

## CASE STUDY

**Brian Bunkers**  
**Mark Koch**  
**Jeanie Lubinsky**  
**Jeffrey A. Weisz**  
**Brian Whited**



## value-based physician compensation a link to performance improvement

Mayo Clinic Health System has found that even small incentives are enough to steer physicians toward value.

As the healthcare industry picks up the pace on its journey to value-based care, many hospitals and health systems are grappling with the question of how to compensate their physicians to drive that value. The response of leading health systems to this challenge can provide valuable insights that can inform these organizations' efforts.

### AT A GLANCE

- > To prepare for the healthcare industry's transition to value-based care, Mayo Clinic Health System implemented a new, value-focused physician compensation plan as part of a larger initiative aimed at systemwide clinical integration.
- > The plan uses three value-based metrics, focusing on outcomes, safety, and patient experience, that initially would determine 5 percent of a physician's compensation.
- > Notable improvements achieved in the first year of the plan's implementation were strong indicators of the potential effectiveness of such a plan.

In 2014, Mayo Clinic Health System (MCHS) implemented a new physician compensation model designed to align physician performance with the organization's strategic goals to achieve integrated, value-based patient care.<sup>a</sup> The new design integrates 13 separate productivity-based physician compensation plans into a single model that incorporates performance-based incentives amounting to 5 percent of a physician's compensation. Results one year after implementation show that, even when a relatively small percentage of compensation is at risk, physicians can be engaged to integrate value-based care into their practices.

### Removing the Barrier to Value

MCHS's decision to create a single compensation model was part of a larger effort to clinically integrate the health system with Mayo's network of community-based providers, hospitals, ambulatory clinics, and other healthcare facilities in Wisconsin and Minnesota, and Mayo Clinic, the Rochester, Minn.-based academic medical center. Pure productivity-based compensation models were not aligned with the change necessary to prepare for value-based payment. In fact, many MCHS sites had been struggling to engage physicians to improve their quality metric performance.

a. See Bunkers, B., Koch, M., McDonough, B., and Whited, B., "Aligning Physician Compensation with Strategic Goals," *hfm*, July 2014.

MCHS's objectives were similar to those of many other organizations in seeking to:

- > Align physician performance with value-based goals
- > Reduce inefficiency resulting from administering disparate compensation plans
- > Improve measurement of physician performance to identify top performers and share best practices across sites

This new transformational model would align with evolving payment models in which value, not volume of care, is rewarded, resulting in accessible, higher-quality care, at lower cost, for a better patient experience.

### Developing the New Model

Guided by a dyad leadership team consisting of a physician and director of physician compensation, a 10-member physician compensation standardization advisory group formed to study best practices of other medical groups, gather input, and develop a plan.

MCHS centralized the management of physician compensation administration and created the role of compensation analyst. Analysts serve as liaisons between central administration and local sites. MCHS also developed a centralized physician performance management system to standardize the process to calculate relative value units (RVUs) and measure/track performance data.

The final plan encompasses one compensation model that is administered centrally and adjudicated locally.

Value-based components, designed in part on a plan implemented at one MCHS site, were selected based on metrics that reflected industry-recognized standards, such as reporting requirements of states and the Centers for Medicare & Medicaid Services. The metrics were approved by the MCHS compensation and benefits committee to be applied initially to 5 percent of a physician's total compensation:

- > 1 percent for outcomes measures by specialty

- > 2 percent for safety with e-prescriptions and medication reconciliation
- > 2 percent for patient experience scores<sup>b</sup>

Payouts for value-based compensation targets, set at three levels, were calculated using 2013 baseline performance to achieve a 100 percent overall payout in the first year of implementation of the compensation model. Metrics were designed to apply to either group performance or individual performance, depending on the specific metric.

Throughout the year, physicians received monthly reports on their productivity and value-based performance so they could understand the impact on their compensation.

The new compensation model would measure physician productivity within their practices, while value-based metrics would be gradually incorporated into physician compensation. Experience has shown that it is critical for physicians to receive accurate data and agreed-upon metrics to motivate improved performance.

