Incentives in Provider Compensation and Management

An exploratory professional paper utilizing literature review

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Executive Summary

An incentive is “something that incites or has a tendency to incite an individual or group to perform a desired action or actions”. The “incentive theory” believes that people are motivated to behave in certain ways in order to gain rewards. The presence of hygiene factors or dissatisfiers (company policy, supervision, interpersonal relations, working conditions, and salary) does not motivate or create satisfaction but their absence leads to job dissatisfaction. In contrast, achievement, recognition, the work itself, responsibility and advancement are motivators (satisfiers) associated with long-term positive effects in job performance. Several common characteristics that can be considered hallmarks of viable provider incentive programs include 1/ focused performance measures derived from accurate data sources using agreed methodology that are within a provider’s control; 2/ design of the incentive scheme is easy to understand and administer, and which has provider buy-in; 3/ performance targets must be both challenging and achievable in an agreed and established time frame; 4/ incentives must be promptly applied and providers must receive timely feedback on their performance to allow for improvement as needed. Systematic reviews have noted that payment for working for a specified time period is generally ineffective. In contrast, payment for distinct service, episode or visit, payment for providing care for a patient or specific population and payment for providing a pre-specified level or providing a change in activity or quality of care. When assessing the effect of financial incentives overall across categories of outcomes, they were of mixed effectiveness on consultation or visit rates; generally effective in improving processes of care; generally effective in improving referrals and admissions; generally ineffective in improving compliance with guidelines outcomes; and generally effective in improving prescribing costs outcomes.
Key words

Group Practice/economics
Physician Incentive Plans
Salaries and Fringe Benefits
Physicians/economics
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Theory, incentives
Models, Econometric
United States
Introduction

This paper examines the rationale for an incentive based culture, the evolution of incentives in provider compensation and management, an analysis of their impact on alignment and the future direction they may take with the continuing changes in the health care. Incentives are a commonplace practice in provider compensation and management, with the intent of aligning provider expectations with organizational goals and priorities (K.P. Glass, L.E. Pieper, & M.F. Berlin, 1999). The need to address the spectrum of incentives that an organization offers to providers has resurfaced with the increasing employment of providers by health organizations and the changing external health care environment (Rakover, 2013). As recruitment increases, physician compensation is expected to increasingly incorporate incentives based on factors such as productivity, quality, outcomes and patient satisfaction. Incentive pay can make up 3% to 5% of the total compensation of employed physicians and is expected to rise to between 7% and 10% in the next few years, according to a survey of 424 health care organizations released Jan. 10, 2012, by Sullivan, Cotter and Associate (Stagg Elliott V, 2013).

Psychology of Incentives

An incentive is “something that incites or has a tendency to incite an individual or group to perform a desired action or actions” (Merriam-Webster, 2015). The “incentive theory” believes that people are motivated to behave in certain ways in order to gain rewards. The most common incentive is a reward. Rewards can be tangible or intangible and are presented generally after the occurrence of the action or behavior that one is trying to correct or cause to happen again. Several studies show that if the person receives the reward immediately, the beneficial effect is greater, but that the perception of benefit decreases as delay lengthens. Repetitive action-reward combinations can cause the action to become a habit and to be become an expectation of the recipient and thus dilute the motivation to attain the incentive.
Herzberg constructed a two-dimensional paradigm of factors affecting people's attitudes about work (Herzberg, Mausner, & Snyderman, 1959). He concluded that such factors as company policy, supervision, interpersonal relations, working conditions, and salary are hygiene factors rather than motivational factors. The absence of hygiene factors can create job dissatisfaction, but their presence does not motivate or create satisfaction. In contrast, elements that enriched a person's job were strong determiners of job satisfaction: achievement, recognition, the work itself, responsibility and advancement. These motivators (satisfiers) were associated with long-term positive effects in job performance while the hygiene factors (dissatisfiers) consistently produced only short-term changes in job attitudes and performance, which quickly fell back to its previous level.

