

Policy Research Perspectives

New Data On Physician Compensation Methods: One Size Does Not Fit All

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Abstract

A 2012 survey of physicians by the American Medical Association provides a rare glimpse into how non-solo physicians are paid by their practices. The data suggest that there is no “one size fits all” characterization of payment methods. While 53.1 percent of non-solo physicians received all or the largest share of their compensation from salary, for 31.8 percent, all or the largest share was based on their personal productivity. The survey also highlights that “salaried” is not synonymous with “employed.” Although more than three-quarters of employed physicians counted salary as a contributor to their compensation, 44.0 percent of non-solo owner physicians did as well. Final compensation is often based on a blend of different methods. Thirty percent of non-solo physicians depended on two payment methods, and 17.9 percent depended on at least three.

Introduction

In an ideal health care system, physicians and other health care providers would face incentives, financial and otherwise, that enable them to provide patients with the right care, in the right place, and at the right time. Proposed changes to the health care system, and especially those that relate to insurer payment methodology, stem from a basic recognition that in many cases, the incentives in place do not encourage that type of care. New and emerging payment models include the Accountable Care Organizations (ACO) outlined by the Centers for Medicare and Medicaid Services (CMS), bundled payments for episodes of care, risk adjusted global budgets, and global or partial capitation. While these models differ in many dimensions, a common element shared among them is what they don’t do—they don’t provide a blanket “more is better” financial incentive. They are a movement away from “fee-for-service” based payments, in which the physician or practice is paid for each service or procedure that is provided.

In the current as well as the new and emerging models, payments from insurers generally flow to a physician practice or to an ACO or similarly integrated entity which then redistributes those payments to the practices that belong to it. Then, those practices pay their physician members. Reschovsky, Hadley and Landon (2006) described this well. “Thus, there is often a cascading set of financial incentives that begin with a health plan but which can be affected by several levels of organizational and contractual structure before reaching the individual clinician.” Because of this multi-tiered dynamic, the incentives present at the practice level may be blunted if the final payment to the physician is made using a methodology or methodologies that encompass different incentives.

Prior research has found that costs of care are influenced both by payment methods at the practice and the physician level (Kralewski et al., 2000).

To better understand the ease with which proposed payment methodologies may be implemented, and the extent to which the incentives they encompass are similar to or different than those currently faced by physicians, this Policy Research Perspective (PRP) describes the compensation arrangements in place between physicians and the practices they belonged to as of late 2012. We find that compensation methods vary according to whether a physician is an owner of or employee in a practice, the type of practice that he or she is in, as well as across specialty. Although more than half of non-solo physicians received all or the largest share of compensation from salary, for almost one-third, their entire compensation or the largest share of it was based on their personal productivity. This suggests that it may be difficult to align practice level incentives that encourage judicious use of resources with physician level incentives that do not.

Existing Literature

There is a small and somewhat dated literature on how physicians are paid. Because of the infrequency with which nationally representative surveys of physicians are fielded, much of it is based on data that is in many cases more than 10 years old. The work of Robinson et al. (2004) offers one of the more comprehensive pictures of physician payment, although the data are limited to large (20+ physician) group practices.¹ The authors examined the relationship between practice size and compensation method. They posited that larger medical groups might base a greater share of physician compensation on individual productivity than smaller groups in order to avoid “free riding” which is harder to monitor in a larger organization. On the other hand, the encouragement of individual productivity in a large group might subvert the shared goals of the group as a whole, and that in order to avoid this, larger groups might use “low powered” payment mechanisms such as salary. If physicians who join larger groups are risk averse, the use of low powered compensation might instead reflect the risk aversion of practice members rather than the promotion of shared goals.

While productivity based pay discourages free riding and the avoidance of potentially high-cost patients, it does not encourage cooperation and cost consciousness. Thus, Robinson et al. (2004) also consider that practices may use blended payments, based both on retrospective (e.g. productivity based pay) and prospective pay (e.g. salary), where the weights assigned to each type of incentive are dependent on the circumstances of the practice and market.

Using 2001 data they concluded that about half of medical groups used blended payments. The rest of the groups were split nearly evenly between those that used only retrospective pay and those that did not use any retrospective pay. With regard to physicians in the surveyed medical groups, 45 percent were paid “mostly” based on productivity (at least 80 percent of compensation was productivity based) and 35 percent were paid mostly from non-productivity based salary (at least 80 percent from that method). Robinson et al. consider that few physicians are paid in a way that

¹ Their data also included independent practice associations. Results for that practice type are not discussed here.

includes significant compensation from both methods because blended payment methods are hard to administer and explain.

