed Physicians). Only two requested no attribution of their re-

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<sup>3</sup>Bisordi, Hanory and Pierdon, "Paying For Performance: Establishing the Culture, Evolving the Concept," *Group Practice Journal*, pp. 20-24 (Sept. 2005).

sponses and one of them provided extremely limited information, which was not substantively helpful anyway.

Based on the self-selected nature of the respondents (willing to answer an e-mail or someone I already knew), the information obtained is not scientific, statistically valid, or even, likely, demonstrative of the full range of small experiments that might be in effect in smaller, single specialty groups or differently configured practices around the country. Still further, because of the brevity of the questions and some answers, it is possible my characterizations are not entirely accurate, although the respondents were given an opportunity to review this section of the chapter to correct errors. Finally, there are undoubtedly IPAs in California (which include medical groups) paying their members for quality, but they were excluded as not representing actual individual compensation as in salary payments, but more in the nature of shadow P4P payments downstreamed from payors. That was not the focus of my inquiry.

The AMGA medical group members have far longer histories of quality measurement, managed care HEDIS reporting, and pay for performance, than most physician groups nationally. It is AMGA members who constitute the bulk of the large groups participating in the Medicare Physician Group Practice Demonstration Project,<sup>4</sup> which was Medicare's first effort at physician P4P, the first year's results of which were generally positive. They represent, therefore, potentially a more sophisticated pool of physician groups in terms of the overall issue of quality measurement and managed care payment.

Almost all the respondents are multi-specialty practices, although a few are primary care only. Almost all the programs put only 5-10 percent of the physician's compensation at risk for quality metrics, although one group does base 15 percent of the physician's compensation on quality metrics and another goes as high as 20 percent. At least three respondents have only just begun or have had not

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<sup>4</sup>Billings Clinic, Dartmouth-Hitchcock Clinic, The Everett Clinic, Geisinger Health System, Middlesex Health System (CT), Marshfield Clinic, Forsyth Medical Group (SC), Park Nicollet Health Services, St. John's Health System (Springfield Missouri), University of Michigan Faculty Group Practice. CMS Press Release, "Medicare Physician Group Practice Demonstration" (July 2007).

much more than a year's experience with their programs. Several are revamping their approaches; and almost all of them consider these incentive systems to be works in progress. That said, there are common principles at work and common lessons learned. Most put more emphasis on primary care, but specialists are included as well. I have divided the responses into three categories: (1) relatively young or relatively limited (only one metric) programs; (2) those in a middle range; and (3) programs with some more depth, longevity and complexity.

**§ 1:9 A snapshot of today—Relatively young or limited programs**

The youngest data in the survey came from a 110 physician multi-specialty group in the Midwest, which launched an internally designed compensation system in October, 2007, to provide for a year-end annual bonus contingent upon organizational success. The bonus is discretionary as determined by the board. Shareholder physicians, who satisfactorily participate in designated clinic quality programs or initiatives during the year, may have their bonus increased by up to \$5000. No information regarding the applied metrics was provided, and the program is too young to have any lessons learned.

Of longer duration, PriMed, a 67 physician multi-specialty group in Dayton, Ohio, has paid their physicians a bonus based upon their adherence to process standards for treatment of hypertension. They are now adding diabetes to the conditions that will be measured and evaluated. Their approach is to increase the incentives incrementally. Traditionally, a 100 percent productivity based practice, now they withhold 3 percent of their gross revenues and set it aside in a pool which is redistributed to those physicians who adhere to the hypertension process at least 75 percent of the time.

They began in 2004 with no payment effect at all with very small samples and gradually increased to a more significant number of participants in 2005, using a system of clinical practice guidelines with reminders, accompanied by education of the physicians. They added the posting of individual scores in front of the entire group in 2005 to create additional peer pressure. Although each of these steps brought significant improvement, their strategic goal is to

generate even better performance. The payment impact was not introduced until 2006 and was not implemented until January 2007. They are aiming toward a model with 95 percent compensation based on productivity and 5 percent on quality with about \$10,000 at risk per physician based on quality and/or citizenship.

They have learned, even before the payment impact was introduced, to start small, develop incrementally and use statistically significant metrics if changed physician behavior is really the goal. In addition, they found it important to focus resources upon a single condition at a time to generate really improved performance, rather than to diffuse their efforts across multiple projects.

A somewhat longer standing program but of different focus is the patient satisfaction reward program of IHA, a 130 physician multi-specialty group in southeastern Michigan. They also began a program of recognizing providers for excellence in patient satisfaction in 2003 through group-wide announcements. Their performance has increased over the last three years as measured against AMGA specialty specific norms, but now they are adding much more of a financial impact to the results of the satisfaction surveys. All of their offices participate and they further refine their recognition to identify offices that are best in division and most improved, creating additional peer pressure from internal competition. Now they will add stipends of \$1000 to recognize each of 8 divisional recipients of annual patient satisfaction awards.

Beyond the annual survey which they have been using for three years, focused around practice sites, they are now directing their attention, with an additional survey, to individual performance. Still using AMGA norms as their base for comparison they will develop individual positive scores taking into account both office composite scores and individual performance on a weighted basis, with the scores generated by better performance than the AMGA norms. They will determine positive points and then will divide the predetermined bonus pool among all the points, giving more money to those with higher cumulative points.

The introduction of the second survey, they believe will keep the pressure on to continuously improve, but participation is optional. They will pay a stipend of \$125 per provider

to participating offices and an additional \$125 per provider for offices whose survey results are better than their prior year's results. Individual results will be calculated as above for the annual survey. By this technique, they provide an incentive both to improve over prior performance as well as to beat national norms.

HealthCare Partners Medical Group in southern California is a combination of medical practices and IPAs which coalesced in the early 1990s to incorporate today 450 multi-specialty physicians practicing in 40 offices in Southern California. Because of the effect of the IHA P4P project, their program is linked directly to the metrics in that system and therefore applies to their 200 primary care physicians. They have planned their compensation model on a multi-year basis to coincide with their multi-year strategic initiatives of increasing revenue, growing the patient base and providing superior patient care and service.

