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# aligning physician compensation with strategic goals

Data-management tools and transparency helped one health system successfully transition from 13 separate productivity-based physician compensation plans to a single plan that aligns physicians with the goals of integrated, value-based patient care.

In 2010, Mayo Clinic in Rochester, Minn., embarked upon a journey toward clinical integration with Mayo Clinic Health System (MCHS), the community-based practice of the academic medical center. A major foundational issue that needed to be addressed was the decentralized and disparate manner in which MCHS physicians were compensated.

By employing strong clinical and administrative leadership, effective operational support, and automated data management and reporting tools, MCHS transitioned its physicians to a single compensation plan in January 2014. The plan standardizes physician compensation methodologies across MCHS, utilizing quality and patient-experience metrics in addition to productivity metrics with the goal of getting physicians to embrace organizational goals and deliver integrated, value-based care.

## Defining the Challenges

Created in 1992, MCHS is an organization of community-based providers, hospitals, ambulatory clinics, and other healthcare facilities serving more than 70 communities in Minnesota, Wisconsin, and Iowa. Until a few years ago, these entities each had separate finance departments, human resources departments, and information systems.

Each entity also had its own physician compensation plan. Although all 13 MCHS physician compensation plans used relative value units (RVUs) to measure the financial value of physician services, each entity administered its plan differently. This inconsistency resulted in variation from one plan to another, even as each entity monitored compensation to ensure physicians were paid according to acceptable benchmarks and

## AT A GLANCE

- > In 2012, Mayo Clinic Health System (MCHS) had 13 different physician compensation models among its operating units, with most based on productivity metrics.
- > MCHS aimed to transition all physicians to a single compensation model that would facilitate its integration with Mayo Clinic and promote physician engagement with emerging value-based payment models.
- > The new model, which was implemented this past January, incorporates quality metrics, provides physicians with regular reports of their performance, and already has resulted in greater physician attention to outcomes, safety, and patient experience.

had its plan reviewed for appropriateness by independent compensation committees of local and regional boards.

For example, RVU values for the same services differed across practice sites. The values associated with modifier adjustments also were inconsistent. Some plans included quarterly RVU compensation settlements; others included annual compensation based on prior-year RVUs. Only three plans included nonproductivity (nonfinancial) measures.

Overall, these variations led to physicians being paid differently for the same type of work. Even more significant, the variation, coupled with decentralized plan administration, impeded MCHS's ability to fulfill the Mayo mission to provide one standard of care and align with emerging value-based payment models.

### Recognizing the Need for Change

MCHS leaders desired a physician compensation plan that reached beyond productivity and better reflected physician performance on outcomes, safety, and patient experience. This type of compensation system would help the organization provide the best care to its patients and align with value-based payment models. The new and evolving payment models reward value (defined as better outcomes and patient experience at a lower cost). Current productivity-based physician compensation models reward only volume of care, which can conflict with the goal of increasing value. To align physician goals with organizational goals, the physician compensation model needed to reflect performance on outcomes and patient-experience metrics, where appropriate.

Change also was motivated by MCHS leaders' desire to improve the efficiency of the compensation administration process. Multiple sites struggled with similar issues and expended significant resources to maintain disparate processes, often resulting in additional plan variation.

Finally, as MCHS continued to clinically integrate, its leaders recognized the need to monitor physician productivity and quality performance across sites to identify top performers and share best practices. Such an assessment was initially impossible due to disparate information systems and metric definitions.

### Building a Framework

MCHS's new goal was to design a systemwide compensation plan that would have consistent metric definitions and be centrally administered, yet locally adjudicated. The ability to centralize reporting of provider performance and offer a detailed view into activities that affected compensation would be central to the initiative.

To implement such change with as little disruption as possible, MCHS leaders employed three key strategies.

*Institute dyad leadership.* The MCHS compensation and benefits committee commissioned a physician compensation standardization advisory group to review the state of physician compensation plans, assess the cultural risk of change, and recommend levels of standardization. The 10-member advisory group included physician compensation leaders from each of the health system's four regions and key administrative leaders from MCHS. All proposals from this group required approval by the MCHS compensation and benefits committee.

Reflecting Mayo's governance philosophy, the advisory group was led by a physician with support from an administrative partner. For the administrative component of this partnership, MCHS created a new position: director of physician compensation. The physician leader was charged with communicating the MCHS vision, addressing physician concerns, and managing cultural issues. The director of physician compensation gathered information on current compensation practices, provided financial analysis of plan changes, ensured operational support,

and led administration of compensation plan calculations and reporting. Both leaders worked to ensure that all policy and design decisions could be implemented effectively and efficiently from an operational perspective—a critical factor in the success of the transformation.