The authors also found that larger medical groups based a smaller portion of physician compensation on productivity, as did medical groups owned by hospitals or HMOs. This suggests either that compensation was structured to emphasize shared goals rather than to avoid shirking or that it reflected the risk avoidance of its members.

Noting that most prior research did not distinguish payment from the insurer to the medical group from payment (from the medical group) to the physician, Reschovsky, Hadley and Landon (2006) examined how physicians' perceived incentives to increase or decrease services to patients are affected by medical group payment, their own compensation methods, and other variables. As part of that work, the authors found that in 2000-2001, nearly two-thirds of employed physicians received a "fixed income" with little or no bonus, and that for 78.1 percent of all physicians, productivity was a factor used in determining their compensation. Landon et al. (2011) found that in 2004-2005, about one-third of employed general internists and general and family practitioners were paid by a fixed salary.

Data and Methods

This PRP is based on data from the American Medical Association's 2012 Physician Practice Benchmark Survey (PPBS), a nationally representative random sample of post-residency physicians who provided at least 20 hours of patient care per week and were not employed by the federal government at the time of the survey.² The response rate for the PPBS was 28 percent and 3466 physicians completed the survey. Weights were constructed to correct for possible non-response bias; all data presented here are weighted. Among other topics, the PPBS collected information on physician practice arrangements and the compensation methods in place within the practice.

All physicians except those in solo practice were asked whether they received compensation from their practice through one of the following four methods: base salary (salary); compensation based on personal productivity; compensation based on practice financial performance; and bonus based on factors other than personal productivity and practice financial performance (bonus). Solo practice physicians were excluded from this series of questions because regardless of what they call their compensation, it is directly related to personal productivity and practice financial performance. Physicians were allowed to select multiple methods and also could provide a fill-in response (other). Physicians who selected multiple methods were asked which one of those accounted for the largest share of their income and for an estimate of that share. The results from the PPBS offer a much more detailed picture of how physicians are paid than the previously cited literature.

An Overview of the Incidence of Payment Methods

Figure 1 shows the frequency with which the five payment methods were used to compensate non-solo physicians. It is evident that multiple payment methods factor into the compensation of many physicians. To that point, while 51.8 percent of physicians were compensated through a single

² See Kane and Emmons (2013) for more information on the PPBS methodology.

payment method, 30.3 percent were compensated by two methods, and 17.9 percent by three or four (Figure 2). This distribution is very similar for owners and employees (data not shown).

Salary was reported more often than other types of compensation (Figure 1). Sixty percent of non-solo physicians said they received at least some of their compensation through this method. Fifty-one percent reported compensation based on their personal productivity, and less than one-third reported compensation based on their practice's financial performance or on a bonus.

These simple statistics highlight that “salaried” is not synonymous with “employed,” a distinction sometimes lost in the discussion of physician compensation and physician ownership or practice type. Although the large majority (76.1 percent) of employed physicians received a salary, 44.0 percent of physicians with an ownership stake in their practice did as well. In turn, 54.2 percent of owners and 46.9 percent of employed physicians had compensation that included pay based on their personal productivity.

Physician payment methods differ across practice type. Figure 1 categorizes physicians into five practice types: single specialty group, multi-specialty group, faculty practice plan, direct employment by a hospital, and an “other” category.³ Salary was reported more often by physicians in multi-specialty groups (58.8 percent), faculty practice plans (84.6 percent) and by direct employees of hospitals (79.4 percent) than by physicians in single specialty groups (54.1 percent). Pay based on personal productivity was more often reported by physicians in multi-specialty than single specialty groups (59.7 percent compared to 50.9 percent). Pay based on practice financial performance was reported less often (23.3 percent compared to 37.6 percent).

Figures 3 and 4 examine physician compensation in more detail, focusing on how often particular payment methods are the sole methods used in determining compensation, and how often they contribute the largest share (but less than 100 percent) toward final compensation. As discussed, slightly over half of non-solo physicians were compensated by a single payment method. Twenty percent were paid solely based on salary, another 21.7 based only on personal productivity, and 7.6 percent based only on their practice's financial performance (Figure 3).⁴ Thirty-three percent of physicians said that although they were compensated by multiple methods, salary accounted for the largest share of their compensation. Ten percent said the same about pay based on productivity (Figure 3).