They choose their criteria, on an annual basis, to reflect the IHA metrics for pay for performance. For 2006-2007 these measures included mammograms performed, cervical cancer screening performed, HbA1c control, LDL control. For pediatrics it includes appropriate treatment of children with upper respiratory infection, children with one MMR vaccine by age 2 and children with one chicken pox vaccine by age 2. Patient satisfaction is added, based on a random sample of the response to a single question ("how satisfied are you overall with your physician?") among a range of satisfaction measurement tools they use. They factor in managed care panel size, weighted for severity by gender and age and continuity. These are added to productivity measures for fee-for-service physicians in addition to non-productive services such as call coverage and administrative service.

**§ 1:10 A snapshot of today—Longer duration, broader metrics programs**

Examples of programs of longer standing and with broader metrics are those in effect in Camino Medical Group in northern California, MedStar Physician Partners in Baltimore, Partners in Boston, Allina Medical Clinic in Minneapolis, and the Billings Clinic in Montana. All of these represent medical groups within the context of integrated delivery systems where the physicians are employed by an affiliate of

the same entity which owns the hospitals where the physicians practice.

For 8 to 10 years, MedStar Physician Partners, a Baltimore based 70 provider practice which is part of a seven hospital system, has put a small part of the physicians' base salary at risk for performance on patient satisfaction surveys, concordance with clinical practice guidelines, scores on HEDIS measures as well as participation in office business activities and attendance at their annual meeting. While basically oriented to the primary care physicians, they have also added specialty specific metrics to motivate specific changed behaviors. Although they have decreased the amount at risk for these metrics over the years, they have found that guidelines compliance and HEDIS scores have improved. Still, they cannot claim that this is because of the incentives alone since they also engage in "constant" auditing and monitoring. They do believe incentives contribute to changed behavior.

Another much larger (more than 700 physicians) wholly owned integrated practice in Minneapolis, Allina Medical Clinic has had quality incentives in place for three years tied to specific clinical conditions. They had many failed efforts trying to get their physicians to focus on many unrelated, diverse, specialty specific goals and outcomes. Their current approach has produced marked improvement in quality on core measures, optimal diabetes care and depression management. They have concluded that fewer, more concrete goals tied to specific tools and processes work while more diffuse efforts do not.

The Camino Medical Group in northern California is a 180 physician multi-specialty group which is part of the Sutter Health Network of hospitals and medical groups. They have been rewarding quality and resource conservation for 6 years. Their approach is more comparative. They award the top half of their physicians a discretionary bonus of generally \$1000 to \$3000 per year, based upon a single blended score of internally collected peer review data and patient satisfaction scores which are collected and reported to them by an outside firm. They had moved from a purely subjective evaluation of physician performance to quantify performance for the application of the bonuses. Physicians are given their scores and feedback for educational purposes, and while they are clearly aware of the existence of the program, the deter-

mination of who will be rewarded depends in part on Medical Director discretion and the performance of other physicians within the group.

The Billings Clinic has a very different approach based at the department level. Of the 225 physicians in this integrated system, 8 departments which include 67 physicians are using quality incentives in compensation. The physicians' base compensation is productivity based, measured by RVUs. Conversion factors for each specialty are established annually, looking to the AMGA median survey as the initial target. As departments declare a desire to participate in their Quality, Service, Leadership (QSL) incentive program, the conversion factor to reward the RVUs is affected since 5 to 10 percent of the compensation for those departments turns on the quality metrics. Depending on the department, compensation based in part on quality has been in effect for between 1 and 6 years.

They offered examples of metrics used in radiology, as well as for the hospitalists, pulmonologists and orthopedists. They range from a focus on core measures, condition specific guideline or protocol compliance (*e.g.*, DVT protocol, sepsis, asthma and COPD) for the pulmonologists, to adopting ACR report guidelines and using reporting templates in radiology, to participation in individual or small group quality or patient safety projects for the hospitalists.

They have found that moving incrementally from department to department has generated growing interest in participation and the incentives have resulted in increased desired behavior. They believe the goals must be tied to organizational strategic goals; the metrics need to be valid, reliable and in front of the physicians on a regular basis; but there is definitely a place for departmental quality incentives in physician compensation. Typical of most of these programs, they have found that the compensation at risk must be at least 5 percent to get the physicians' attention, but more than 10 percent seems to take physicians out of their comfort zone.

Of greater similarity to the Billings approach is that of the Duluth Clinic, in Minnesota, a practice of more than 425 physicians which is part of the SMDC Health System, a fully integrated organization which includes four hospitals. Their model has evolved over the last six years from one which

held physicians at risk for production targets, patient satisfaction goals and individual section totals to one which is simpler and allows appropriate distribution customization at the section level. The sections have discretion to distribute their compensation pool based on achievement of section service, clinical and operational excellence goals. The distributions (which they emphasize are not bonuses) are based on team metrics, since leadership and culture are the primary drivers of the organizational processes, with compensation serving as support. Providing an example of their hospitalist compensation, that section put 9 percent of each FTE's salary in a group incentive pool with two goals: (1) achieve the CMS Heart Failure Core Measures at more than 60 percent accuracy; and (2) exceed their most recent fiscal year end weighted average length of stay for their top ten DRGs by 0.2 days or more.

By contrast with the large, long-standing integrated systems of the midwest and west, Partners in Boston is a newer, more complex organization with two separate large academic practice groups, 7 stand alone practices which range in size from 8 to 50 physicians, a pediatric IPA and 5 community PHOs. The system itself has quality-based performance contracts with the three managed care payors in the state. Based on a withhold, if the system as a whole does not meet its targets, they don't get all of the compensation. While there are HEDIS scores at issue within the program, much of it is also oriented around infrastructure (use of CPOE and EMR), and controlling costs. They have shied away from using actual outcomes measures.

The system measures physician performance to accomplish the targets in the P4P programs and focuses on specialty specific goals, for example, lowering high cost imaging for the radiologists; managing drug use more effectively for dermatologists, and meeting HEDIS standards for diabetic care for primary physicians and endocrinologists, whether they are in the stand alone groups or the IPAs, all of which are considered co-equal "regional service organizations" (RSOs) for these purposes.

The withhold model has been in place with one payor since 2001 and the other two since 2005. They are moving in 2007 from the regional service organization focus to one where the local practices will be more directly at risk, but in their experience, given the complexities of their delivery mecha-

nism, they have found that individual financial incentives are a difficult way to really improve quality. Unblended reporting of scores is more effective in getting the physicians' attention.

