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### *Transforming the Way We Pay Doctors*

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#### I. INTRODUCTION

As President Obama and the 2009 Legislature take on the issue of comprehensive healthcare coverage, a corollary and inextricably linked measure has been widely adopted,<sup>1</sup> but not without much controversy: paying portions of physicians' compensation based off of their performance, or patient outcomes. The cost of providing more Americans with healthcare access cannot thoughtfully be resolved without addressing one of the healthcare industry's most fundamental questions: How do we compensate physicians to obtain the most efficient and cost effective outcomes while increasing patient access and health? This article intends to answer that question. Part II will provide general statistics regarding the contemporary healthcare system in America, the realities of medical cost disparities, and physician salaries. Part III will review the two primary methods and models currently employed to compensate physicians in America, emphasizing fee-for-service. Finally, Part IV will analyze the pay-for-

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<sup>1</sup> RAND Corporation, *Overview of Physician Pay for Performance Policy Options*, [http://www.randcompare.org/options/mechanism/physician\\_p4p](http://www.randcompare.org/options/mechanism/physician_p4p) (last visited Oct. 15, 2009).

performance physician compensation model that is enthusiastically sweeping America, its benefits, and criticisms.

## II. INTRODUCING THE STATUS QUO OF OUR HEALTHCARE SYSTEM

The American healthcare system is fraught with incontrovertible “inefficiencies and gaps in patient care,” as documented by the Institute of Medicine, the Agency for Healthcare Research and Quality, and the National Committee for Quality Assurance.<sup>2</sup> These inefficiencies manifest themselves through “over-utilization of expensive and unnecessary procedures, the system’s focus on treatment rather than prevention of costly chronic diseases, costly end-of-life care, and fraud and abuse.”<sup>3</sup> An estimated 90% of American healthcare expenditures go to treat patients, while the remaining 10% go to keeping people well.<sup>4</sup> Additionally, an estimated \$390 billion a year is needlessly squandered on outmoded and inefficient medical procedures.<sup>5</sup> Moreover, poor-quality care leads to an estimated 66.5 million avoidable sick days each year.<sup>6</sup> These statistics are not what one would expect from the world’s most expensive healthcare system and it has increasingly become apparent that throwing more money at the problems does not result in better care.<sup>7</sup>

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<sup>2</sup> Rachel Groman, *Linking Physician Payments to Quality Care*, AMERICAN COLLEGE OF PHYSICIANS, Oct. 28, 2005, at 6, available at [http://www.acponline.org/advocacy/where\\_we\\_stand/policy/link\\_pay.pdf](http://www.acponline.org/advocacy/where_we_stand/policy/link_pay.pdf).

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> *Id.* at 6-7.

<sup>7</sup> *Id.* at 7.

Aside from some of the overall inefficiencies and perversions of our healthcare system as a whole, a closer look yields drastic procedure and price disparities.<sup>8</sup> A survey by America's Health Insurance Plans, which represents 1300 health insurance companies, showed how two different patients, one insured by a private carrier and the other a member of Medicare, pay drastically different prices for the same procedure.<sup>9</sup> To illustrate: an Illinois patient paid \$12,712 for cataract surgery and Medicare paid only \$675; a California patient was charged \$20,120 for knee surgery where Medicare would only pay \$584; and a New Jersey patient was billed \$72,000 for a spinal fusion procedure when Medicare would pay only \$1629.<sup>10</sup> Medicare was used as the controlling standard in the study because, on average, about 80% of what private insurers pay, Medicare pays.<sup>11</sup> For this reason, Jonathan S. Skinner, a health economist at Dartmouth, calls the price levels of medical procedures in the American healthcare system the "wild, wild West."<sup>12</sup>

Consequently, American physicians make substantially more money than physicians in other industrialized countries.<sup>13</sup> Accounting for physician pay by adjusting salaries for purchasing-power parity shows American doctors are at the

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<sup>8</sup> See generally Gina Kolata, *Survey Finds High Fees Common in Medical Care*, N.Y. TIMES, Aug. 12, 2009, at A15, available at [http://www.nytimes.com/2009/08/12/health/policy/12insure.html?\\_r=2](http://www.nytimes.com/2009/08/12/health/policy/12insure.html?_r=2).