Owner and Employee Differences

Salary. While the compensation methods of owners and employees are overlapping, employees are more likely to depend exclusively on salary than are owners, 32.0 percent compared to 6.6 percent (Figure 3). Another 40.7 percent of employees said that although salary was used among multiple

³ In 2012, 18.4 percent of physicians were in solo practice, 45.5 percent in single specialty groups, 22.1 percent in multi-specialty groups, 2.7 percent in faculty practice plans, 5.6 percent were direct employees of hospitals, and 5.7 percent were in other types of practice (Kane and Emmons, 2012). The “other” category includes ambulatory surgery centers, urgent care facilities, HMOs/MCOs, medical school, and fill in responses.

⁴ Less than 1 percent of physicians were compensated exclusively via a bonus.

methods, it contributed the largest share to their compensation. Among owners this percentage was only 25.9 percent.

Personal Productivity. More than one-quarter of owners were compensated exclusively based on their personal productivity (26.3 percent). Another 14.9 percent had compensation that depended on multiple methods, with personal productivity accounting for the largest share. Each of those percentages was lower among employees.

Practice Financial Performance. Few employees indicated that their practice's financial performance was a key driver of their compensation. Even among owners, while close to half said that they received some pay from this method (Figure 1), only 15.0 percent said they were compensated exclusively from this method and another 6.8 percent said it accounted for the largest share, but not all, of their compensation (Figure 3).

Practice Type Differences

Approximately 80 percent of physicians who were in faculty practice plans, directly employed by a hospital, or in the "other" practice type category said that they were compensated exclusively by salary, or that salary contributed the largest share to their compensation (Figure 3). The dependence on salary was much lower among physicians in single specialty groups. In that practice type, about 45 percent of physicians had compensation which was solely determined by salary or for which salary contributed the largest share.

The compensation of physicians in multi-specialty groups was slightly more likely to be dependent on salary than that of physicians in single specialty groups. Fifty-three percent of multi-specialty physicians said salary determined all or the largest share of their compensation. These overall estimates, however, are driven by the different mix of owners and employees in single and multi-specialty practice. Physicians in single specialty groups were much more likely to be owners than physicians in multi-specialty groups, 63.1 percent compared to 34.5 percent (data not shown).

To better understand the observed differences in payment methods among physicians in single and multi-specialty practice, the estimates in Figure 4 are based on physicians in only those two practice types, categorized according to whether they are owners or employees. For both owners and employees, physicians in multi-specialty groups were more likely than those in single specialty groups to have compensation closely tied to their personal productivity. Among owners, half of physicians in multi-specialty groups, but under 40 percent of those in single specialty groups, were paid solely based on their productivity or received the greatest share of compensation from this method. Similarly, among employees, those estimates were 30.6 percent and 25.0 percent for physicians in multi- and single specialty groups, respectfully.

There are a number of possible reasons why physician compensation in multi-specialty groups rests more heavily on productivity based pay. First, revenue streams differ across specialty due to the different types of visits and procedures that physicians provide. Compensation in multi-specialty groups may be structured to reflect that variation. Second, physicians in multi-specialty groups report larger practice sizes than do physicians in single specialty groups. Thirty-nine percent of single specialty physicians said their practice had 4 or fewer physicians and only 5.3 percent reported that

their practice had at least 50 physicians. In contrast, 9.9 percent of multi-specialty physicians were in practices with 4 or fewer physicians and 35.5 percent were in practices with at least 50 physicians (Kane and Emmons, 2012). Thus, the greater emphasis on productivity based pay in multi-specialty groups may reflect a compensation structure designed to avoid free riding that otherwise might be present in a large organization (Robinson et al., 2004). Payment method differences may also reflect specialty differences between physicians in single and multi-specialty practice.

Pay based on practice financial performance is very seldom used in the compensation of employees in either single or multi-specialty groups. Among owners, however, there are differences across practice type. Twenty-four percent of single specialty practice owners were paid solely based by this method or received the largest share of their compensation from it, about twice the rate among multi-specialty practice owners.

Specialty Differences

Although previous research has addressed the question of whether medical groups differ in terms of how they pay primary care and non-primary care physicians (Robinson et al., 2004), there is little available research that examines this from a more detailed specialty perspective. Figures 5 through 7 show that there is a great deal of variation across specialty, especially for physicians who are owners.

Figure 5 looks at the compensation methods of non-solo physicians in 12 broad specialty categories without regard to whether they are owners or employees. For ease of exposition, physicians who are exclusively paid by a payment method and physicians for whom that method accounts for the largest share but not all of their compensation are combined in a single category. That payment method is termed the “dominant” or “primary” one for those physicians.