**§ 1:11 A snapshot of today—The oldest, broadest programs**

This third group of organizations may not be so different from the Billings Clinic or Duluth Clinic, but their programs have been in effect more or less as they are now for at least six years and sometimes more; they have had more experience, it seems, with primary care focus and some have now moved beyond primary care to include specialists. Because their programs had been in effect longer, these groups had more conclusions to draw and lessons learned from what they had done to date. All of their reporters believe that compensation has had an impact on their quality performance, but they cannot attribute all of their results to compensation only. Each reports that the compensation model is in support of a host of other quality-driven initiatives in which the organizations are involved.

The Everett Clinic in Washington State is a multi-specialty group practice with more than 250 physicians. Their compensation for quality experience began 9 years ago with modest bonuses of \$1500 for PCPs based on quality. Their program has evolved so that for 2007, adult PCPs will be eligible for bonuses for effective management of quality which might be as high as \$15,000 per physician for top performers. More specialty departments are now eligible for quality bonuses which are a modest \$1500 per physician.

The compensation stands within a larger effort toward cultural change, standard work for all clinic employees and strategic focus on moving their metrics on effectiveness of care in a more significant way. They calculate their effectiveness by the percentage of unique registry patients which are up to date for needed studies (*e.g.*, HgbA1c, LDL, etc.) and in control for blood pressure, etc. Their bonus pool is determined for internal medicine and family physicians, and the stipends are distributed based on three components designed to reflect effective work done: panel size (patients seen in the last two years), disease burden (in accordance with Medicare risk score logic), and effectiveness of care (the registry data just noted).

Overall their quality metrics improved by 25 percent in the first twelve months of offering the larger bonuses. Like some of the smaller programs that moved to concentration on single metrics, this clinic has found that using a single roll up key metric for the entire organization focuses attention better at improving results, but multiple interventions in addition to compensation are essential to keep progress moving.

Although also affiliated with the Sutter Health Network, the Sutter Medical Group, began their compensation for quality program earlier than the Camino Medical Group. Sutter is a 230 physician multi-specialty group which began about eight years ago, putting 10 percent of the PCPs' managed care compensation at risk for factors including patient satisfaction, HEDIS measures, meeting attendance and utilization. They have increased the dollars at risk to 15 percent for the 2007-2008 year.

Their motivation came from an expectation that pay-for-performance programs were likely on the horizon, but more than that, they found they needed their compensation incentives to align with their core values. The change from what had been a primarily productivity-driven payment model with some consideration for panel size required a shareholder vote. The development of their process has contributed to significant improvements in their quality metrics over the last five years with annual recognition in the California P4P program as one of the top 20 percent in the state for quality, service and patient satisfaction that went from a group average near the median to the 84th percentile most recently. By external measures, they believe they have gotten to a setting where there is high clinician pride and satisfaction with their own performance. They also believe that increased transparency within the group has contributed significantly to these results. When asked about the lessons they have learned, they reported “communicate, communicate, communicate,” and provide tools for support.

In addition to an interview, The Geisinger Clinic in Danville, Pennsylvania—an integrated system of more than 600 physicians, acute care hospitals, a heart hospital, a children's hospital, cancer center, rehabilitation center and

more—offered the only published article on point.<sup>1</sup> Geisinger began its now robust approach to compensation for quality also seven years ago at a moment when they were going through major reorganization and transition, terminating their relationship with an academic medical center, importing new leadership and redesigning their delivery system along clinical service lines. With input from their physicians, they designed a new approach with explicit principles and goals. The full transition process took four years. Quality performance was a key component to how they would base compensation with a specific eye toward expanding through recruitment. This explicit connection meant that their program would have to present clear performance expectations, and be stable over time, emphasizing productivity, profitability, growth, access and patient satisfaction.

All physicians receive a base salary, which is not changed unless their productivity, measured against national benchmarks, falls below the 60th percentile for their specialty. Different from most of the other programs, the incentive portion of the compensation represented 10 to 20 percent of the physician's compensation by 2005, and by 2007, 35 percent of their incentive compensation turned on quality. The system is designed to reflect individual performance with an opportunity for still additional compensation when the service line contribution budgets are exceeded. New physicians are given “ramp up” expectations.

Each physician gets a letter at the beginning of the year informing him of the criteria against which he will be measured. Reports are provided monthly for individual physicians by each targeted criterion so they know how they are doing. Incentive payments are made twice a year.

By the end of the first four years, productivity had improved from the 55th percentile to the 73rd percentile. Patient access improved significantly. Physician turn over stabilized to about 6 percent while recruitment expanded substantially. At the launch of the program, only 10 percent of the physicians were eligible for incentive bonus payments

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**[Section 1:11]**

<sup>1</sup>Bisordi, Hanory and Pierdon, “Paying For Performance: Establishing the Culture, Evolving the Concept,” *Group Practice Journal*, pp. 20-24 (Sept. 2005).

above their base salary. By the end of four years, 50 percent were eligible and participating. As time went on they eliminated the patient satisfaction payments because all the scores were so high.<sup>2</sup>

Recognizing the challenges of communicating the evolution of the metrics, within their fundamental framework of explicit articulated goals and principles, has been important to the success of the program. Market competition and changes in compensation outside the group must be accommodated to continue to grow and retain the physicians they have. To generate ongoing funding, a focus on productivity fuels revenues which can be dedicated to non-revenue producing performance and clinical care. In other words, if some productivity is not included as a measure, it becomes more difficult to fund the pools from which the quality incentive revenues can come. They report that the keys to their success lay in using measures which are easily and objectively measurable, specialty specific and not so volatile that changes to the measures are perceived as changing the compensation system.

Finally, Health Partners in Minneapolis has used the essential incentive program it has in place now in part since 1994 and the rest since 1998. With more than 600 physicians, and a 400 bed hospital, the quality incentive program has been focused mainly on the 220 physician primary care division of the medical group. Beginning with a production based model, over the years they have added other elements to include patient satisfaction, access to care and then, once they had an electronic medical record, more quality measures. Over a period of five years they evolved to a position where the compensation was based roughly 90 percent on productivity and 10 percent on service, quality and participation (citizenship) elements.