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> Catherine Rampell, *How Much do Doctors in Other Countries Make?*, N.Y. TIMES, July 15, 2009, available at <http://economix.blogs.nytimes.com/2009/07/15/how-much-do-doctors-in-other-countries-make/?apage=2>.

top of the group.<sup>14</sup> Unsurprisingly, measuring physician pay by comparing their salaries to those of the average citizen<sup>15</sup> (GDP per capita) or to those of other professionals<sup>16</sup> in that country produces the same result. Thus, the gap between physician income and other professionals in the U.S. as compared to Germany, Canada, France, and the United Kingdom is much larger.<sup>17</sup> American physician salaries, however, are in large part due to the exceedingly high cost of medical school in the U.S.; and unfortunately, reducing American physician salaries would not affect the overall cost of healthcare.<sup>18</sup> In the American system, understanding *how* physicians get paid, and not how *much*, is important when trying to produce more efficient and better patient outcomes.<sup>19</sup>

### III. AMERICAN PHYSICIAN COMPENSATION MODELS

#### A. Salary

A common way to compensate physicians is by providing a salary based on a fixed amount of predetermined hours according to qualifications, years of practice, seniority, and scope of responsibility.<sup>20</sup> Typically salaried physicians are

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<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> Christopher Beam, *Let's Pay Doctor: Couldn't We Fix the Health Care System by Paying Doctors Less?*, SLATE, Sept. 10, 2009, <http://www.slate.com/id/2227965/>.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> Jon R. Gabel & Michael A. Redisch, *Alternative Physician Payment Methods: Incentives, Efficiency, and National Health Insurance*, 57 MILBANK MEMORIAL FUND Q.: HEALTH & SOC'Y 38, 41 (1979).

associated with a type of institution, such as a hospital, clinic, medical school, or health maintenance organization.<sup>21</sup>

Salary compensation models contain both beneficial and adverse consequences for patients. The favorable effects of salaried physicians are: there is no incentive to deny access to any patient and thus, patient access is high; there is no incentive to provide excessive treatment, tests, or referrals; and the physician's income is consistent and secure.<sup>22</sup> However, the harmful effects of salaried physicians are: there is no incentive to provide the optimal or desired level of care; there is no incentive to limit increasing operating costs from requested services; there is no incentive to monitor patient care; and there is no incentive to build and foster close patient relationships.<sup>23</sup> Thus, the biggest pitfall of a salary compensation model, while simple to implement and easy to monitor, is that physicians have no incentive to do more than the bare minimum of what is required to keep their jobs.<sup>24</sup>

### *B. Fee-for-Service*

The United States employs many different types of physician compensations models, but the predominant system utilized in the U.S., and a common model elsewhere, is fee-for-service.<sup>25</sup> Fee-for-service is a method where the physician charges a fee for each individual service, such as an office visit, X-

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<sup>21</sup> *Id.*

<sup>22</sup> MUKESH CHAWLA ET AL., PAYING THE PHYSICIAN: REVIEW OF DIFFERENT METHODS 7 (1997), available at <http://www.hsph.harvard.edu/ihs/publications/pdf/No-70.PDF>.

<sup>23</sup> *Id.* at 7-8.

<sup>24</sup> *Id.* at 8.

<sup>25</sup> Gabel & Redisch, *supra* note 20, at 39.

ray, treatment, or consultation.<sup>26</sup> When third parties are responsible for paying the bill, such as insurance companies, they either reimburse the physician based off of predetermined schedules or the customary, prevailing, and reasonable (CPR) reimbursement method.<sup>27</sup> Fee schedules are established by surveying the average charges for a certain procedure or negotiated with the physician to establish the maximum the third party is willing to pay.<sup>28</sup> The CPR method establishes a separate fee schedule for each physician and reimburses services based on the lowest actual charge, customary charge, or the geographic area's prevailing charge.<sup>29</sup>