The percentage of physicians for whom salary was the primary payment method ranged from 36.3 percent of surgical sub-specialists to 73.2 percent of pediatricians. Having pay based on productivity as a primary payment method was least likely among radiologists (5.3 percent). Excluding that specialty, this share ranged from 17.8 percent among pediatricians to 47.1 percent among surgical subspecialists. Thirty-three percent of radiologists and 20.2 percent of anesthesiologists said that pay based on their practices’ financial performance was their primary payment method. Among all other specialties this share was at or below 13 percent.

As discussed earlier, there are differences in how owners and employees are paid. Also, the percentage of physicians who have an ownership share in their practice differs by specialty (Kane and Emmons, 2012), ranging from 37.3 percent of pediatricians to 71.9 percent among surgical sub-specialists. For those reasons, it is informative to look at the specialty-level payment methods separately for non-solo owners (Figure 6) and employees (Figure 7).

Salary. Across specialty, there is an over 30 percentage point spread in the percentage of owners for whom salary was the primary payment method, ranging from 16.2 percent among psychiatrists to 48.1 percent among radiologists (Figure 6). For employees, the variation across specialty is more narrow (Figure 7). Sixty-four percent of employed internists said that salary was their primary payment method and, at the high end, 87.3 percent of pediatricians said the same.

Personal Productivity. Less than 2 percent of owner radiologists said that productivity based pay was their dominant payment method (Figure 6). Among other owner physicians this share ranged from 32.8 percent among pediatricians to 64.3 percent among psychiatrists. Among employees, the range was from 9.2 percent among pediatricians to 31.9 percent among internists (Figure 7).

Practice Financial Performance. Radiologists were by far the specialty most likely to have compensation that was heavily dependent on practice financial performance. Forty-six percent of owners in that specialty said that method was primary (Figure 6). Owner anesthesiologists were next at 30.6 percent. Among employees, radiologists were again on top but still, only 11.0 percent said that pay based on practice financial performance was their primary compensation method (Figure 7).

While in some specialties the compensation of owners and employees is structured similarly, in others, it is not. Pediatricians, regardless of whether they are owners or employees, were relatively more likely than physicians in most other specialties to have compensation that was heavily dependent on salary, and relatively unlikely to say that personal productivity was the dominant factor in determining their compensation. Radiologists were the specialty most likely to have compensation based on practice financial performance regardless of whether they were owners or employees. Psychiatrists, on the other hand, were the specialty least likely to have salary dependent compensation if they were owners, but relatively likely to if they were employees.

Discussion

Just as there is no “one size fits all” characterization of physician practice arrangements, the same appears to be true with regard to the methods that practices use to pay their physician members. Based on data from the AMA 2012 Physician Practice Benchmark Survey, salary was reported more often than other types of compensation. Sixty percent of non-solo physicians said they received at least some of their compensation from salary, and for 53.1 percent, salary accounted for all or the largest share of their compensation. At the same time, almost one-third of non-solo physicians received all or the largest share of their compensation based on their personal productivity. Many physicians reported that their final compensation was a blend of different methods. Thirty percent of physicians depended on two payment methods, and 17.9 percent depended on at least three.

The data also showed that payment methods were overlapping between practice owners and employees. For practice owners, although pay based on personal productivity was cited more often than other payment methods, salary was not uncommon. Productivity based pay accounted for all or the largest share of compensation for 39.0 percent of single specialty group owners and 50.4 percent of multi-specialty group owners. Still, almost one-third of owners received all or the largest share of their compensation from salary. Salary was the payment method cited most often among physician employees. For 72.7 percent, it accounted for all or the largest share of their compensation. However, 16.6 percent received compensation based solely on personal productivity. This was more often the case for employees of multi-specialty groups than single specialty groups.

We also observed a great deal of variation in payment methods across specialty, especially for physicians who were owners. For owner physicians, productivity based pay was of top importance for psychiatrists. Sixty-four percent of owners in that specialty received all or the largest share of

their compensation from that method. At the other extreme, less than 2 percent of owner radiologists said that personal productivity was the primary factor in their compensation. For physician owners in two specialties, salary was a more important component of compensation than personal productivity. One was radiology, where 48.1 percent of owners said that salary was their primary compensation method. In pediatrics, 47.4 percent of owners said that salary was primary compared to 32.8 percent who said the same for personal productivity.

Twenty-two percent of owner physicians said that all or the largest share of their compensation was determined by practice financial performance. Owner radiologists were by far the most dependent on this type of payment method, with 46.4 percent of them saying that it was their primary method. Anesthesiologists were next, at 30.6 percent.