Their measures have become increasingly outcome focused, so, for example, in diabetes, the target is that 20 percent of patients with diabetes will have HgbA1c and LDL screening and results below specific levels, blood pressure control below 130, aspirin use for those above 40 and non-smoker status. In addition, 90 percent of their patients should have BMI measured and documented. Fifty-percent of patients seen

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<sup>2</sup>Personal communication, Joseph Bisordi (Aug. 8, 2007).

with a new diagnosis of depression should have a PHQ-9 assessment. There are similar targets and measures for pediatrics. Approximately 15 percent of the physicians' compensation turns on these metrics.

They have created their bonus pools by taking increases in the market compensation rates per work RVU each year and setting that aside to add or expand the size of non-production related compensation. They believe that this has enhanced the acceptance of the program as distinct from those groups in their region which tried to carve back their production rate or RVU allocation to fund quality or other performance incentives. Keeping the number of measures manageable has facilitated the ability to focus on delivering the care that will produce good scores. They also reward improvement by a clinic unit rather than the raw performance which gives them more flexibility to account for the diversity of the population seen by their physicians in varying locations.

While the effect has contributed to their significant quality performance gains, they do not believe it is the driver of improved quality but a critical catalyst for improvement. The program has reinforced their leadership and strategic message that measurable quality is important and has placed additional scrutiny on the measurement and goal-setting processes, drawing more physicians into that aspect of the program because they have compensation at risk.

### **§ 1:12 A snapshot of today—Common lessons learned**

The connection between strategic goals and compensation incentives is one message of those programs that have claimed some successes, both in terms of physician satisfaction as well as quality results. While the compensation at risk is very variable among the reporting groups (minor stipends of \$1500 to 20 percent of total compensation), all unrolled their programs gradually with an emphasis on communication and easily measurable and clear objectives. Transparency of results within the group was cited more than once as a powerful contributor to performance. Some claim better results with tighter focus on single metrics; others have fared better with specialty specific, service line driven departmentally focused programs; while others have used rolled up multi-factorial universal measures across the organization. A minority use comparative results, in essence,

tiering their own physicians. None believes their compensation scheme is the sole driver of improved quality performance, but all except one believe it has had a significant, positive effect.

All still have some element of productivity at the core of their compensation approach. While some reflect directly the pay for performance environment in which they sit, most have linked their measures and style to their overall strategic emphasis on quality improvement, measurement and reporting. The real question is whether these experiences will prepare these most sophisticated medical groups, which are almost all part of larger integrated systems, for what is on the horizon in terms of new payment models. For groups who have not yet tried to compensate for quality performance, it may be important to focus on what is coming rather than what is.

### § 1:13 Coming payment changes—In general

There is widespread recognition that today's payment systems, which generate the revenues to be allocated within physician groups to their members, including revenue from P4P programs, have not generated, and cannot be expected to produce, sustainable improved health care quality while meeting the other needs of the payment system from the perspective of providers, patients, insurers and purchasers. Many commentators and interest groups are struggling with the design of payment reforms. In response to the Institute of Medicine's call for the development of new payment models, a number of initiatives have emerged at least to propose principles that should apply for such new programs.

### § 1:14 Coming payment changes—Primary care/ medical home

In 2005, the AMGA convened a panel of experts to meet over a multi-year time span to create a "Results Based Payment" model,<sup>1</sup> the outputs of which were not yet published as of this writing. Forty years ago (1967) the American Academy of Pediatrics (AAP) introduced the concept of the "medi-

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[Section 1:14]

<sup>1</sup><http://www.amga.org/RPS/PR/pr08052005.pdf>.

cal home” as a way to encapsulate a range of services, not then recognized as a system of care, to deliver health care services to children with chronic special medical needs. In today’s world, the concept has particular resonance in primary care for adults; and the American Academy of Family Physicians, the American College of Physicians, with the American Osteopathic Association and the AAP have promoted the concept of the “medical home” and the “advanced medical home” in Joint Principles of the Patient-Centered Medical Home. NCQA is developing 10 “priority criteria” which would indicate the presence of a true “medical home” which is characterized by a personal physician, physician-directed medical practice, whole-person orientation, coordinated care, quality and safety and enhanced access and adequate payment.<sup>2</sup>

The advanced medical home, as propounded by the American College of Physicians, is characterized by seven specific attributes. The advanced medical home would: (1) use evidence-based medicine and clinical support tools to guide decision-making at the point of care; (2) organize the delivery of care according to the Wagner Chronic Care Model<sup>3</sup> applied to patients with or without chronic conditions; (3) create an integrated, comprehensive plan for ongoing medical care in partnership with patients and their families; (4) provide enhanced and convenient access to care not only through face-to-face visits but also via telephone, e-mail and other modes of communication; (5) identify and measure key quality indicators to demonstrate continuous improvement in health status indicators for individuals and populations treated; (6) adopt and implement the use of health information technology; and (7) participate in programs that provide feedback and guidance on the overall performance of the practice and its physicians.<sup>4</sup> The ACP has called for demon-

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<sup>2</sup>Robeznieks, “Of Primary Importance,” *Modern Healthcare*, pp. 6-7 (Nov. 12, 2007); Backer, “The Medical Home: An Idea Whose Time Has Come . . . Again,” *Family Practice Mgt.*, 14:38-41 (Sept. 2007); <http://www.aafp.org/fpm/FPMprinter/20070900/38them.html?print=yes>.

<sup>3</sup>Von Korff, Gruman, Schaefer, Curry and Wagner, “Collaborative Management of Chronic illness,” *Ann. Intern. Med.*, 127:1097-1102 (1997).

<sup>4</sup>American College of Physicians, “The Advanced Medical Home: A Patient-Centered Physician-Guided Model of Health Care,” A Policy Monograph (2006), at [http://www.acponline.org/hpp/adv\\_med.pdf](http://www.acponline.org/hpp/adv_med.pdf).

strations of its implementation supported by adequate payment.