### Ensuring Physician Engagement

The underlying question in the transition to value-based incentives was whether a relatively small amount of risk would be enough to engage physicians in implementing value-based care practices. Year-end results in outcomes, safety, and patient experience were compared with baseline data gathered in the prior "shadow" year, in which value-based performance was tracked, but did not affect compensation.

Again, the metrics included three areas of focus: outcomes, safety, and patient experience.

Following are a few details about these value-based metrics and the overall results, which improved in the first year of implementation of the program (2014) over the prior shadow year in

---

b. For additional details on how value-based metrics were selected, see sidebar, "The Evolution of MCHS Value-Based Compensation Metrics," Bunkers, B., Koch, M., McDonough, B., and Whited, B., "Aligning Physician Compensation with Strategic Goals," *hfm*, July 2014.

every region of MCHS, including Southeast Minnesota, Southwest Minnesota, Northwest Wisconsin, and Southwest Wisconsin.

**Outcomes.** For family medicine/internal medicine physicians, the outcomes measure was focused on patients with type 3 diabetes.

Targets were:

- > An HgbA1c level of less than 8
- > A blood pressure level of less than 140 over 80
- > An LDL cholesterol less than 100 based on most recent tests in a 12-month look back period

The percentage of patients in the MCHS registry who reached all three diabetes targets increased by 7.6 percent between 2013 and 2014.

**Safety.** The safety metric looked at the numbers of eligible prescriptions that were sent to a pharmacy electronically, and the numbers of patients discharged from MCHS by hospitalists who had medication reconciliation completed at the time of discharge. The number of eligible prescriptions sent to a pharmacy electronically increased by 4.1 percent, and the number of patients discharged by a hospitalist that received medication reconciliation increased by 4.2 percent.

**Patient experience.** This metric tracked the number of patients who gave the highest experience score to physicians in third-party patient surveys. The percentage of patients giving physicians the highest score on third-party satisfaction surveys (i.e., 5 out of 5) increased by 2 percent.

Results initially were measured against internal, publicly reported clinical outcomes and patient satisfaction scores. In 2016, MCHS will consider regional benchmarking data from statewide organizations, such as MN Community Measurement, to help set value-based performance goals.

These first-year results provide clear evidence that a value-focused compensation plan that is properly designed, explained, and administered can influence physician performance outcomes and is well worth pursuing.

Each measure had three payout targets: If a physician met the first target, he or she received 50 percent of the associated risk-based payout; meeting a second target garnered 100 percent of the payout; and meeting a third target resulted in a small bonus. Financially, the new compensation model was intended to remain budget neutral.

The improved performance meant that physicians overall received the full 5 percent of their at-risk compensation. A few physicians exceeded targets, resulting in an overall payout by MCHS of 5.15 percent of total physician compensation.

For the outcomes metric, for example, 264 physicians were assigned the type 3 diabetes targets. Of those, all physicians met the first target for the

**PERFORMANCE ON KEY MEASURES OF OUTCOMES, SAFETY, AND PATIENT EXPERIENCE: DECEMBER 2014 YTD COMPARED WITH SEPTEMBER 2013 YTD**

Measures	December 2014 Average	September 2013 Average	Percentage Increase/Decrease
Diabetes 3	45.9%	42.3%	7.6%
Northwest Wisconsin	45.9%	41.5%	10.6%
Southeast Minnesota	41.9%	39.5%	6.3%
Southwest Minnesota	48.3%	42.1%	0.4%
Southwest Wisconsin	47.3%	42.4%	11.6%
e-Prescribe	94.5%	90.8%	4.1%
Northwest Wisconsin	94.3%	89.7%	5.1%
Southeast Minnesota	94.0%	88.6%	6.1%
Southwest Minnesota	96.0%	93.5%	2.7%
Southwest Wisconsin	94.3%	92.6%	1.8%
Hospital Discharge Medication Reconciliation	97.3%	93.8%	4.2%
Northwest Wisconsin	98.7%	94.2%	4.8%
Southeast Minnesota	93.6%	85.7%	9.3%
Southwest Minnesota	98.9%	98.0%	0.9%
Southwest Wisconsin	99.6%	97.4%	2.3%
Percentage Top Box	86.2%	84.5%	2.0%
Northwest Wisconsin	87.1%	85.1%	2.4%
Southeast Minnesota	84.9%	83.2%	2.0%
Southwest Minnesota	85.5%	83.8%	2.0%
Southwest Wisconsin	86.7%	85.3%	1.7%

50 percent payout, 209 achieved the second target for a 100 percent payout, and 55 physicians (21 percent) met the third target and received a small bonus.