For employed physicians, all specialties reported a high reliance on salary for their compensation. Salary was the primary compensation method for 63.5 percent of general internists at the low end to 87.3 percent of pediatricians at the other extreme. The percentage for whom personal productivity was primary ranged from 9.2 of pediatricians to 31.9 percent of general internists.

Only a handful of employees (2.2 percent) said that compensation based on practice financial performance was their primary compensation method. This reflects the results for one “outlier” specialty, radiology, in which 11.0 percent of employed physicians received all or the largest share of their compensation from this method.

It is not possible to compare the data reported in this Policy Research Perspective (PRP) with that from earlier research to see how physician payment methods have changed over time. There are too many differences in the sample frames, and how payment methods were characterized. What is clear is that payment filters down to the physician in different ways that depend on the characteristics of a physician’s practice. Changed incentives at the practice level may be felt differently at the physician level depending on what compensation methods are in place.

Figure 1. Percentage Of Non-Solo Physicians Who Receive At Least Some Compensation From Five Types Of Payment Methods (2012)

	Salary	Personal productivity	Practice financial performance	Bonus	Other	N
All physicians	60.2%	50.5%	30.1%	27.1%	3.0%	2886
Ownership status						
Owner	44.0%	54.2%	48.6%	26.7%	2.2%	1350
Employee	76.1% ^a	46.9% ^a	14.7% ^a	28.4%	3.1%	1396
Independent contractor	49.6%	52.1%	17.1% ^a	19.0% ^b	8.9% ^a	140
Type of practice						
Single specialty group	54.1%	50.9%	37.6%	24.8%	2.2%	1617
Multi-specialty group	58.8% ^b	59.7% ^a	23.3% ^a	30.4% ^a	2.9%	794
Faculty practice plan	84.6% ^a	46.2%	21.3% ^a	39.6% ^a	2.8%	110
Direct hospital employee	79.4% ^a	37.2% ^a	15.8% ^a	22.7%	6.8% ^a	176
Other	83.7% ^a	26.4% ^a	14.9% ^a	31.5% ^b	6.6% ^a	189

Source: AMA 2012 Physician Practice Benchmark Survey.

Notes: For ownership status, significance tests are shown relative to the owner category. For type of practice, they are shown relative to the single specialty category. 'a' is $p < 0.01$, 'b' is $p < 0.05$ and 'c' is $p < 0.10$.

Figure 2. Distribution Of Non-Solo Physicians By Number Of Payment Methods (2012)

Number of payment methods that factor into final compensation	
One	51.8%
Two	30.3%
Three	13.2%
Four	4.7%
More than four	0.0%
	100.0%

Source: AMA 2012 Physician Practice Benchmark Survey.

Figure 3. Distribution Of Non-Solo Physicians By Payment Method (2012)

	Salary		Personal productivity		Practice financial Performance				
	Only	Largest share but not 100%	Only	Largest share but not 100%	Only	Largest share but not 100%	Other		N
All physicians	20.0%	33.1%	21.7%	10.1%	7.6%	3.6%	3.9%	100%	2886
Ownership status									
Owner	6.6%	25.9%	26.3%	14.9%	15.0%	6.8%	4.4%	100%	1350
Employee	32.0% ^a	40.7% ^a	16.6% ^a	5.8% ^a	1.3% ^a	0.9% ^a	2.7% ^b	100%	1396
Independent contractor	23.0% ^a	24.1%	30.1%	9.5% ^c	3.7% ^a	0.0% ^a	9.5% ^a	100%	140
Type of practice									
Single specialty group	15.4%	29.5%	23.2%	11.4%	10.9%	5.5%	4.1%	100%	1617
Multi-specialty group	18.7% ^b	34.7% ^b	26.7% ^c	11.6%	4.1% ^a	1.3% ^a	2.9%	100%	794
Faculty practice plan	25.5% ^a	55.5% ^a	12.7% ^b	3.9% ^b	2.0% ^a	0.0% ^b	0.4% ^c	100%	110
Direct hospital employee	38.4% ^a	39.9% ^a	10.1% ^a	2.8% ^a	2.8% ^a	0.5% ^a	5.5%	100%	176
Other	41.0% ^a	38.6% ^a	6.6% ^a	4.3% ^a	1.8% ^a	1.7% ^b	5.9%	100%	189

Source: AMA 2012 Physician Practice Benchmark Survey.

Notes: For ownership status, significance tests are shown relative to the owner category. For type of practice, they are shown relative to the single specialty category. 'a' is p<0.01, 'b' is p<0.05 and 'c' is p<0.10.