None of these ideas is actually a payment reform model but are a call for appropriate recognition in payment systems of patient-centered care delivery which is grounded in a primary care-based home. The impetus for this approach comes, in part, from the failure of the current payment systems to recognize in any meaningful way the information technology infrastructure, care coordination processes and communication techniques which many acknowledge as essential to move quality forward in significant ways, along with a crisis in the role of primary care and its reduced share of health care dollars. From 1995-2003, primary care physician income declined by 10.2 percent as contrasted with other professionals who saw a 7 percent increase over the same time period and other medical specialists whose incomes remained more stable over the same period.<sup>5</sup> By 2003, adjusted for inflation, the average income for a primary care physician was about \$121,000. A 2007 survey in *Medical Economics* found, based on 2006 data, that primary care physicians' total compensation, including salary, bonuses and retirement plan contributions, had increased to \$140,000 for general physicians, \$155,000 for family physicians and \$170,000 for internists, although solo practitioners earned less and physicians in larger groups fared the best.<sup>6</sup>

Against that background and to confront that specific problem, a new model for payment of adult primary care has been proposed to replace encounter-based, fee-for-service payment. This model takes into account the operation of the "advanced medical home" with comprehensive payment for comprehensive care.<sup>7</sup>

Proposing risk adjusted payment to physician practices to provide a panoply of services through enhanced infrastruc-

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<sup>5</sup>Tu and Ginsburg, "Losing Ground: Decline in Physician Income 1995-2003;" Tracking Report No. 15 (June 2006), Center for Health System Change, at <http://www.hschange.com/CONTENT/851/>.

<sup>6</sup>Lowes, "Working Harder to Stay Even," *Medical Economics*, pp. 22-25 (Nov. 16, 2007).

<sup>7</sup>Goroll, Berenson, Schoenbaum and Gardner, "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," *J. of Gen. Int Med.* (Mar 2007), at <http://www.springerlink.com/content/x864841076775u6p/fulltext.html>.

ture and support personnel, the authors identify the costs associated with a hypothetical physician practice delivering care in this system. They presume a \$250,000 per year physician salary, before bonus and fringe benefits—literally more than twice the 2003 average income data noted above. That physician would be supported by a nurse practitioner, a nurse, a half time nutritionist, a half time social worker, receptionist, medical assistant, rent, insurance, information technology for patient safety and quality monitoring, data manager, electronic health record purchase and installation, and a performance bonus.

All of this could be provided they claim, assuming an average comprehensive payment of \$500 per patient per year, with a panel of 2000 patients. Even after this exposition, and a further comparison of the difference in payment for average clinical risk patients (\$500/year) versus higher risk patients of \$800/year, they say they are not proposing a specific payment formula, but are putting forth the principle that it is possible to design many global compensation models that would provide adequate resources to ensure comprehensive, coordinated care to patients. This model would put 15 to 25 percent of the payment at risk based on achieving “valued outcomes.” Payment would be made monthly for the assigned panel of patients.

The authors distinguish this approach from traditional capitation because it would reflect risk/need adjustment, additional payment for actual performance to guard against under-service, and dollars allocated sufficient to support the requisite infrastructure to make the care comprehensive. Primary care practices would not have risk for specialty or hospital care, imaging, laboratory tests or other ancillary services which would continue to be paid as they are in a fee-for-service model. But, although the description purports to offer a payment model, where the dollars come from, how payment rates are established and allocated is not elucidated at all. The authors acknowledge that their approach would substantially increase incomes to primary care physicians, which is part of their point, and therefore cannot be seen as budget neutral, nor could they estimate that savings from more effective care delivery would offset such an increase.

**§ 1:15 Coming payment changes—More than primary care**

A spring 2007 summit meeting of 95 multi-stakeholder thought leaders produced a report setting forth 12 goals of a reformed payment system, contrasting existing principles of today's payment model with the characteristics of a preferred model, and elucidating how a new model ought to be applied to preventive care, chronic illness, and major acute episodes of care,<sup>1</sup> acknowledging that their episode-of-care proposal for acute care reflected the thinking in the PROMETHEUS Payment® model, described further below. The thrust of the principles here is that payment would reflect appropriate resource utilization grounded in clinical practice guidelines where they exist. The amount would be risk-adjusted in accordance with the patient's condition. Payment would reward teamwork among providers, account for the infrastructure to coordinate care and give providers some risk for downstream services. One of its primary consultants has published a separate paper restating the goals of a new system and posing nine questions regarding incentives that any new system ought to address.<sup>2</sup> But none of these articles offers an actual new payment model itself, rather they describe characteristics one might hope to see in any such new system.

All of the principles and proposals described, though, share features of increased use of information technology, team-oriented care, and some kind of aggregation of bundled payments to avoid the piecemeal orientation of fee-for-service payment. All of them pay far more attention to primary care and chronic care than acute care episodes. The relevance in a discussion of physician compensation within groups, though, is to look at the values embedded in coming payment systems, their incentives if any, and the implications for implementing consistent physician compensation within

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**[Section 1:15]**

<sup>1</sup>Jewish Healthcare Foundation, "Incentives for Excellence: Rebuilding The Healthcare Payment System from The Ground Up" (Sept. 2007), at [http://www.jhf.org/Resources/PaperPdfs/ROOTS\\_percent20\\_percent20Incentives\\_percent20For\\_percent20Excellence.pdf](http://www.jhf.org/Resources/PaperPdfs/ROOTS_percent20_percent20Incentives_percent20For_percent20Excellence.pdf).

<sup>2</sup>Miller, "Creating Payment Systems to Accelerate Value-Driven Healthcare: Issues and Options for Policy Reform" (Sept. 24, 2007), at [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=522583](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=522583).

groups. The only new detailed and elaborated payment proposal on the horizon today is the PROMETHEUS Payment® model.

**§ 1:16 Coming payment changes—The PROMETHEUS Payment® model**

The PROMETHEUS Payment® model<sup>1</sup> incorporates many of the principles noted above. Starting with good clinical practice guidelines, a payment budget is established for all the providers who will interact with the patient for that condition, no matter their type or organizational relationship with any other providers. This Evidence-informed Case Rate™ (ECR) is allocated among the providers in accordance with that scope of care they have voluntarily bargained to provide to patients in their negotiation with the health plan. A two person oncology practice, for example, likely would contract to provide a smaller range of services than a comprehensive cancer center with all treatment modalities available in association with a hospital.