In 1954, Maslow first published "Motivation and Personality," which introduced his theory about how people satisfy various personal needs in the context of their work (Maslow, 1970). The common drivers described by Maslow are often presented as a five tiered pyramid of needs ranging from the lowest physiological safety to the highest self-actualization. In healthcare, providers may be motivated just by knowing that a job is done well and as Maslow has pointed out they can be driven by a desire to achieve individual goals and garner the respect of their peers.

In the well-known book, Drive, Pink examined the dysfunctional nature of the current business-operating model, which is built around a “carrots-and-sticks” rewards system (Pink, 2011). In his opinion, this model was well suited to the working practices of previous generations, which was mainly dependent on algorithmic tasks, or work that followed a set path with clear outcomes. The current working model is dominated by heuristic tasks and requires breaking from a prescribed path to discover novel solutions or creative strategies. In this model, the “carrots-and-sticks” model is not only ineffective but may be harmful. (Pink, 2011). The research of psychologist Samuel Glucksberg of Princeton University has shown a drop in
performance when heuristic tasks are incentivized using bonuses and other additive compensation (McGraw, 1978). In these working environments, incentives not only fail to inspire better results, but also can negatively affect output on heuristic tasks because they can invoke the “Sawyer Effect” which described turning a task from play into work, minimizing creativity and intrinsic motivation. In the worst-case scenarios, bonuses encourage unethical behavior, create addictions, and foster short-term thinking (Ariely, Loewenstein, & Prelec, 2006). According to Pink, the world of compensation needs an upgrade to the next model, which should be designed to reward the “third” drive: intrinsic motivation (Pink, 2011). The maximization of intrinsic motivation is dependent on three elements:

**Autonomy:** The desire to direct our own lives, including tasks (what we do), time (when we do it), team (who we do it with), and technique (how we do it)

**Mastery:** The urge to make progress and get better at something, to see your abilities as infinitely improvable through effort, grit, and deliberate practice

**Purpose:** The yearning to do what we do in the service of others, to be a part of a cause greater and more enduring than one’s self, to accompany profit maximization with purpose maximization.

These several findings raise the idea that to achieve the best possible physician performance, health systems are better served considering the drivers of intrinsic motivation and how they can maximize them for their physicians, rather than focusing solely on remuneration. Beyond a base level (which can be defined as falling close to the market norm for salary = 50th percentile MGMA), compensation makes little difference, but intrinsic motivators do.

Pay for performance is based on the economic theory of “agency”, which posits that compensation is strategic, in that a firm will use the compensation program that best maximizes profits based on its unique intrinsic costs and benefits structure. While “agency” theory has dominated economics for 35 years, it has been questioned more recently. In any system
employing pay for performance and “agency” theory, costs arise due to differences between firms (payors) and employees (payees) in two areas: objectives and information: an employee may not exert maximum effort (or effort may be inefficiently allocated), and the firm may pay workers more than they are worth (i.e. their expected marginal product) (Larkin, Pierce, & Gino, 2012). Poor alignment in these areas can disrupt a successful pay for performance initiative. In healthcare, the balance, between the size of the financial benefit considered worthwhile to the eligible practitioner and the value of the outcomes to the enterprise linked to the eligible practitioner, is key to an economically viable program. An additional cost to the enterprise is how expensive will it be to collect and process the data necessary to track performance measures. (Ryan & Werner, 2013).

### Maturity of the Medical Group

A medical group, is defined as a formal association of three or more providers, who provide services in more than one medical field or specialty, with income from medical practice pooled and redistributed to the members according to some pre-arranged plan (Goldstein, 1950). In general, medical groups are in different phases of development, which has been described as group maturity (Tuckman & Jensen, 1977). The more mature the group, the better the ability of the group to respond to the environment in an appropriate manner and the more robust the culture will be within the group. The desired compensation model will change with the level of group maturity (Tables 1 and 2). The increasing strength of the group culture provides capacity to assess and assume risk. As the tolerance of risk increases, so does the compensation model favored by the provider group. The pros and cons of the common compensation models groups may utilized in relation to their internal culture are shown in Table 3.
Evolution of incentives in medical groups