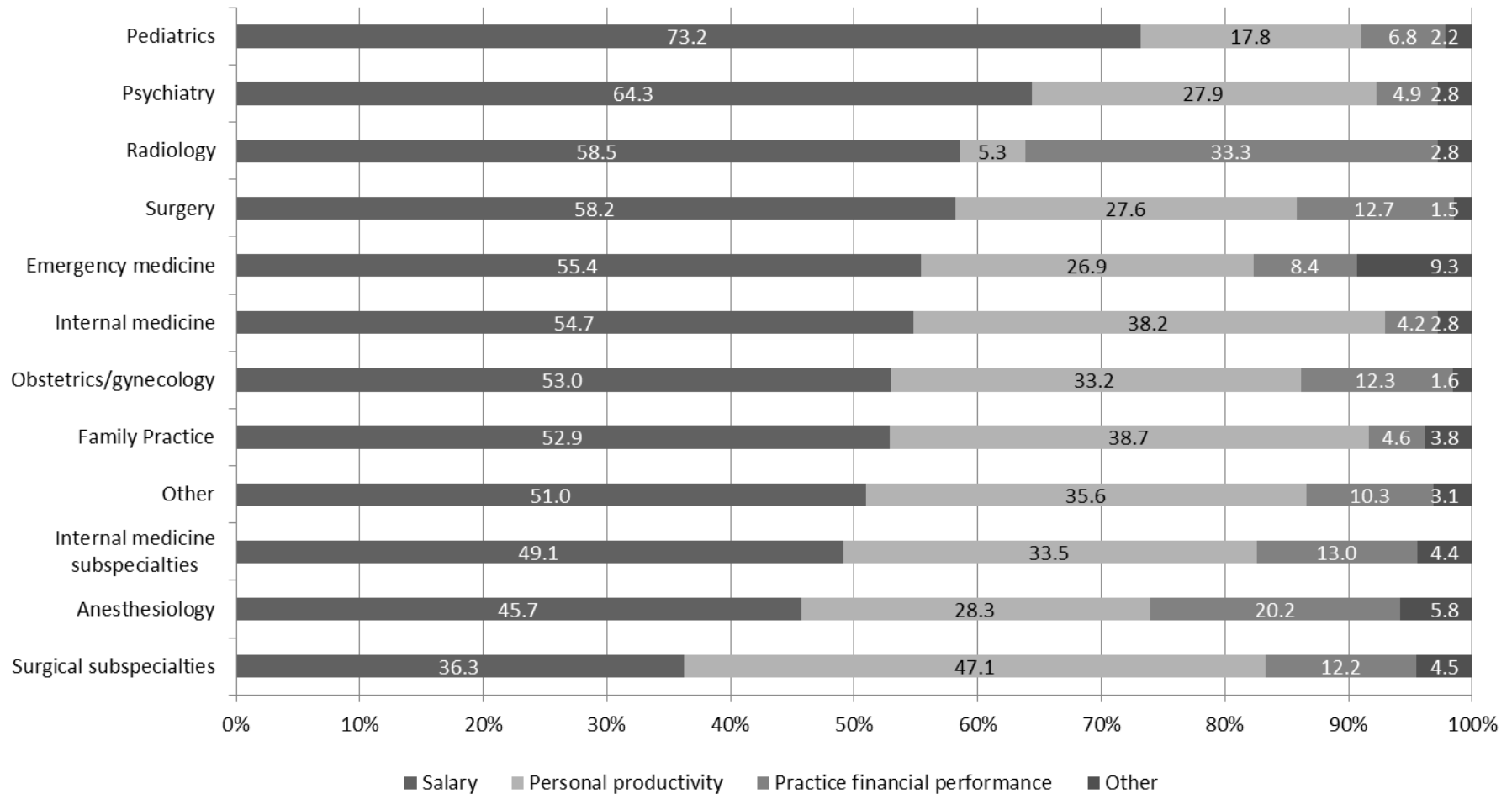
Figure 4. Distribution Of Group Practice Physicians By Payment Method (2012)

	Salary		Personal productivity		Practice financial performance				
	Only	Largest share but not 100%	Only	Largest share but not 100%	Only	Largest share but not 100%	Other	N	
Owner									
Single specialty group	6.6%	25.2%	25.3%	13.7%	16.4%	7.9%	4.9%	100%	1039
Multi-specialty group	5.9%	29.4%	30.5% ^c	19.9% ^b	9.6% ^a	2.3% ^a	2.4% ^c	100%	293
Employee									
Single specialty group	32.0%	38.0%	17.8%	7.2%	1.2%	1.5%	2.3%	100%	504
Multi-specialty group	25.5% ^b	38.5%	23.4% ^b	7.2%	1.3%	0.9%	3.3%	100%	467

Source: AMA 2012 Physician Practice Benchmark Survey.

