Compensating Physicians for Quality and Value: A Changing Landscape

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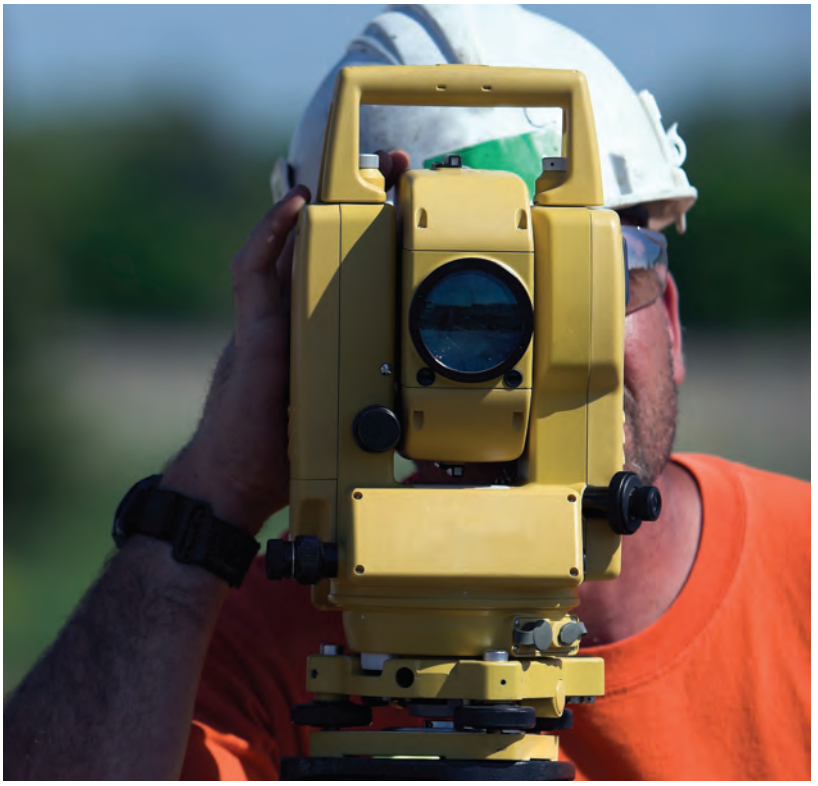

In 2007, a primary driver of improved quality of care was expected to be the advent of pay for performance (P4P) programs. But initial reports on their impact were fairly equivocal and the results more tepid than expected.[1] It seemed logical to consider whether the dollars in the incentives were actually making their way into the wallets of the physicians whose behavioral change was the point of these programs. Against that background, with virtually nothing available in the published literature, I undertook an informal survey of the American Medical Group Association (AMGA) membership as to whether they rewarded their physicians in their personal compensation for quality performance. The results were published in this journal in May 2008.[2]

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Today's Context

Today, the pressures for improved quality have intensified with the passage of the Affordable Care Act, and there is added emphasis on demonstrated value—better quality with controlled costs. Medicare has experimented with P4P for physicians in the Group Practice Demonstration Program, which has been widely reported in the debates about the Medicare Shared Savings program for approved accountable care organizations (ACOs).[3] The now-controversial ACO program will offer volunteer organizations the opportunity to share in savings while being held accountable for both Part A and Part B payments, with any gains received to be allocated among the hospitals and physicians of the ACO.

Against that voluntary opportunity, which is not even a pilot or demonstration,[4] a *mandatory* value-based performance modifier will be applied to payments under the Medicare Physician Fee Schedule beginning in 2012 (to take effect in 2013). The modifier will start with quality measurement and will later add efficiency measurement as captured in a government-sponsored, open architecture "episode grouper."[5] This program is to be coordinated with the Medicare hospital value-based purchasing modifier on which final regulations have been published.[6] The effect will be to pay more money to better-performing physicians.

In addition, health reform has provided a platform for increasingly widespread performance measurement with mandates for more measures and public reporting of results, which has already begun with PhysicianCompare.[7] Also, the Center for Medicare and Medicaid Innovation will be testing new approaches with the intention of disseminating them more widely.

In the meantime, commercial P4P programs have continued to proliferate.[8] Commercial payors have also begun to introduce more programs that pay physicians for improved quality with contained costs in homegrown versions of ACOs.[9] Public report cards on the Internet have spread and are increasingly used by provider systems in their advertising and branding.

In this exquisitely heightened performance measurement context, with expanding impacts from the judgments made based on those measurements, how are medical groups aligning their compensation models with the external pressures regarding performance? It seemed time to revisit the question of what is happening in physician compensation regarding quality and value within group practices.

Methodology and Limitations

AMGA e-mailed a 10-question electronic survey to the CEO (or designated contact) at each of the 385 AMGA member groups (see "Survey Questions"). They were given three weeks to respond. Two reminders were sent. There were 35 responses (9%), which was a considerable increase over the 14 groups that participated in 2007. Of those answering, however, two were IPAs and therefore not relevant to a survey on salaried compensation. Another 7 groups that responded stated they are not using quality metrics at all. Many groups that did not reply likely still are basing their compensation primarily on productivity, which is the traditional approach to paying physicians.[10] But others undoubtedly *are* using quality metrics to determine some compensation, because some of the groups that replied in 2007 did not participate in the survey this time. No group reported terminating a physician for failure to earn at-risk or bonus compensation. Some reported that not all physicians earn the maximum.