For physicians, 10 percent of the bargained for payment is held back in a performance contingency fund and for hospitals and other providers, 20 percent is withheld. These monies are paid to the providers based on their scores on a scorecard which takes into account whether the salient elements of the guideline were delivered, the patient's experience of care and the outcomes of that care. Payment from the contingency fund is made pro rata in accordance with the scores. The scores, however, are based 70 percent on what the contracted provider does and 30 percent on what everyone else who interacts with the patient in delivering the care paid for under the ECR does. This creates an explicit incentive for providers to collaborate clinically so as to maximize their scores and therefore their payment.

The over arching goal is to pay the right amount for what science tells us the patient needs to treat his or her condition, with risk adjustment upward as co-morbidities increase and therefore more resources must be brought to bear to

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**[Section 1:16]**

<sup>1</sup>For a description of the program and its legal implications, see Gosfield "The PROMETHEUS Payment® Model: A Legal Blueprint," Health Law Handbook, pp. 79-129 (Gosfield, ed. 2007).

treat him or her. The incentives are intended to reward efficient, resourceful use of science-based treatment within the bargained for rate, the highest and best use of clinicians to meet the patient's needs, optimal referral to the provider who will perform best for the patient for that condition, clinical collaboration with those from whom referrals are received, and, because the entire system is transparent and public including the scores as well as the rates, all of the participants—providers, patients, and payors—have information around which to center their actions and exercise choices.

### § 1:17 Coming payment changes—Implications

The behaviors that are rewarded financially in the models that are coming are very different from incentives in traditional payment models, where more services generate more money in fee-for-service and fewer services generate more financial margins in capitation. The key to success under the PROMETHEUS Payment® model is a solid knowledge of what resources are brought to bear to treat a patient in accordance with applicable guidelines, their costs, the clinical time to administer appropriate care, good patient scores, and effective collaboration with other high performing providers.

Traditional compensation models which reward productivity measured purely in terms of RVUs generated, would not be consistent with these new approaches. Since optimal payment opportunities in the new models would turn on different measures of performance, to persist in rewarding physicians in their individual compensation for volume of services or patients in a panel, or even level of effort expended, would not capture what these proposals are intended to reward. Consequently, under any of these new payment programs, new forms of compensation to physicians to respond to the new incentives would seem logical. These would include differential compensation reflecting such issues as the extent of collaboration in teams, effective and timely use of ancillary personnel, deployment of communication systems and techniques that permit patients to manage their care effectively, patient experience of care, adherence to clinical practice guidelines which are the basis for the case rate, and making and accepting referrals from high performers. The new payment models generate new definitions of what con-

stitutes “productivity.” But would these approaches run afoul of the law?

### § 1:18 The law—In general

The most critical federal law affecting physician compensation within groups is the Stark statute because it defines as a “referral” any request by a physician for a service, item or good, payable by Medicare Part B.<sup>1</sup> Therefore, referrals within group practices fall under the ambit of this statute. Medicare has begun to pay physicians for reporting their own performance, but has not yet created a true physician pay-for-performance program. There is interest at CMS in the PROMETHEUS Payment® model, but the Design Team has to generate proof of concept before the risks of embedding the model in a public program would be prudent. Although Stark is not immediately relevant to the new forms of payment, it is relevant to compensation generally within groups, so that new attempts to pay for quality must accommodate its strictures.

In order to be able to refer to other physicians within a group practice for designated health services or to ancillary personnel under the in-office ancillary services (IOAS) exception, the group must meet the definition of a group practice.<sup>2</sup> The critical statutory provision which establishes the basis for orienting compensation for groups is the following:

A physician in a group practice may be paid a share of overall profits of the group or a productivity bonus based on services personally performed or services incident to such personally performed services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by such physician.<sup>3</sup>

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#### [Section 1:18]

<sup>1</sup>42 U.S.C.A. § 1395nn(h)(5).

<sup>2</sup>It is beyond the scope of this chapter to deal with the indicia of group practice that go beyond the compensation formulas. *See* Gosfield, “Is Your Group A Group? How the Stark Law Applies to You,” *Physicians Practice* (June 2004), at <http://www.physicianspractice.com/index.cfm?fuseaction=articles.details&articleID=530>.

<sup>3</sup>42 U.S.C.A. § 1395nn(h)(4)(B)(i).

**§ 1:19 The law—The difference between profits and productivity bonuses**

Productivity bonuses are money paid to the physician directly related to the fruits of his own labors. The statutory definition of productivity bonus allows inclusion of services that are “incident to” the physician’s services (explained more fully below).<sup>1</sup> Group practice members may not be compensated based on their ability to generate referrals for others. This definition of productivity does not turn on the capture of revenue alone but rather on the actual performance of activities by the physician. Therefore, the statutory definition of productivity may be at variance with traditional compensation principle notions of productivity. Productivity, though, can also take into account quality performance within the group.

In addition to productivity payments, a group practice may pay physicians a “share of overall profits” meaning a share of the entire profits derived from designated health services of the entire group practice or any component of the group that consists of at least five physicians.<sup>2</sup> Therefore, the Stark statute does allow a group practice that otherwise meets the definition to subdivide membership for compensation purposes into “pods” of at least five physicians.

We believe the threshold of at least five physicians is likely to attenuate the ties between compensation and referrals. We are rejecting the suggestion to use the threshold of three physicians because we believe the lesser threshold would result in pooling that would be too narrow and therefore, potentially too closely related to DHS referrals.<sup>3</sup>

The inconsistencies created by this analysis are that a stand alone group of four physicians can only share profits in accordance with a single formula. In other words, they could not share profits to two physicians one way and to two other physicians another way, even if the physicians in the group are of different specialties (*e.g.*, two gastroenterologists and two cardiologists). Nonetheless, they each can be

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**[Section 1:19]**

<sup>1</sup>66 Fed. Reg. 909 (Jan. 4, 2001).

<sup>2</sup>66 Fed. Reg. 909 (Jan. 4, 2001).

<sup>3</sup>66 Fed. Reg. 909 (Jan. 4, 2001).

paid their own productivity apart from profit sharing issues. A multi-specialty group of more than five physicians can shift pods among its members whether by location, by specialty, by value of evaluation and management codes, by numbers of patients, by volumes of surgeries. There are essentially no boundaries as long as the pod is at least five and no one is directly compensated for the volume or value of the referrals of designated health services.