It should be noted that the majority of MCHS contracts remain fee-for-service models, and each region is still responsible for meeting its net operating income targets. As such, MCHS monitors physician work effort closely and has not experienced a measurable drop-off in productivity since introducing the redesigned compensation.

### Addressing Plan Limitations

Moving disparate compensation plans to a single model and transitioning to value-based metrics are major endeavors that require considerable effort and buy-in from all stakeholders including administration and physicians. Not surprisingly, MCHS met with several challenges along the way.

*Lack of outcomes (versus process) metrics.* The plan attempted to model outcome measures, as a true gauge of performance based on national standards; however, there are few national quality metrics that are based on true outcomes outside of those in primary care. For example, type 3 diabetes metrics offer a reasonable measure on how well physicians are managing the care for their diabetes panel. Surgical specialties currently do not have corresponding outcomes measures. When a practice type does not have such outcomes measures, process metrics are used instead.

MCHS has created a research and development program to develop a limited number of new or replacement outcomes measures. The longer-term goal is to develop by year four (2017), for every practice type, outcomes measures that ideally are based on national standards

*Data integrity.* As with any professional faced with changes to their compensation, physicians will question any real or perceived inconsistencies in scorecard data. One issue arose with the

e-prescribe safety measure. The intention was to use the same data reported for meaningful use requirements to internally measure physician performance with electronically prescribed medications. As physicians began receiving reports about their performance for this measure, they questioned why they were not fully meeting the targets, given they never used nonelectronic means (paper or the telephone) to prescribe medications.

A deep dive into the data revealed that the criteria used to measure meaningful use requirements differed from the criteria used to measure physician performance for e-prescribing. This inconsistency required further detailed planning and refinement in the reporting to reassure the physician staff that they were being measured on the correct elements. In an effort of good faith and to generate trust in the compensation program, it was decided that physicians should be held harmless in the first year as this issue was being corrected.

*Change fatigue.* The original strategy called for increasing the amount of at-risk compensation from 5 percent to 7 percent during year two of implementation of the new model. This strategy was not supported at local MCHS sites. Although physicians easily accepted standardization of RVU values as part of the new plan and understood the goals related to adding value-based incentives, they were not yet fully comfortable with the new measures and how they affected compensation. MCHS leaders agreed to hold performance compensation at 5 percent for year two and focus on improving data integrity and strengthening trust.

### Effecting Sustainable Change

MCHS leaders, through commitment and perseverance, were able to effectively manage such challenges because of the considerable amount of planning that went into devising not only the compensation model itself, but also the framework surrounding development of the entire initiative.

As part of the change management process, the framework involved devising an implementation schedule, creating a solid leadership/governance structure, forming comprehensive communication strategies, developing an information system to manage the data, and setting up considerable support systems to help physicians understand the changes. If MCHS leaders had simply changed the compensation plan without seeking and attaining physician buy-in, the significant performance improvement that was achieved would likely have been elusive.

Key elements of the change management process included the following.

*Methodical rollout of program with full leadership support.* Each step in the transformation process was carefully planned and structured.

A new leadership dyad was created, in which a physician compensation leader and an administrative director of physician compensation would collaborate to guide the initiative. The dyad was imbedded in a shared-services model to centralize administration of physician compensation. In addition to the physician advisory group, compensation committees were established at each site.

A compensation advisory group, comprising physician members from local sites, was created to minimize disruption and build trust. The group outlined priorities and set a timeline for operationalizing each part of the transformation.

Less controversial changes to the compensation model were introduced first. Such changes included automating data management and standardizing productivity metrics—both of which met with physician support. Guidelines for administering compensation and on-call pay were also standardized, thereby helping to ensure that decisions made at the local level were made in accordance with system policies and fair-market-value requirements.