Fee-for-service compensation models contain both beneficial and adverse consequences for patients. The favorable effects of the fee-for-service system are: the ease for a patient to change or compare prices between doctors; patients that require many treatments or complex operations are unlikely to be turned away; and incentives for a physician to increase the quality of care to produce returning patients.<sup>30</sup> However, the harmful effects of fee-for-service models are: physicians have a strong financial incentive to increase the amount of services billed to the patient and thus, increase healthcare costs; and “physicians have a strong incentive to induce demand.”<sup>31</sup> In fact, it has been found that the cross-price elasticity of demand for services between doctors is inelastic; thus, physicians can

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<sup>26</sup> *Id.*

<sup>27</sup> *Id.* at 39-40.

<sup>28</sup> *Id.* at 40.

<sup>29</sup> *Id.*

<sup>30</sup> CHAWLA ET AL., *supra* note 22, at 17.

<sup>31</sup> *Id.*

discretionarily recommend additional services, at a price they determine, and patients will likely stay with the physician.<sup>32</sup> This is particularly troubling because the more physicians can induce demand, the less responsive they will be to price incentives, and thus, pay-for-performance models.<sup>33</sup> Furthermore, the administrative costs borne by fee-for-service programs are relatively high for both physicians and third party payers.<sup>34</sup> Finally, experience indicates that fee-for-service models generally create swift increases in overall healthcare costs.<sup>35</sup>

#### IV. PAY-FOR-PERFORMANCE COMPENSATION MODELS

##### *A. Introduction*

Existing deficiencies<sup>36</sup> in the fee-for-service model, the American majority model,<sup>37</sup> which rewards doctors based on quantity rather than quality, have convinced many policymakers to support pay-for-performance models,<sup>38</sup> which have been implemented in more than half of all private sector healthcare contracts.<sup>39</sup> For instance, the Centers for Medicare and Medicaid Services (CMS) implemented pay-for-performance measures in its programs beginning in 2007.<sup>40</sup> Widespread adoption of pay-for-performance models have not come without

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<sup>32</sup> Gabel & Redisch, *supra* note 20, at 43.

<sup>33</sup> *Id.* at 45.

<sup>34</sup> CHAWLA ET AL., *supra* note 22, at 18.

<sup>35</sup> *Id.*

<sup>36</sup> RAND, *supra* note 1.

<sup>37</sup> Gabel & Redisch, *supra* note 20, at 39.

<sup>38</sup> Bonnie Darves, *Physician Pay-for-Performance Programs Taking Hold*, NEW ENG. J. MED. (2007), available at <http://www.nejmjobs.org/printpage.aspx?fid=pay-for-performance&af=/content/career-resources/pay-for-performance.htm>.

<sup>39</sup> RAND, *supra* note 1.

<sup>40</sup> Darves, *supra* note 38.

criticism. Specifically, the American Medical Association (AMA) and various other specialty societies have publically opposed many early pay-for-performance programs, questioning their effectiveness, methodologies, and motives.<sup>41</sup> So, why is it that pay-for-performance plans, some paying out as much as \$55 million in 2006<sup>42</sup> (CMS paid \$36 million in 2007<sup>43</sup>), are here to stay? The CEO of Bridges to Excellence (BTE), an organization promoting efforts to recognize and reward high-performing physicians,<sup>44</sup> has answered that question stating: “The bottom line is simple: P4P [pay-for-performance] works.”<sup>45</sup>

### B. Structure

Pay-for-performance compensation systems can be organized in many different ways, but are primarily set up to provide monetary, and non-monetary, incentives to physicians for attaining predetermined goals.<sup>46</sup> The American Academy of Family Physicians (AAFP) supports pay-for-performance goals that: “[f]ocus on improved quality of care . . . [s]upport the physician/patient relationship . . . [u]tilize performance measures based on evidence-based clinical guidelines . . . [i]nvolve practicing physicians in program design . . . [u]se reliable, accurate, and scientifically valid data . . . [and] [o]ffer voluntary

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<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

<sup>43</sup> Centers for Medicare & Medicaid Services, *Physician Quality Reporting Initiative 2007 Reporting Experience*, DEP’T OF HEALTH AND HUMAN SERVICES, Dec. 3, 2008, at 10, available at <http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportFinal12032008CSG.pdf>.