**§ 1:20 The law—“Permissible safe harbored” formulae**

The government has offered three specific safe harbors that are available for each of profit sharing and productivity bonuses. In general, a group practice can segregate its designated health services (DHS) revenues from its other revenues for purposes of compensating physicians. The Stark statute only applies to a practice’s DHS revenues.<sup>1</sup>

For distribution of overall profit shares, the government has endorsed: (1) per capita equal division of the profits; (2) a distribution of DHS revenues based on the distribution of the group practice’s revenues attributable to the services that are not DHS (*e.g.*, ratio of EM services, ratio of RVUs on non-DHS); and (3) any distribution of DHS if the group practice DHS revenues and no physician’s allocated portion of those revenues is more than five percent (5 percent) of the physician’s or the total compensation of the group.<sup>2</sup>

With respect to productivity formulae, another three opportunities are offered allowing allocation of these bonuses based on: (1) the physician’s total patient encounters or RVUs; (2) physician’s compensation that is attributable to services that are not DHS; and (3) any productivity bonus that includes DHS if the group practice’s DHS revenues is less than 5 percent of the group practice’s total revenues and no physician’s allocated portion of those revenues is more than 5 percent of the physician’s total compensation from the group.<sup>3</sup>

Expense allocation may be made in any way the group

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**[Section 1:20]**

<sup>1</sup>66 Fed. Reg. 908 (Jan. 4, 2001).

<sup>2</sup>66 Fed. Reg. 908 (Jan. 4, 2001).

<sup>3</sup>66 Fed. Reg. 908 (Jan. 4, 2001).

wants. The productivity bonuses and the profit sharing allowance pertain exclusively to the moneys actually paid to the physicians as compensation and not the expenses deducted from their revenues. Despite the creation of the safe harbors, the government has made it abundantly clear that physicians need not use such methods.

The regulations clarify that other methods (including distributions based on ownership interests or seniority) are acceptable so long as they are reasonable, objectively verifiable and indirectly related to referrals. These compensation methods should be adequately documented and supporting information must be made available to the Secretary upon request. Under this latter ‘catch-all’ provision the group practice essentially bears the risk of non-compliance.<sup>4</sup>

Based on this statement, quality-focused payments would certainly be legitimate, provided they do not directly reward the volume or value of referrals of DHS among the physicians.

To the extent that some have believed that the Stark statute only allows for per capita allocation of profits, or profits purely on the basis of the shares held by the physician, that is not accurate. Overall profit shares must be derived from aggregations of the entire practice or any component of the practice consisting of at least five physicians. Therefore, pods can be constructed that do reflect profits generated by ancillary services which are DHS. For example, if in a large group, only some of the physicians use physical therapy or MRI or infusion services, as long as there are five of such physicians in the pod, they might be the only physicians that share profits for those services. Similarly, in larger groups, any tiering that includes a group of at least five might also be created. So, there might be three tiers of physicians sharing MRI revenues; low, middle and high utilizers. As long as each tier has at least five physicians and no compensation directly reflects any single physician’s volume of MRI orders, the formula is legitimate. Finally, there is no requirement that profits be paid as dividends; and profit-sharing may be paid as compensation. Within this construct pods might be constructed around quality metrics or scores, with higher performing physicians sharing more profits.

With respect to “incident to” services, in the Stark Phase

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<sup>4</sup>66 Fed. Reg. 909 to 910 (Jan. 4, 2001).

III regulations, CMS has explicitly clarified that “incident to” services include both services and supplies, so that oncologists, for example, can be given direct credit not only for the administration of drugs performed incident to their treatment of patients, but also for the drugs themselves.<sup>5</sup> The regulators further clarified in Phase III that direct allocation of revenues from “incident to” services does not violate the prohibition on compensation that reflects volume or value of referrals. The “incident to” compensation opportunity is itself an exception, in essence.

To bill for services as “incident to,” all the “incident to” indicia must be met including that a physician in the group must be within the office suite, immediately available, otherwise rendering medical services. Even where services need not be rendered subject to in office supervision (*e.g.*, physical therapy) under Stark, to have the opportunity to allocate these revenues directly as compensation to the treating physician they must meet the definition of “incident to;” so one of the physicians “in the group” must be in the suite. This is different from the Stark measure of premises to meet the office location rule for IOAS. Stark uses the measure of a post office address to define a building.

“Incident to” billing requires presence in the same office suite in the building. “Incident to” billing is not permitted by physician groups for services in the hospital setting whether inpatient or outpatient; but Transmittal 1776<sup>6</sup> permits shared evaluation and management services to be billed under the physician’s number—even when a non-physician practitioner performed the bulk of the visit. As long as the physician performed some or any portion of the visit in a face to face encounter with the patient, the services may be billed under the physician’s number as if completely performed by him. This effectively transforms them into “personally performed” services, so that they can be allocated as direct productivity to the physician even when a non-physician practitioner shared the visit with the physician.

Some services which are eligible for “incident to” billing also have their own benefits as well. These include physical and occupational therapy, outpatient prescription drugs,

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<sup>5</sup>72 Fed. Reg. 51023 (Sept. 5, 2007).

<sup>6</sup>Amending Carriers Manual 15501, Claims Processing Manual 100-104, Ch. 12, § 30.6.1 (Oct. 5, 2002).

nurse practitioners, physician assistants and clinical nurse specialists which can be billed separately or “incident to.” However, diagnostic testing has been explicitly excluded from the services which can be counted as “incident to” services.<sup>7</sup> Therefore, allocation of technical components of diagnostic testing revenues must be consistent with profit sharing formulas under Stark, and not be included in productivity formulae unless the physician literally performs the technical component himself.

**§ 1:21 The law—Hospital and integrated system issues**

The Stark statute and regulations do not recognize that purportedly “integrated systems” are any different from any hospital-physician relationships. It is noteworthy that those physician groups cited here with the deepest history in compensating physicians for quality, though, are integrated systems where the strategic goals of the entire enterprise generate consistent approaches at the hospital and the physician group levels. Still, though, the pool of money from which quality bonuses might be paid to physicians must be carefully segregated from the hospital’s dollars generated by Medicare reimbursement lest the group fall afoul of the exceptions available under the statute and regulations.