More controversial changes came next, including the introduction of value-based measures in outcomes, safety, and patient experience. To keep the analysis simple and ease the transition for physicians, the number of value-based metrics was kept to a maximum of three per physician. The effective rollout of the initial set of priorities helped smooth the way for these new additions.

The full support of executive leadership was critical to ensuring the integrity of the compensation initiative. When issues surfaced, these leaders made sure they articulated support for the work accomplished as well as the underlying rationale for the transition to value-based compensation.

*Robust physician performance management tools.*

In the beginning, the initiative faced severe operational challenges, specifically regarding data management and reporting. Across MCHS, there were disparate systems with limited reporting capabilities. Support departments that would be responsible for calculating RVU values, administering compensation, and generating reports were overwhelmed and short-staffed.

To address such challenges, MCHS now uses a centralized, automated system for managing and reporting data. Physician performance management tools provide the analytics capabilities and operational efficiency that have been integral to the goals achieved with the initiative. One tool calculates and standardizes RVUs using billing data gathered from 15 different systems. A second tool uses data from the electronic health record and patient experience surveys to measure physician performance on the value-based metrics.

The administrative system provides key analytics, efficient data management, and concise reporting for leaders, operations staff, and physicians. The performance management system not only provides the means to gather data and measure physician performance, but also ensures that

MCHS subject-matter experts (SMEs) have access to analytics and reporting to adequately support physicians as they assimilate to the new compensation plan.

The ability to more easily access data also allows for internal and external benchmarking of physician performance across the system, which enables best practices to be identified.

**Multi-faceted communication strategy.** The establishment of solid, multifaceted communication channels that reinforced the value-based message was absolutely critical to gaining physician buy-in and building relationships. The means for communicating this message included periodic conferences, consistent and continual messaging, and online resources.

During the redesign process, MCHS compensation leaders held semiannual compensation conferences attended by compensation analysts, physician members of site compensation committees, and site leaders to explain the plan, provide progress updates, and address concerns. The conferences, now held annually, provide a link between compensation leadership and site-based physicians.

Physicians also receive periodic messages via email from physician leadership to reinforce the concept and provide support. An intranet web page provides an overview of the compensation model, a log of leadership communications, definitions of measures, program contacts, and a frequently asked questions section.

Compensation leaders understand that physicians require ongoing communication to be engaged in the transitioning process and to be aware of the impact on their compensation.

**Data transparency and frequent reporting.** As the compensation initiative progressed, a key factor in maintaining physician support was the transparency of data provided mainly through regular reporting. Physicians receive progress reports monthly via email messages that include

hyperlinks to their individual data. The reports—one for RVU productivity and one for value-based measures—provide information in a user-friendly, dashboard-type format that delivers a clear and concise line of sight from effort to outcome, comparing actual performance with payout targets. (A sample report is shown on page 8.)

Dashboards that summarize a physician's compensation status are included in the reports as are more detailed dashboards for productivity (RVUs) and value-based measures (outcomes, safety, patient experience). The summary report header prominently displays the impact of year-to-date performance on compensation (what percentage of value-based incentives the physician has achieved), so physicians can instantly see what percentage of at-risk compensation they have earned based on performance.

Physicians also can access data at the granular level, such as billing detail with RVUs for every patient visit code billed, diabetes-care test values and dates by patient, and their patient satisfaction scores with links to tools for improvement.

**Substantial physician support.** Demonstrating a commitment to continuing improvement, MCHS has made it simpler for physicians to express concerns, question data and processes, and seek assistance. Physicians are provided with individual support to help them understand how they are performing relative to goals and identify opportunities to improve performance.

The RVU report includes contact information for site-based compensation analysts and the value-based report includes contact information for site-based SMEs who are available for addressing physician feedback and concerns. The compensation analysts and SMEs also review the data prior to delivery of the reports to verify accuracy.

Physicians also can provide feedback and voice concerns electronically via an online appeals

form. The issue regarding e-prescriptions described above, for example, was communicated in multiple ways to compensation administrators, including via the appeals form, SMEs, and email.

### Achieving Performance Improvement

Questions regarding how to achieve clinical integration in an era of value-based care are being addressed throughout the industry. The results of the first year of implementation of the MCHS physician compensation plan strongly indicate that significant gains can be achieved in physician performance on value-based practices even when a relatively small percentage of compensation is at risk. Each value-based measure saw improvement from 2013 (the baseline year) to 2014, the first year of active implementation.