<sup>44</sup> Cary Conway, *Research Shows that Physician Pay-for-Performance Programs Work with Appropriate Incentives*, BRIDGES TO EXCELLENCE, May 7, 2009, available at <http://www.bridgestoexcellence.org/Content/ContentDisplay.aspx?ContentID=195>.

<sup>45</sup> *Id.*

<sup>46</sup> Karen Llanos & Joanie Rothstein, *Physician Pay-for-Performance: A Guide for States*, CENTER FOR HEALTH CARE STRATEGIES, INC. 5 (2007), available at [http://www.chcs.org/usr\\_doc/Physician\\_P4P\\_Guide.pdf](http://www.chcs.org/usr_doc/Physician_P4P_Guide.pdf).



physician participation.”<sup>47</sup> Similarly, the AMA supports pay-for-performance goals of an analogous nature.<sup>48</sup>

Pay-for-performance programs often utilize both, financial and non-financial, incentives to encourage physicians to achieve the plan’s goals.<sup>49</sup> Non-financial incentive models include: public disclosure of performance reports and public recognition; technical assistance; assignment of patients; reduced administrative requirements; and patient assignment sanctions.<sup>50</sup> Financial incentive models include: payments for participation in the program or its related workshops; payments for timely conducted and recorded procedures; bonuses for achieving certain levels of care with all patients; tiered bonuses for high rankings relative to other physicians; bonuses for improvement; forfeiture of Medicaid fee schedule increases until reaching a threshold; and withholding compensation until meeting certain thresholds.<sup>51</sup> Pay-for-performance plans should also send, with the actual bonus check, a voided check of what the physician could have received had performance been better – incentivizing participation.<sup>52</sup>

### C. Outcomes

Studies seem to agree that pay-for-performance programs do accomplish desirable physician practices. A 2009 study published in *The American Journal*

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<sup>47</sup> American Academy of Family Physicians, *Pay-For-Performance*, (2009) <http://www.aafp.org/online/en/home/policy/policies/p/payforperformance.html>.

<sup>48</sup> See generally American Medical Association, *Principles for Pay-for Performance Programs*, July 21, 2005, available at <http://www.ama-assn.org/ama1/pub/upload/mm/368/principles4pay62705.pdf>.

<sup>49</sup> Llanos & Rothestein, *supra* note 46, at 7.

<sup>50</sup> *Id.* at 8.

<sup>51</sup> *Id.* at 12.

<sup>52</sup> *Id.* at 22.

of *Managed Care* reports that pay-for-performance benefits all stakeholders, including physicians, health plans, and patients.<sup>53</sup> The study further finds that participation increases with larger rewards or incentives.<sup>54</sup> Additionally, a study published in *Health Services Research* concluded similar results, finding a “strong correlation between quality of patient care and physician participation in a quality-based incentive program.”<sup>55</sup> This correlation, the study finds, grew even stronger over time ultimately resulting in patients experiencing significantly better quality of care.<sup>56</sup> Finally, a study published in *Medical Care* found that compensation incentives can be used by physicians to influence desired patient care procedures.<sup>57</sup> Moreover, the study found that using a more “nuanced portfolio approach to compensation,” as in mixed incentives, produced more desirable outcomes.<sup>58</sup>

#### D. Criticisms and Improvements

Despite the overwhelming success and pervasive movement towards implementing pay-for-performance compensation models into physician contracts not everyone is happy. For example, the American College of Physicians (ACP) is worried that these programs will: motivate doctors to avoid treating difficult

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<sup>53</sup> Francois S. de Brantes & B. Guy D’Andrea, *Physicians Respond to Pay-for-Performance Incentives: Larger Incentives Yield Greater Participation*, 15 THE AM. J. OF MANAGED CARE 305, 305 (2009), available at [http://www.ajmc.com/media/pdf/AJMC\\_09May\\_deBrantes305to310.pdf](http://www.ajmc.com/media/pdf/AJMC_09May_deBrantes305to310.pdf).