**Implement shared services.** A shared-services model was created to centralize management of physician compensation administration under the director of physician compensation. Today, compensation analysts act as liaisons between local sites and the central compensation administration. Although they are centrally managed by and report to the director of physician compensation, these analysts remain on-site, providing information directly to leaders, giving insight related to data, and addressing physician concerns face-to-face. Weekly online meetings between the compensation director and the site-based analysts ensure appropriate communication, alignment, and support.

**Automate data management and reporting.** Establishing a central automated system for managing and reporting data represented the greatest operational change. Developed internally, the tools support enhanced operational efficiency and analytics capabilities. One tool gathers billing data from 15 different systems, normalizes the data, and calculates RVUs according to industry standards so that values are consistent across sites and with external benchmarks. A second tool imports data from the electronic health record and patient-experience survey vendor to calculate physician performance on quality metrics.

Together, the tools give compensation analysts more control over and improved access to physician performance data. Easier access to systemwide data also allows for internal and external benchmarking on physician productivity and quality performance.

### Planning for and Managing Change

Leaders understood that a phased implementation approach would minimize turmoil. Once the framework was in place, the compensation advisory group established priorities and a timeline for operationalizing them. The goal was to minimize disruption by promoting communication, data transparency, open decision making, and adherence to a carefully thought-out timeline.

**Setting priorities.** Because the nonfinancial (quality) compensation metrics would be new for most MCHS physicians, the initial changes focused on less-controversial compensation plan enhancements, such as automating data management and standardizing productivity measurement. It was important to leaders that the organization's initial efforts focus on building the operational infrastructure and trust that would be required to effectively implement and administer the new compensation plan.

The switch to standardized RVU calculations, which were implemented across the system in 2013, met with little resistance. Physicians could easily accept the fairness of measuring the value of services of two physicians doing the same kind of work with the same RVU value.

Other top priorities included standardized guidelines for administrative compensation and on-call pay. MCHS leaders recognized the need for site leaders to have some autonomy to address these issues locally; however, policies and boundaries were put in place to ensure local decisions were in line with fair-market-value requirements. For example, individual sites were not allowed to set on-call pay above a specified percentile of the call-pay benchmark without approval by the MCHS compensation and benefits committee.

After standardization, the advisory group focused on more controversial changes, such as connecting physician compensation with performance measures related to outcomes, safety, and the patient experience.

*Engaging physicians.* Efforts to gain physician buy-in have centered on effective communication and relationship building. Physicians want to understand the reasons behind decisions and be able to voice concerns.

Throughout the redesign process, MCHS focused not only on informing physicians of the need for a redesigned physician compensation plan, but also on seeking their input regarding what changes should be made. MCHS leaders decided to hold conferences every six months to address the why, what, and how of the compensation redesign, with representation from compensation analysts, physician members of site compensation committees, and site leaders.

The conferences also provided a venue for discussing physician concerns. For instance, physicians were concerned that compensating based on individual providers' diabetes measures would make some physicians reluctant to see patients with the most severe health symptoms. As a result of this and other feedback, compensation for diabetes outcomes is measured according to each practice group's performance.

The willingness of health system leaders to listen and respond to physicians' concerns has helped to minimize pushback from physicians regarding the design of the compensation program. For example, several physicians at one site objected to having a portion of their pay tied to two diabetes quality outcomes measure that they did not feel they had control over. (The measures concerned whether patients smoked and took aspirin.) After careful analysis, the health system dropped these two requirements and adjusted the targets to account for the change. This accommodation did not significantly change the goal to improve outcomes for diabetic patients, yet the health system gained significant physician engagement because leaders listened to physicians' feedback.

As the conferences have continued to be held (four have taken place so far), the atmosphere

within the group has evolved from one of questioning and concern toward gradual acceptance of and enthusiasm for the changes proposed. It is anticipated that additional conferences will be held at least annually in the future to discuss additional metrics or changes to the plan.

*Providing transparency.* Automated data management and reporting tools enable physicians to easily see and understand the data that directly affects their compensation. MCHS delivers reports monthly via email, with hyperlinks directing physicians to their individual data. The RVU reports include the name and phone number of a site-based financial analyst, and the quality compensation reports contain contact information for quality experts, making it easy for physicians who have questions regarding the data or who wish to improve their performance to contact the appropriate individuals for assistance.