Incentives for providers have evolved from the simple “eat what you kill” productivity formula to more complicated formulae driven by multiple variables and simple formulae based on discrete measures (Greenfield, 1998) (Martin, 2014). This evolution has been mirrored by the evolution of the solo practice to the group practice inside and outside of an employment model. The commonest measure remains clinical productivity and the commonest productivity benchmarks are those derived from the MGMA based on RVUs, charges or collections (Figures 1 and 2). However, incentive-based compensation for providers is evolving away from metrics derived entirely on volume (which encourage physicians to “do more”) and towards metrics that encourage physicians to be more cognizant of quality and cost issues (which encourage physicians to produce “value”) (Table 4) (Robinson, 2011a, 2011b). This is in answer to the payors’ movement to contain cost, to develop the value proposition and to share the risk with the providers. Many of the new metrics are qualitative and subjective, rather then quantitative (Robinson, 2011b), which presents a challenge in the areas of acquisition, analysis, attribution and interpretation of practice data. In 2011, the average mix for physician compensation was 81% guaranteed salary and 19% incentives (Figure 1) (Johnson & McCook, 2013). More recently, the prevalence of ‘at risk’ payments and withholds has becoming more common with some organizations advocating up to 50% of a provider’s salary be ‘at risk’ annually (Rakover, 2013).

Guaranteed compensation models

Guaranteed compensation models are typically only used for the first one or two years after a physician has completed a residency or fellowship. This model works well for these new physicians, as they generally do not have the patient load and administrative ability to support a production-based compensation model. Various factors will influence the first-year guaranteed
compensation, including medical practice type, practice ownership and location of placement, all of which may differ, depending on whether the practice is in primary care or specialty care. Another factor will be the current level of activity of the other practice providers (i.e. are they working above or below their RVU requirements) and whether the hire is an incremental hire for potential growth or a hire to replace a departed provider with an established practice. According to the MGMA *Physician Placement Starting Salary Survey Report*, specialty-care physicians received 46 percent more in median first-year guaranteed compensation than their primary care counterparts in 2011 (MGMA, 2016).

**Creating an incentive program**

As an organization develops an incentive program, there are several key components necessary to create an effective physician compensation plan (Kathryn P Glass, Lisa E Pieper, & Mark F Berlin, 1999).

- **Statement of overall objectives:** The incentive program should align with and support the needs of the business, employees, shareholders and/or customers. Each reward element should have a defined role that aligns with the business plan of the organization.

- **Importance of incentive program to the enterprise:** The incentive program should explain how the rewards compare with other company identifiers such as technology, culture, size, or leadership (e.g. work place at Google) and must consider if the compensation plan is linked to the company’s reputation (e.g. Morgan Stanley or Goldman Sacks)

- **Performance measures:** The incentive program should identify the performance criteria to be rewarded and should define the framework of metrics and levels of performance. In addition, the incentive plan should outline the degree that rewards are expected to drive employee’s actions.
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- **Competitive reference points:** The incentive plan should describe the key reference benchmarks that will allow a comparison across the industry by position and geography.

- **Competitive positioning:** This section should describe the desired position of the incentive plan in respect to the market: at, above or below the market average. This information is important and should be shared with the employees.

- **Internal equity and consistency:** This section should review the application of the incentive plan and ensure internal and external consistency across all employee groups; this will allow a public stance of fair and uniform treatment without favoritism between groups.

- **Communication:** This section should describe the communication plan, the key elements of the incentive plan, that will be disclosed and the level of transparency that will be afforded the employee groups. In this section, the responsibility for communication and for the design of the incentive plan should be clearly delineated and responsibility for the incentive plan delegated.

- **Governance:** This section should outline the governing structure for the incentive plan and the timetable for its periodic review and refreshment. Importantly, the frequency and responsibility for review of the incentive plan needs to be established.

**Areas of incentives**

A core competitive, well-rounded benefits package is the first step in creating an incentive package that engages the workforce and creates opportunity to provide incentives (Kathryn P Glass et al., 1999). Core provider benefits include: medical and dental insurance with competitive cost sharing, short- and long-term disability insurance, life insurance, paid time off, qualified retirement, credits for CME/professional dues and appropriate malpractice coverage.