<sup>54</sup> *Id.* at 308.

<sup>55</sup> ScienceDaily, *Doctor ‘Pay-for-performance’ Improves Patient Care, Study Shows*, Jan. 11, 2008, <http://www.sciencedaily.com/releases/2008/01/080110123913.htm>.

<sup>56</sup> *Id.*

<sup>57</sup> Stephen M. Shortell ET AL., *Implementing Evidence-Based Medicine: The Role of Market Pressures, Compensation Incentives, and Culture in Physician Organizations*, 39 MED. CARE I62, I70 (2001), available at <http://www.jstor.org/stable/3767914>.

<sup>58</sup> *Id.* at I72.

patients; cause some doctors to focus on “gaming” the system rather than actually improving care; misalign the perceptions between patients and physicians; and increase unnecessary care and medical costs.<sup>59</sup> More specifically, physicians fear that patients with chronic illnesses will be disfavored for treatment.<sup>60</sup> Chronic illnesses, such as asthma, diabetes, and obesity depend so much on the patient’s lifestyle that doctors worry that they will be unfairly penalized for failing to meet certain outcomes or standards.<sup>61</sup> Other physicians worry about the costs of implementing the data recording systems required to track and reward physicians under the pay-for-performance models.<sup>62</sup>

Fortunately for pay-for-performance advocates, many of the program’s criticisms are relatively easy to address. Incentive programs can be tailored for individual markets and or regions to address certain local nuances. Moreover, incentives can recognize and account for chronic illnesses by rewarding “high performance, in addition to continuous quality improvement.”<sup>63</sup> Additionally, Congress has recognized the prohibitive costs to such programs and passed the Health Information Technology for Economic and Clinical Health Act, which invests \$20 billion in health information technology<sup>64</sup> and provides other financial

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<sup>59</sup> Lois Snyder and Richard Neubauer, *Pay-for-Performance Principles that Promote Patient-Centered Care: An Ethics Manifesto*, ANN. OF INTERNAL MED. 792, 793 (2007), available at <http://www.annals.org/cgi/reprint/147/11/792.pdf>.

<sup>60</sup> Silvia Brandt, *Against Physician Pay-for-Performance*, THE WASH. POST. July 30, 2009, available at [http://voices.washingtonpost.com/hearing/2009/07/against\\_physician\\_pay-for-perf.html](http://voices.washingtonpost.com/hearing/2009/07/against_physician_pay-for-perf.html).

<sup>61</sup> *Id.*

<sup>62</sup> Groman, *supra* note 2, at 19.

<sup>63</sup> *Id.* at 16.

<sup>64</sup> MAJORITY STAFF OF THE COMMITTEES ON ENERGY AND COMMERCE, WAYS AND MEANS, AND SCIENCE AND TECHNOLOGY, HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL

incentives to hospitals and doctors to implement such data collection systems.<sup>65</sup> Finally, pay-for-performance programs work in conjunction with traditional compensation models and can be adjusted and customized readily to avoid undesirable outcomes.

#### V. CONCLUSION

The American healthcare system, although superior in many aspects, has been plagued with much inefficiency. Specifically, the fee-for-service method of compensating physicians has decreased the quality of care and dramatically raised costs. Pay-for-performance methods of physician compensation have been introduced into the status quo to combat such inequities. Although these models are not without their critics, they are receiving widespread adoption and recognized success. Ultimately, the forces behind pay-for-performance compensation models have yielded a surprising, and much needed, turnaround in patient outcomes and physician practices. Finally, the key to choosing and adopting a pay-for-performance model is to adequately research and implement the model's goals, incentives, and concurrent compensation method, such as salary or fee-for-service; doing so has been shown to benefit all involved.

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HEALTH ACT OR HITECH ACT, Jan. 16, 2009, *available at* <http://waysandmeans.house.gov/media/pdf/110/hit2.pdf>.

<sup>65</sup> *Id.*