Notes: Significance tests are within owner status category, for single compared to multi-specialty groups. 'a' is $p < 0.01$, 'b' is $p < 0.05$ and 'c' is $p < 0.10$

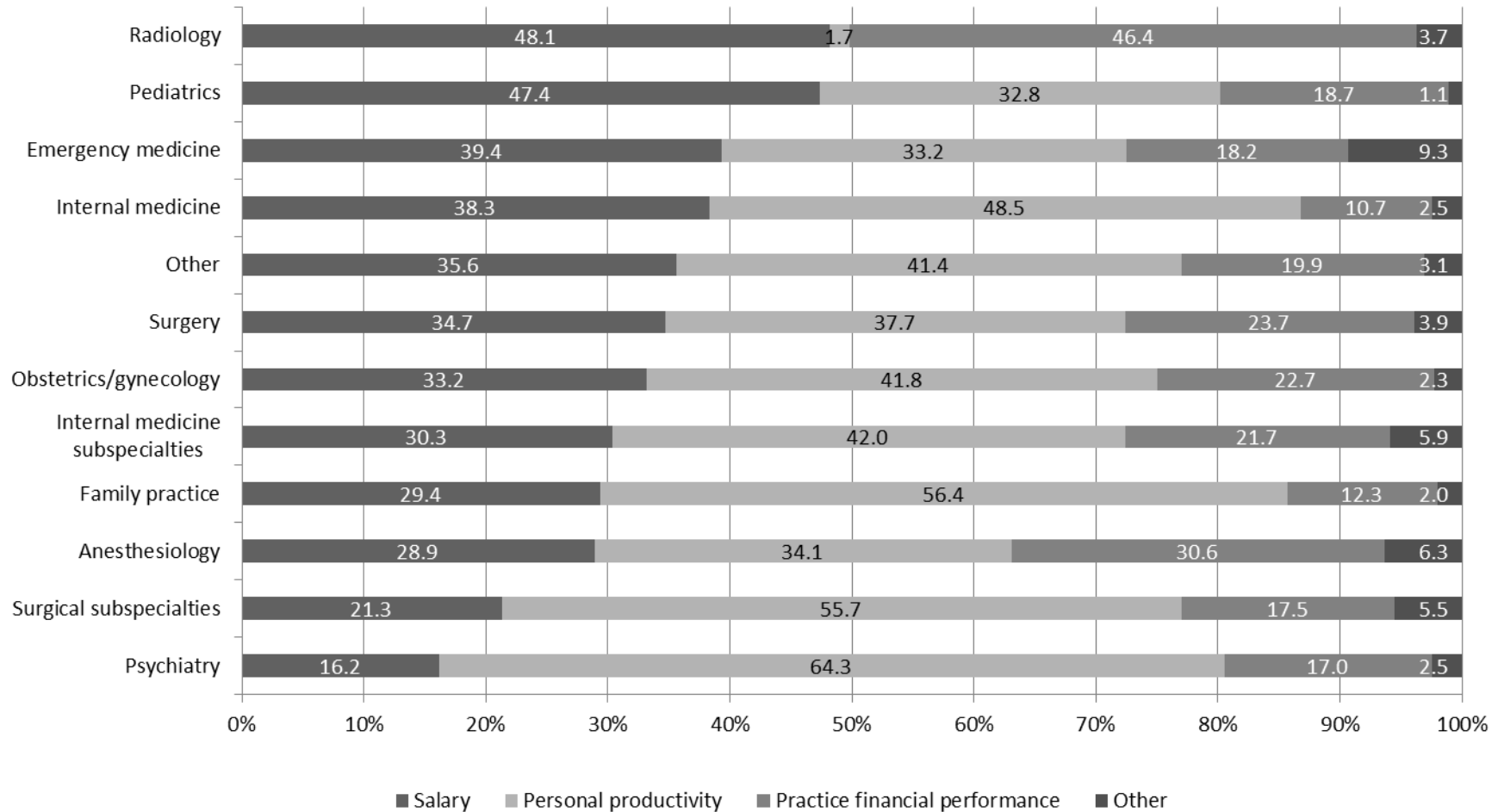
Figure 5. Distribution Of Non-Solo Physicians By Dominant Compensation Method, Specialty Level Results (2012)



Source: AMA 2012 Physician Practice Benchmark Survey.

Note: A compensation method is "dominant" if it accounts for all of compensation, or contributes the largest share toward compensation.