The reports provide a clear, concise picture of physician performance versus expectations, comparing actual performance with payout targets. For the quality compensation plan, the impact of year-to-date performance on compensation is displayed prominently in the report header. When physicians open the report, they can clearly see what percentage of compensation tied to quality metrics they have earned based on their performance.

The reporting tool also gives physicians access to data at the granular level. Physicians can see billing detail with RVUs for every patient visit and code billed, diabetes-care test values and dates by patient, and patient-experience performance by survey question. This level of transparency has improved physicians' trust in the initiative and enables them to be partners in the quest for data integrity. If physicians believe there are errors in the calculations, they are encouraged to contact the data expert listed on the report for investigation and remedy, if appropriate. This approach gives them further assurance that their concerns will be respected and acknowledged.

### Adding Value Metrics

Consistent with the strategy to introduce change slowly, nonfinancial metrics are being gradually mixed in with productivity measures in the health system's physician compensation plan. This year, 5 percent of compensation will be based on quality measures, meaning that 95 percent of clinical compensation will remain RVU-based for most specialties.

As quality measures are introduced, RVU compensation settlements are no longer paid quarterly at any sites. Instead, annual compensation is paid on the basis of prior-year RVU performance. This approach allows MCHS to keep productivity a priority for now but gradually reduces its emphasis as quality metrics are incorporated and payer incentives shift. Over time, the percentage of compensation that is based on nonproductivity measures will increase.

The new compensation design includes measures for patient outcomes, safety, and patient experience tailored to each specialty and including both group and individual measures (see the sidebar at right). The number of metrics was kept to a maximum of three per physician to minimize complexity for the physicians and the analysts.

In designing the compensation plan, the MCHS quality oversight executive committee provided a list of quality metrics to be considered in the compensation plan. The MCHS compensation and benefits committee had ultimate approval over which metrics to include.

Once the metrics were selected, the standardization advisory group proposed the compensation methodology, drawing upon the experiences gathered in initial nonfinancial compensation pilots at one MCHS site (see the sidebar). Key components of the plan include the following.

**Three payout targets for each metric.** Because experience had demonstrated that physicians would not be motivated by an all-or-nothing approach, three payout targets were created:

- > Target 1 value: 50 percent payout
- > Target 2 value: 100 percent payout
- > Target 3 value: 100 percent + 1 to 2 percent additional payout

### The Evolution of MCHS Value-Based Compensation Metrics

The design of the compensation component for quality performance in the Mayo Clinic Health System (MCHS) model was based on a successful plan that had been in place since 2009 at one MCHS site. From that plan, MCHS learned:

- > Even small percentages of compensation allocated to quality metrics are enough to elevate engagement.
- > Physician engagement increases dramatically when physicians receive monthly dashboards detailing performance and the impact of performance on compensation.
- > There must be strong cooperation between the compensation committee and quality leaders. Quality leaders and staff must be prepared to assist physicians in improving performance.

The metrics used in the MCHS compensation model were based on criteria such as:

- > Reliability and accuracy
- > Electronic availability
- > Ease of data collection
- > Transparency
- > Reporting status to public agencies and payer contracts
- > Alignment with MCHS quality priorities

The metrics were put through a thorough due-diligence process. Quality data and information systems experts were interviewed for insights into potential data-integrity issues (e.g., what physicians might say is unfair about using a given metric in compensation), and the metrics were modified, where needed. Physicians were thoroughly informed about why each metric was chosen.

The second part of the due-diligence process was a thorough scrubbing of metric detail by physician leaders. For example, a physician reviewed patient-level detail for the hospital-discharge medication-reconciliation metric. This physician discovered that certain patient discharge statuses (e.g., patient deaths) were being counted in the denominator even though they didn't require medication reconciliation. Inclusion of these cases was understating metric performance. The data extract was reprogrammed to exclude all such situations from the denominator.

Targets and additional payouts were set using baseline data to ensure 100 percent total payout in year one. MCHS leaders did not want physicians to see the new plan as an effort to reduce costs.

**Annual compensation based on prior-year performance.** Annual compensation for MCHS physicians will be calculated on the basis of calendar-year performance for the prior year. The annual compensation period runs from May through April (i.e., performance in CY14 will affect annual compensation beginning in May 2015). This timeline allows for calculations, approvals, and appeals.