Additional benefits that are often included are insurance coverage for catastrophic medical
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events, prepaid legal services, corporate wellness programs, corporate associated discounts at local businesses and the presence of a provider lounge.

According to the MGMA Physician Placement Starting Salary Survey Report (MGMA, 2016), several hiring incentives for specialties that are in high demand are becoming more popular: larger sign-on bonuses and loan forgiveness mechanisms (the employer of paying off a part or all of a new physician's student loans). However, both are often protected by a promissory note for 3-5 years to ensure pay back for early departure. Currently, 53 percent of providers receive signing bonuses as a part of their employment offers. Slightly more primary care physicians than specialty care physicians - 54.4% vs. 53% - report receiving a signing bonus in their contract. In addition, almost 13% of new physicians received loan forgiveness packages as part of their employment offers.

The local setting will most often prescribe the inputs, that best suit the employing enterprise (Chernoff-Kaplan, 2012). Weighting the various areas in which incentives are placed, allows the employer to signal and the providers to understand, where the organization wishes their efforts to be concentrated. As an incentive plan is developed, organizations will prioritize those potential areas with the perceived greatest opportunities for improvement, those areas for which there are sufficient data available to measure performance, and importantly those areas, that are most likely to achieve a buy-in from the majority of the affected providers. As with any incentive plan, a series of goals and stretch goals should be outlined and agreed upon before the beginning of the fiscal year. Incentive models can be applied to individual practitioners, medical groups, independent practice associations, hospitals, physician-hospital organizations, or health plans. In general, quality incentives are more effective if they are related to individual physicians, rather than groups or organizations. Incentive models can address a wide range of clinical, administrative, access, and patient safety measures.
The National Health Care Purchasing Institute (NHCPI) commissioned Bailit Health Purchasing (BHP), LLC to identify viable provider incentive models and the authors identified several common characteristics that can be considered hallmarks of viable provider incentive programs (Bailit Health Purchasing LLC, 2002):

- Performance measures are focused on areas that are priorities for the enterprise offering the incentives.
- Incentive approaches are relatively easy to understand and administer.
- Providers recognize that performance indicators are valid measures of quality that are within their control.
- Actionable provider performance data are available in the targeted areas.
- The enterprise offering the incentive collaborates with the providers to obtain and retain buy-in to the incentive plan.
- All stakeholders agree on the sources of the data and the methodology, by which the metrics that reflect provider performance are calculated.
- Incentives for providers to attain their performance targets are both challenging and achievable, in an agreed and established time frame.
- Incentives are promptly applied and providers receive timely feedback on their performance to allow for improvement as needed.
- Incentive plans are evaluated regularly and modified as needed.

BHP identified eleven incentive models in their review that can be offered to providers (Bailit Health Purchasing LLC, 2002):

**Model #1: Quality Bonuses:** Under this model, providers receive an annual quality bonus for their performance over a limited number of quality measures, which are benchmarked to an absolute external benchmark. The bonus generally represents 5% - 10% of a total compensation. There is an upside risk for the provider group, since providers rated below the baseline
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performance expectation do not receive a bonus or a penalty. Geisinger Clinic follows an 80/20 compensation model for its employed physicians, in which 80% of total compensation is based on the usual volume metrics, including panel size, the number of patients seen and number of RVUs performed. The remaining 20% of total compensation is linked to how well providers improve quality and reduced costs in both hospital-based and outpatient based care (Rosin, 2015).

Model #2: Compensation at Risk: In this model, a percentage of a provider’s compensation is placed “at risk” based on performance in a series of quality measures linked to an acceptable benchmark. The incentive plan withholds the percentage of the provider’s total annual compensation (5 to 10%). Some organizations will have an independent vendor verify provider performance data and compensation calculations. Providers receive some or all of the compensation with held based on the achievement of the identified targets. There is an upside risk for providers rated below a minimally accepted floor of performance, which is established in consultation with the provider group. The target performance rate and the minimum performance floor should be re-calibrated regularly to ensure metrics remain up to date.