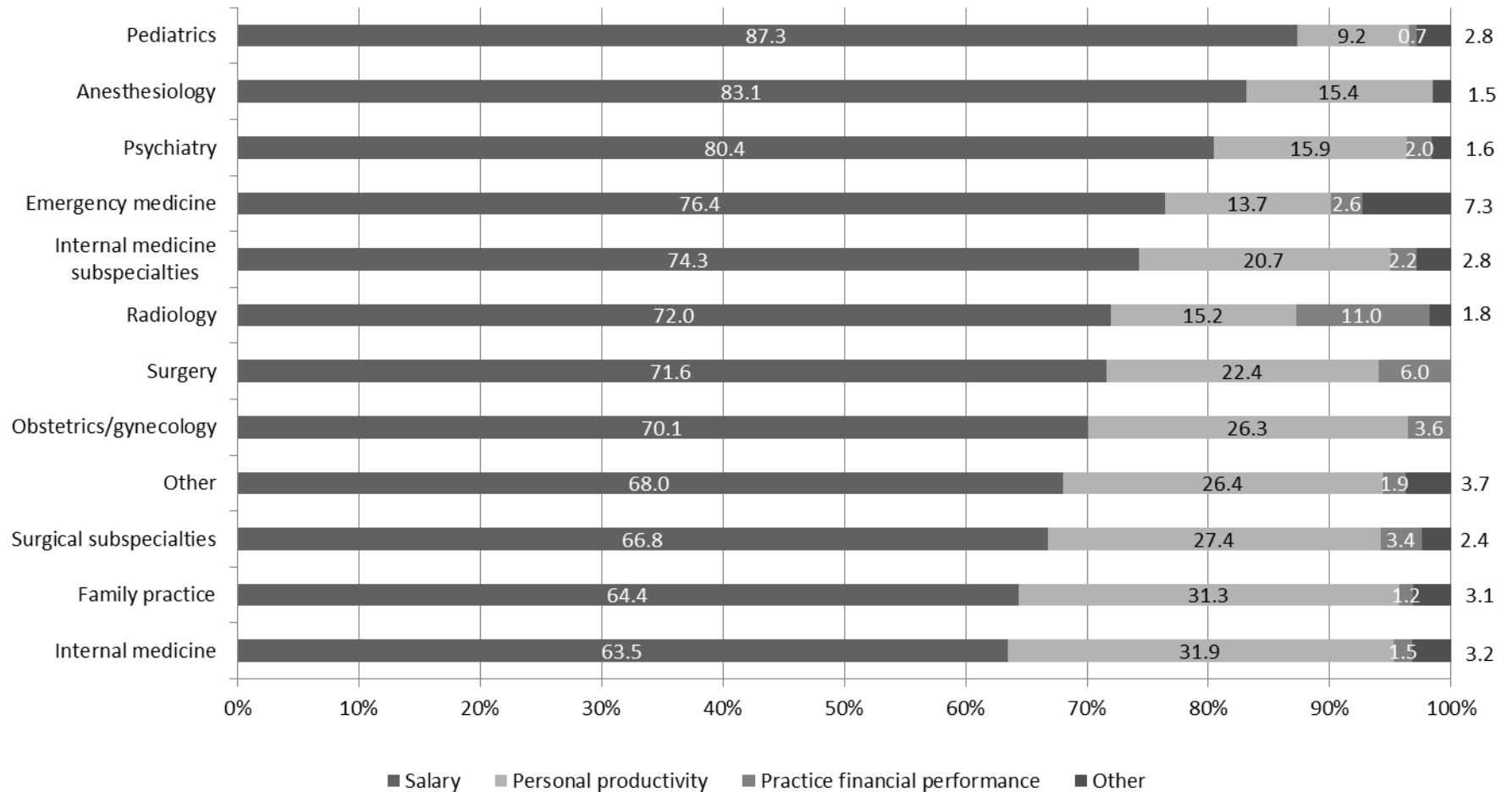
Figure 6. Distribution Of Non-Solo, Owner Physicians By Dominant Compensation Method, Specialty Level Results (2012)



Source: AMA 2012 Physician Compensation Benchmark Survey.

Note: A compensation method is "dominant" if it accounts for all of compensation, or contributes the largest share toward compensation.

Figure 7. Distribution Of Non-Solo, Employee Physicians By Dominant Compensation Method, Specialty Level Results (2012)



Source: AMA 2012 Physician Practice Benchmark Survey.

Note: A compensation method is "dominant" if it accounts for all of compensation, or contributes the largest share toward compensation.

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