**Shadow-compensation reports.** It was important that physicians knew going into the initial measurement year where they stood in terms of their assigned quality measures and the potential changes to their compensation. Data from January to September 2013 were used to provide physicians with an online shadow-compensation report in early January 2014. These reports showed baseline performance compared with payout targets and the resulting impact their performance would have

had on compensation had the plan been in place during the baseline period. Physicians also were given detailed reports, formatted in an intuitive manner, to help them identify opportunities to improve their individual performance, potentially minimizing their reliance on compensation and quality analysts. For example, performance associated with each patient-experience survey question is sorted so that questions pertaining to areas of poorest performance appear at the top of the report, allowing physicians to quickly identify which behavioral changes might enable them to improve patient experience and, accordingly, compensation. These same report formats are now issued monthly.

**Looking Forward**

It is too early to fully evaluate the new compensation model's success, given that it has been in place only since January 2014. Anecdotal reports, however, show that physician engagement has increased in all quality areas: outcomes, safety, and patient experience. Whereas obtaining physician attention to quality measures was challenging previously, quality staff report that many physicians are now actively

**PATIENT-EXPERIENCE SURVEYS ELEVATE PHYSICIAN ENGAGEMENT**

**Mayo Clinic Health System  
Avatar Provider Core Composite Detail  
For the 9 Months Ended September, 2013**

For questions or to report a potential data issue please contact Jack Black at (999) 999-9999.

| Provider Name - Specialty   | Overall Results         | Physician Office                 | Ambulatory Surgery                  |
|---|-------------------------|----------------------------------|-------------------------------------|
| <b>Number of Surveys Returned Year-to-Date:</b>   | <b>26</b>               | <b>16</b>                        | <b>10</b>                           |
| <b>Avatar Survey Question *</b>   | Wtd Avg Percent Top Box | YTD Percent Top Box              | YTD Percent Top Box                 |
| I was given the chance by my surgeon to provide input into decisions about my surgery.      | 62.5%                   |                                  | 62.5%                               |
| My doctor answered my questions about my health.  | 84.6%                   | 84.6%                            |                                     |
| My doctor explained my illness or treatment in a way I could understand.                    | 85.7%                   | 85.7%                            |                                     |
| My surgeon answered my surgery-related questions.   | 87.5%                   |                                  | 87.5%                               |
| My surgeon explained my surgery in a way I could understand.                                | 90.0%                   |                                  | 90.0%                               |
| My surgeon showed concern and sensitivity to my needs.                                      | 90.0%                   |                                  | 90.0%                               |
| I was given the chance by my doctor to provide input to decisions about my health.          | 91.7%                   | 91.7%                            |                                     |
| My doctor showed concern and sensitivity to my needs.                                       | 93.3%                   | 93.3%                            |                                     |
| <b>Provider Core Composite</b>  | <b>86.7%</b>            | <b>88.9%</b>                     | <b>83.3%</b>                        |
| <b>Compensation Percent Top Box Target Values Based on Avatar Benchmark Values for 2013</b> | Wtd Avg Comp Targets    | Comp Targets for General Surgery | Comp Targets for Ambulatory Surgery |
| <b>30th Percentile (50% payout)</b>   | <b>85.3%</b>            | 85.1%                            | 85.6%                               |
| <b>50th Percentile (100% payout)</b>  | <b>88.2%</b>            | <b>88.6%</b>                     | 87.5%                               |
| <b>70th Percentile (100% payout + 2%)</b>   | <b>91.0%</b>            | 92.1%                            | 89.4%                               |

Patient-experience staff at MCHS report that with the ability of physicians to see their performance by survey question, more physicians are asking for assistance in addressing their poorest-performing areas.



engaged with the measures, providing feedback on them and using them to better understand how to improve their performance.

For example, if patient responses to a patient-experience survey regarding a physician are worst relative to the statement “I was given the chance by my surgeon to provide input into decisions about my surgery,” the patient-experience staff can provide the physician with guidance on what actions are most likely to make patients feel that they do have input. Similarly, if survey responses are poorest regarding the statement “My doctor answered my questions about my health,” physicians intuitively know that they need to invite patients to ask questions and take the time to ensure that patients understand the answers provided. This effort not only protects the physician’s compensation but also improves the patient experience. (See the exhibit on page 6.)

Changing formulas and metrics is challenging. Gaining physician trust through two-way communication, data transparency and reporting, and gradual—rather than instant—change was imperative to the success of this initiative. Today, MCHS has a compensation framework in place that will allow the health system to meet the directives of new payment models and, ultimately, support the Mayo philosophy of providing truly integrated, high-value care that best serves the needs of its patients. ●

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