Model #3: Performance Fee Schedules: In this model, the incentive plan is incorporated into the fee schedule. The employing organization creates a provider fee schedule, which is linked to the national performance patterns. Based on this comparison, providers are designated to one of three performance levels: high, neutral or low. High quality providers are paid greater than 100% of the Medicare fee schedule, average quality physicians are paid 100% of the Medicare fee schedule and the lower performing providers receive 85% of the Medicare fee schedule. This model provides both an upside and a down side risk.

Model #4: Quality Grants: An insurer, an employer, or a consortium of insurer and employer publicizes a request for proposals (RFP) to providers, medical groups, hospitals, and PHOs requesting the submission of quality improvement (QI) proposals that can be completed within an 18-month period and at a cost below the maximum financial assistance level specified in the RFP.
RFPs are evaluated based on pre-identified scoring criteria that evaluate their potential to improve operations performance in targeted quality improvement areas and the potential to be disseminated and replicated by other providers not involved in the original RFP. Successful RFPs receive financial and administrative grant support to pilot quality improvement projects. There is a shared risk component, in that the providers agree to furnish in-kind support to the sponsoring organization, which can include dedicated clinical and operational staff time (i.e. costs). The projects are monitored and must submit progress reports and data on an agreed upon time schedule, and present their findings in semi-annual meetings.

**Model #5: Reimbursement for Care Planning:** In this model, participating providers receive additional reimbursement for coordinating care and establishing care plans for specific patients with chronic conditions (i.e. diabetes, COPD, asthma, congestive heart failure, and hypertension). In return for completing an annual health risk assessment or developing an action plan for each specific patient with a chronic condition, individual providers receive a small fee, generally in the range of $50. Providers or their group directly bill the insurer or employer participating in the incentive plan on a fee-for-service basis. To establish the population at risk, insurer and/or employers pre-identify the participating patients with chronic conditions through claims data, develop lists of disease-management program participants, and referrals and place them in the eligibility pool.

**Model #6: Variable Cost Sharing for Patients:** Insurers or self-insured employers often offer insurance products in the marketplace with three-tiered structure of patient deductibles and co-pays for both hospital admissions and for medical office visits (e.g., a $100, $500, or $1,000 deductible for non-emergency hospital admissions, and a $10, $25, or $50 co-pay for medical office visits). The deductibles are used to steer patients economically to preferred providers and facilities. The deductibles are determined on the basis of the provider’s combined score on clinical quality, patient safety measures and total cost of care, such that patients electing to use
high scoring providers, benefit from the lowest cost sharing, and those who see the lowest-scoring providers. are encumbered with highest cost. Multiple-tier cost sharing is only successful, when patients have a choice of hospitals and provider groups within a reasonable travel distance (e.g. an urban area). To be effective, the insurer or employer must have sufficient volume or access to all-payer data to assess each provider’s performance in the designated areas. To develop the tiers, performance metrics are derived from the most recent two years of completed and verified data often using an independent vendors acceptable to the insurer and the providers electing to be involved.

**Model #7: Performance Profiling:** Organizations, who offer this type of incentive, have access to performance data for a wide range of providers and facilities. Using a standardized approach to assess performance related to access-to-care measures, clinical quality, patient satisfaction, patient safety, cost, utilization or patient outcomes, provider and facility performance is compared across statistically similar groups, taking into account significant differences in volume and characteristics of patient populations that might affect performance. Parties are excluded from the profile report, if there is insufficient volume to support a robust assessment. The profile report will show both relative and absolute measures for each performance metric. Incentive and/or withholds with an upside and down risk are then applied in a similar manner to the proposed MIPS formulation.

**Model #8: Publicizing Performance:** In this model, external organizations publicly distribute information on provider or facility performance and inform providers of their intent to do so in advance (e.g. US New and World Report, Leapfrog and Health Grades). Potential positive or negative publicity is used to motivate providers to improve performance. The public release of performance information may be through a published report, a press release, a website, an award ceremony, or a combination of efforts. The profiling organizations develop publicity strategies.
designed to educate the public and news media about variations in provider performance with the goal of influencing their choice of providers.