Clearly, compensation plans are part of an organization's culture and significantly influenced by market forces. What has worked for MCHS may not necessarily work for other organizations.

However, what the MCHS experience may provide is a blueprint for compensation redesign that is part of a larger change management process, carefully developed to earn physicians' trust and acceptance and aligned with the organization's strategic goals to help achieve the ultimate objective: high-quality, cost effective care. ■

---

Brian Bunkers, MD, is president and site CEO, Mayo Clinic Health System, Owatonna and Fairbault, Minn., chair of the Mayo Clinic Health System Physician Compensation Standardization Advisory Group, and a member of HFMA's Minnesota Chapter ([bunkers.brian@mayo.edu](mailto:bunkers.brian@mayo.edu)).

Mark Koch is chief administrative officer, Mayo Clinic Health System, Rochester, Minn. ([mkoch@mayo.edu](mailto:mkoch@mayo.edu)).

Jeanie Lubinsky is director, physician compensation, Mayo Clinic Health System, Rochester, Minn., and a member of HFMA's Wisconsin Chapter ([lubinsky.jeanie@mayo.edu](mailto:lubinsky.jeanie@mayo.edu)).

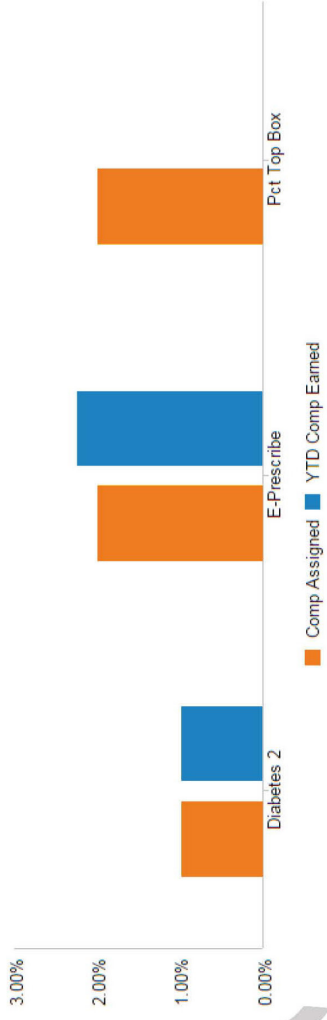
Jeffrey A. Weisz, MD, is managing principal and consulting physician, Sullivan, Cotter and Associates, Inc., Denver, and a member of HFMA's Southern California Chapter, ([jeffreyweisz@sullivancotter.com](mailto:jeffreyweisz@sullivancotter.com)).

Brian Whited, MD, is vice chair, operations, Mayo Clinic Health System, Rochester, Minn. ([whited.brian@mayo.edu](mailto:whited.brian@mayo.edu)).



Compensation impact is visible

Compensation Impact by Measure



YTD Comp Amount Earned



Performance against targets clearly displayed

Compensation Performance by Measure

Measure	Measure Direction	Measure Unit	YTD Actual	Target 1	Target 2	Target 3	Target 4	YTD N Size	Comp Assigned	YTD Comp Earned	YTD Comp Impact
Diabetes 2	Up is Better	Percent	59.3	45.0	50.0	65.0		590	1.00%	1.00%	0.00%
E-Prescribe	Up is Better	Percent	97.9	65.0	90.0	95.0		1,978	2.00%	2.25%	0.25%
Pct Top Box	Up is Better	Percent	84.7	86.0	89.4	92.7	97.5	63	2.00%	0.00%	-2.00%

Clear direction on where to go with questions

For Questions, Contact:

Topic	Contact Name	Phone	Email Address
Compensation	Audrey Young	(800)111-222-3333	Email1148@demo.prd
Diabetes 2	Curtis O'Connell	(800)111-222-3333	Email1134@demo.prd
E-Prescribe	Aspen Samson	(800)111-222-3333	Email1149@demo.prd
Pct Top Box	John Sequoia	(800)111-222-3333	Email1136@demo.prd