Increasingly, all hospitals, even outside of the integrated delivery system setting, are looking to engage physicians in a shared quality agenda.<sup>1</sup> Among the techniques to do so is payment to physicians, and/or their groups, from the hospital for services rendered to the hospital to improve quality.<sup>2</sup> The ability to pay physicians for the hospital’s quality results has now been explicitly recognized and approved by CMS in

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<sup>7</sup>72 Fed. Reg. 51016 (Sept. 5, 2007).

**[Section 1:21]**

<sup>1</sup>See Reinertsen, Gosfield, Rupp and Whittington, “Engaging Physicians in a Shared Quality Agenda,” IHI Innovation Series White Paper. Cambridge, MA: Institute for Healthcare Improvement; 2007; <http://www.uft-a.com/publications/publications.htm>, and Gosfield and Reinertsen, “Sharing The Quality Agenda with Physicians,” Trustee, pp. 12-17 (Oct. 2007).

<sup>2</sup>For a broader discussion of some of the potential strategies to do this and engage around the physicians’ business case for quality, see Gosfield, “In Common Cause for Quality,” Health Law Handbook, pp. 177-

the Stark III regulations.<sup>3</sup> Compensation related to patient satisfaction goals or other quality measures unrelated to the volume or value of business and unrelated to reducing or limiting services could be paid under the Stark personal services exception, provided all the other criteria for the exception are met.<sup>4</sup> Still further, the removal of the “safe harbor” hourly payment method of compensation from the definition of “fair market value” for payment to physicians (which the Stark III regulations accomplished) opens the door to far greater flexibility in constructing payments which reflect new approaches to fair market value taking into account achievement of quality results.

So, today, physician groups which have not yet developed an approach to physician compensation for quality can look at performance based compensation formulas without fear of violating Stark, and should consider their relationship with the hospitals to which they refer patients, as they contemplate creative approaches to enhance and reward the achievement of improved care for patients. They will also have to address what their existing employment contracts provide.

### § 1:22 Employment contracts

Most physician employment contracts provide compensation terms. Traditionally these entail a base salary, or a base salary with some productivity enhancement. Physicians considering joining a group want to know and understand the environment in which they will be working and what their revenue generating opportunities are. Where new metrics will be used to determine compensation, capturing the approach in appropriate contract language becomes important. In some settings, to maintain flexibility, merely stating the base salary and the amount at risk or potentially achievable, based on combined factors of productivity, quality performance, efficiency, and patient satisfaction “as

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222 (Gosfield, ed. 2006), at <http://www.uft-a.com/PDF/commoncausequalityCh5.pdf>.

<sup>3</sup>72 Fed. Reg. 51046 (Sept. 5, 2007).

<sup>4</sup>For a broader consideration of Stark III, see Gosfield, “The Stark Soap Opera (Act III): Rejections, Clarifications, Reaffirmations, New Visions,” AGG Notes (Sept. 2007), at <http://www.gosfield.com/notes/index.html>.

determined by the board” and “applied equally to similarly situated physicians” may be sufficient to recruit new physicians. Where existing contracts do not provide for such flexibility, amendments will be necessary.

At the same time that a group addresses the compensation itself, it also ought to take into account the compliance implications these new models create, and not just in the terms of strict compliance with fraud and abuse laws. As groups move to less traditional bases for compensation, they may consider payment for quality simply an opportunity for some additional bonuses—the approach taken by most of the groups surveyed here. But some groups today consider performance based payments part of their basic compensation distribution and therefore not entirely discretionary. Over time, as a more quality-driven culture expands in the group, or for those groups who want to put a serious stake in the ground on these points, those who don’t change behavior in response to the compensation incentives may be at risk of termination.

For termination to be based on failure to perform to threshold levels of quality, patient satisfaction, citizenship, teamwork and more, the documentation of how these constitute a breach becomes critical. Putting these expectations, at least in general principles, into the employment contract or by reference to a group compact or generally applicable goals and principles incorporated by reference, would be essential to provide a basis to terminate for breach.

Today, most payment for quality performance is a bonus to higher performing physicians. There is a tension between productivity in the traditional sense (working hard to generate additional revenues) and productivity in the new frame of reference (facilitating a team culture, clinically collaborating with referral sources, contributing to patient satisfaction and compliance, adhering to clinical practice guidelines, accomplishing specified outcomes efficiently with effective use of resources, and being a good citizen) New payment models would stimulate more creative approaches to accomplishing these goals while maintaining the financial viability and sustainability of the group practice model. For example, under the PROMETHEUS Payment® model, the ability to be paid the full amount contracted for turns on whether the physician meets a quality threshold in order to be paid the 10 percent or 20 percent withheld in the performance

contingency fund. Groups which are really changing their culture, might take the position that failure to earn back the withhold in a defined percentage of cases is grounds for termination. Similarly, in the current payment systems, as physician groups position themselves to differentiate based on quality and compete more effectively, how quality is taken into account in compensation will inevitably have to consider what level of performance is so inadequate as to merit severance from the group.

### § 1:23 Conclusion

We have seen that P4P programs are expanding despite their limited results. But they all exist on top of the predominant American payment schemes which have not optimized the quality we would want for ourselves as patients. The newer versions of payment on the horizon would reflect this desired societal goal far more directly, and current views of physician compensation will be inadequate to account for those changes. Above all, the new payment models would reward “productivity” very differently from today’s world of more dollars generated in the shortest amount of time. To remain successful, then, physician groups will have to align their compensation systems with the new measures of performance.

We have also seen that there are physician groups, most in integrated delivery systems, which are beginning to make headway in improving their overall quality performance rates with the support of more consistent compensation systems which take into account the new desired values. With pay for performance and tiered networks with variable compensation based on reported performance, the business success of physician groups is increasingly tied to their quality results. Current payment reform proposals will exacerbate the risks of relying on traditional physician compensation schemes in the future. How physician groups confront the issue of motivating better care for their patients and recognizing that value in the way their physicians are paid will be an increasing challenge both in the short and long term.

The good news is that the law does not get in the way, and creative approaches can be crafted with safety. In the new world order, physician group compensation models which

simultaneously support and sustain the business of the group while they propel their physicians' quality performance will not only improve patient care, they will enhance the value of the group to its physician members.