**Model #9: Technical Assistance for Quality Improvement:** In this type of incentive model, organizations offer technical assistance to hospitals, medical groups, or individual providers to help them achieve quality improvements (e.g. The Advisory Board). High-volume providers that have relatively low performance on selected quality indicators are both targeted and can avail of these services. The organization offering the technical assistance surveys the provider group or facility, provides an analysis and diagnosis of the issues that are the potential causes for low quality performance, and offers best clinical or administrative practices to guide improvements. These best practices are gleaned from industry standards and providers’ peer groups.

**Model #10: Practice Sanctions:** In this model, an organization that contracts directly with providers, measures provider performance on selected quality indicators annually. After a minimum performance level in each targeted area is established, providers not meeting these minimum thresholds are required to implement quality improvement initiatives. Failure to improve in the following year’s measurement will result in sanctions, ranging from practice limitations to non-renewal of the contract.

**Model #11: Reducing Administrative Requirements:** This model is implemented by an organization with administrative requirements for providers, such as pre-certification that the provider consistently follows nationally accepted clinical guidelines of care. The organization audits the performance of their cohort of providers on targeted measures regularly to determine outliers. Those, who continue to meet a best practice threshold, are not required to meet existing administrative requirements and the waiver remains in effect, unless a more recent audit indicates that the provider’s performance has fallen below the organization’s specified benchmarks.
Merit-Based Incentive Payment System (MIPS)

The Federal Government is introducing an incentive scheme that will supersede many local plans. On October 14, 2016, CMS released the final rule for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA repeals the Medicare Part B Sustainable Growth Rate (SGR) reimbursement formula and replaces it with a new value-based reimbursement system called the Quality Payment Program (QPP) (CMS, 2016a). The QPP consists of two major tracks: the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (Advanced APMs) (CMS, 2016b). CMS predicts that 600,000 Part B providers will be subject to MIPS with few exemptions applicable. An important change in this program, is that MACRA now includes providers, who were not previously eligible for the EHR Incentive program (i.e. physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and hospital-based eligible providers). Exemptions are available if the providers are new to Medicare, have $30,000 or less in Medicare charges, have 100 or fewer Medicare patients, or significantly participate in an APM. MACRA defines two types of financial impacts for clinicians participating in MIPS: 1/ A small, annual inflationary adjustment to the Part B fee schedule and 2/ MIPS value-based payment adjustments (incentives or penalties) based on the MIPS 100-point final score. The inflationary adjustment is an annual +0.5% increase for the payment years CY2016 to CY2019, which is the first payment year for MIPS under the QPP. The inflationary adjustment resumes in CY2026 and thereafter, where MIPS eligible clinicians will receive a +0.25% annual adjustment. The potential MIPS incentives and penalties, via value-based payment adjustments, are much more substantial than the inflationary adjustments. MACRA consolidates three currently disparate Medicare quality programs into MIPS: (1) the Physician Quality Reporting System (PQRS); (2) the Value-Based Modifier Program; and (3) the ‘Meaningful Use’ of electronic health records (MU) (Hussey, Liu,
Under MIPS, CMS proposes that eligible providers receive a composite score relative to their performance in each of four categories:

- **Quality**: 50 percent of total score in year 1;
- **Advancing Care Information**: 25 percent of total score in year 1, formerly EHR Meaningful Use;
- **Clinical Practice Improvement Activities**: 15 percent of total score in year 1, this is essentially the “new” domain added to the previously existing other three; and,
- **Cost or Resource Use**: 10 percent of total score in year 1, based on Medicare claims data - no reporting necessary.

Following a comment period, CMS built in a flexible performance period, reduced the Quality Reporting Threshold to 50%, reduced Resource Use Category Weight to 0% for first year, and eased the requirements for Advancing Care Information. MIPS will have a direct impact on Medicare Part B providers’ bottom line, and it will be important for all healthcare industry stakeholders to understand how their business might be affected. A provider’s MIPS score has the potential to impact their reimbursement by +/- 4% for the 2019 payment year (which will likely be based on 2017 performance) and up to +/- 9% by 2022 (Doran, Maurer, & Ryan, 2017).

**Effectiveness of Incentives**

Incentives can work for both the employer and the provider, if they are properly constructed, delivered in a timely manner, revised periodically and not taken for granted. Incentives must align with the current business plan and the enterprise’s longer-term strategy. However, many incentives can lead to unintended consequences if there is lack of weighting or the metrics used are nebulous. Research on the use of financial incentives to drive performance improvement has had mixed results (Chaix-Couturier, Durand-Zaleski, Jolly, & Durieux, 2000; Ryan & Werner, 2013). Incentive schemes, both financial and non-financial, always have a risk of generating unintended consequences. The principal type of unintended consequence is
'gaming', where participants find ways to maximize measured results, without actually accomplishing the desired objectives (Robeznieks, 2007). A second major concern is known in the economic literature as the multi-tasking problem. If the goal of the payer is multi-dimensional and not all dimensions lend themselves to measurement, rewarding performance based on available measures will distort effort away from unmeasured objectives (Rosenthal & Frank, 2006).

In a recent overview of all systematic reviews that evaluated the impact of financial incentives on healthcare professional behavior and patient outcomes, it was noted that payment for working for a specified time period was generally ineffective. In contrast, other financial incentives were found to be effective: payment for distinct service, episode or visit, payment for providing care for a patient or specific population and payment for providing a pre-specified level or providing a change in activity or quality of care (Flodgren et al., 2011). When assessing the effect of financial incentives overall across categories of outcomes, the authors noted mixed effectiveness on consultation or visit rates; general effectiveness in improving processes of care; general effectiveness in improving referrals and admissions; general ineffectiveness in improving compliance with guidelines outcomes; and general effectiveness in improving prescribing cost outcomes (Flodgren et al., 2011).

**Conclusion**

Incentive based compensation remains important in the management of providers and the services that organizations provide. Designing motivators (satisfiers) to induce long-term positive effects in job performance, while avoiding hygiene factors (dissatisfiers) that consistently produced only short-term changes in job attitudes and performance, are key to a durable and successful incentive scheme. In the current health care environment, these incentives must
continue to change in response to the market and the continuing pursuit of value-based care. The change may lead to more complicated plans and will shift more risk to the provider over time.

Bibliography


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<th>Increasing provider risk</th>
<th>Model</th>
<th>Description</th>
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<td>Fee for service</td>
<td>Providers paid a specific amount for a service</td>
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<td>Pay for Performance</td>
<td>Incentives for quality measured by evidence based standards</td>
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<td>Value based Purchasing</td>
<td>Percentage of reimbursement at risk which is earned back by achieving high quality outcomes</td>
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<td>Bundled Payments</td>
<td>Single payments for episodes of care shared by hospitals and providers</td>
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<td>Shared Saving</td>
<td>Percentage of saving from reduced cost of care shared by hospitals and providers</td>
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<td>Global Payments</td>
<td>All Services are included in one payment that manages the patient across the health care delivery system</td>
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### Table 2: Progression Criteria for Group Maturity

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<th>Increasing Risk</th>
<th>Progression of Medical Group Maturity</th>
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<td></td>
<td>Salary + Risk Sharing</td>
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<td>Salary + Performance objectives</td>
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<td>Productivity + more weight on performance incentives</td>
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<td>Productivity + production incentives</td>
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<td>Salary / Substantial Guarantee</td>
<td>Productivity without Guarantee</td>
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<td>Early</td>
<td>Maturing</td>
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<td>Mature</td>
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### Table 3: Pros and Cons of Compensation models

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<th>Compensation model</th>
<th>Pros</th>
<th>Cons</th>
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| 1 Salary or substantial guarantee                      | No income at risk  
Competitive salary option                                          | Absence of performance expectations and accountability  
Limited negotiation leverage  
Limited physician buy-in to system objectives  
No patient access incentives |
| 2 Productivity with some income floor guarantee         | Aligns Provider with revenue payment streams  
Retains income protection  
Provider accountability for overall performance | Alignment gap identified in #1 persists  
Weak physician engagement which hampers patient access and business development |
| 3 Productivity without guarantee                       | Achieves full alignment with revenue payment streams  
Provides highest short term revenue improvement  
Provides financial incentives to achieve targeted patient access  
and business development | No provider income protection  
Negative provider perception  
Does not address other desirable performance criteria |
| 4 Productivity plus other performance criteria (20–25%) | Introduces provider risk with compensation tied to incentive criteria (quality, service, financial)  
Commences alignment of providers with emerging revenue stream criteria | Criteria are not well defined, meaningful or measurable |
| 5 Productivity plus more weight on other performance criteria (26–50%) | Improvement in provider satisfaction  
Prioritizes productivity  
Partial alignment with system goals  
Assumes productivity as a certainty  
Heavy emphasis on other criteria (including system goals)  
Builds on maturity of medical group culture | Criteria are not well defined, meaningful or measurable |
| 6 Salary plus performance incentives                    | Establishes productivity targets as a minimum specification for incentives  
Places greater emphasis on other criteria than productivity  
Builds on a mature medical group culture, an optimal development of clinical delivery model, and established readiness for next-generation compensation models | Only functions when culture and infrastructure are well-developed |
### Table 4 Commonly used quality and incentive metrics

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<thead>
<tr>
<th>Primary Care Metrics</th>
<th>Preventative Metrics</th>
<th>Specialist Metrics</th>
<th>Quality Metrics</th>
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<tbody>
<tr>
<td>Patient Access</td>
<td>Mammogram screening</td>
<td>Post discharge</td>
<td>Inpatient SCIP and Core Measures</td>
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<td>Panel Size</td>
<td>Colon Cancer screening</td>
<td>Readmission Reduction</td>
<td>NCQA, HEDIS, NQF Standards</td>
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<tr>
<td>Mild level Supervision</td>
<td>Cervical screening</td>
<td>On time Surgical Starts</td>
<td>Care Model Development</td>
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<tr>
<td>Care Co-ordination</td>
<td>Osteoporosis screening</td>
<td>Discharge Planning</td>
<td>Patient outcomes for identified conditions</td>
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<tr>
<td>PCMH Development</td>
<td>Flu Vaccination</td>
<td>Patient access</td>
<td>Completed Health risk assessments</td>
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<tr>
<td>Chronic Disease management</td>
<td>Pneumonia vaccination</td>
<td>Supply Standardization</td>
<td>33 ACO quality metrics</td>
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<td>BP screening</td>
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<td>Timely consults</td>
<td>Use of Disease registries</td>
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<tr>
<td>Cholesterol screening</td>
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<td>Care co-ordinations</td>
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<table>
<thead>
<tr>
<th>Patient Satisfaction Metrics</th>
<th>Citizenship Metrics</th>
<th>Finance Metrics</th>
<th>Academic Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMGA, Press Ganey, NPC Pickard</td>
<td>Timely medical record completion</td>
<td>Expense control</td>
<td>Grant funding</td>
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<td>Peer-Peer Review</td>
<td>Successful Coding Audits</td>
<td>Meet or Exceed Budget Targets</td>
<td>Educational Metrics</td>
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<td>Staff-Peer Review</td>
<td>MU adoption</td>
<td>Profitability of provider group</td>
<td>Professorships, honoria and stipends</td>
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<td>Patient Phone or email surveys</td>
<td>Meeting Attendance</td>
<td>ACO Shared Savings</td>
<td>Publications</td>
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<td>Call Coverage</td>
<td>Timely submission</td>
<td>Presentations</td>
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<td>Risk Management/Compliance Education</td>
<td>Meaningful use Dollars</td>
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<td>Societal Activity</td>
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</tbody>
</table>
Figure 1  Pay based on Productivity in PCP and Specialty groups
Figure 2  Prevalence of Compensation Models

Physician Compensation Models

- Patient Satisfaction
- Individual Financial Goals
- Clinical Outcomes
- Cost Containment
- HEDIS
- Access
- Citizenship
- Dept RVU
- Peer chart Review
- Departmental

AMGA Survey Prevalence