Some respondents provided explanations for their responses, while some provided cryptic comments. Where clarifications were sought, some people responded to subsequent e-mails, while others did not. In 2007, telephone interviews were used for some of the participants, who are among those who have been compensating physicians for quality for more than 10 years. Some recent respondents preferred a telephone interview as well. That means there is some asymmetry in the scope of the data received. Still, the information provided does offer a snapshot of some of what is happening in this arena.

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Overview of Respondents

Much like in 2007, the responses stratify into 3 longitudinal groupings: 8 groups have been compensating physicians on quality for 2 years or less; another 6 have been doing it between 3 and 6 years; and 12 groups have been compensating their physicians on quality in some measure for more than 10 years. In addition, some organizations, including Sutter Medical Group, had more than one respondent because their individual medical groups are given some significant autonomy in designing the compensation within the individual group under the larger organizational umbrella. For example, within the Sutter organization, one group had just started, but another has been at it more than 12 years.

The respondents were from all over the country, including, not surprisingly, Minnesota, California, Washington, and Oregon, where integrated groups have been around for a long time and managed care, with its greater emphasis on measurement of quality, has had more power than in the Northeast and South. But respondents were also located in Michigan, Massachusetts, New York, Florida, Iowa, Montana, and Pennsylvania; and among those compensating physicians for quality the longest was a group in North Carolina that did not answer the survey in 2007. In fact, three groups that have been compensating for quality for more than 10 years didn't answer the last time. Interestingly, some groups that have just begun are in markets such as Montana and Minnesota where some of their peers, although not necessarily their competitors, have been compensating for quality for a long time. The respondents include two multispecialty pediatric groups.

Of the 7 responding groups that have been compensating physicians for quality for between 3 and 6 years, 4 would not have answered the 2007 survey because they have not been doing it long enough.

Recent Adopters

Similar to recent adopters in 2007, some in the current class of respondents started with measurement for a year with no financial impact, followed by adoption of a range of 3%-7.5% of base compensation at risk for quality, with most at about 5% of base compensation. Some characterize it as a withhold and others as a bonus. In one group, the payment is a stipend of $2,500 for completing quality projects, although reportedly, the projects have had some measurable impact on outcomes. In another, the overall performance incentive for the physicians is 10% of base salary, but 25% of the 10% is quality based. In more than one instance, group citizenship is rewarded, with particular attention to attending meetings. In at least two instances, respondents reported a group can't effect real cultural change if the physicians don't interact with each other, so attendance at group meetings was worth including in the financial incentives—and it has worked.

More than one group specifically mentioned optimal diabetes care as a

time their programs have been in place, with the amount at risk ranging from 3% to a high of 15% at HealthPartners in Minneapolis. That program is based on quality outcomes and participation in improvement activities. One group has moved from $10,000 at risk to $2000-$3000 bonuses. Some have not altered their metrics much, with Healthcare Partners in California incentivizing primary care physicians only and primarily around HEDIS measures. Others, such as Geisinger, have maintained the amount at risk but have balanced group-wide and individual measures. The group performance data are shared, but since compensation is individualized for each physician and within specialties, Geisinger does not publicize individual performance data.

The Billings Clinic was in the mid range in the last survey but now has moved into pioneer status. The group began with 8 physicians in 2001 but now has 12 specialties paid in part on their quality performance with 76 physicians participating. Billings uses a combination of approaches with a 3% withhold for some physicians and a lump sum bonus for others, based on performance. In primary care Billings places strong emphasis on diabetes care quality, but in the subspecialties the group tracks focused behaviors including specialty-specific core measures, and in cardiovascular surgery it measures quality improvement projects including reducing hospital readmission, blood usage, and length of stay. These are certainly value producers, but are also core quality issues.

Regarding the three groups that did not respond to the 2007 survey, one compensates primary care only with 10% of base compensation at risk, while another with more than 10 years of doing this with primary care has added specialists over the last three years. The third is also focused on primary care with 5% at risk. Like the others, which recommend limiting measures to achievable metrics of no more than 8-10 a year, these groups maintain focus on outside payor demands in selecting metrics and maintain flexibility to alter measures to achieve additional results.

Some groups have already used their data with payors and almost all expect to.

Those groups with the longest experience report that it is embedded in their culture. It is an expectation and part of a cultural and organizational focus on high performance. They tweak over time. Some of the pioneers are considering expanding the amount at risk for quality. None has said they expect to terminate or decrease these programs, although even these groups express some frustration with their health plan partners. Still, they are the groups that report the highest volume (still not much) of compensation turning on quality and/or value. Some have said they expect this to increase over time. But not all pioneers are in markets where there is much of an emphasis on third parties paying for quality and/or value. They continue with these compensation models because they see higher-quality physician performance where incentives are tied to behavior.

This third tranche includes the Billings Clinic, MedStar Physician Partners, the Everett Clinic, Sutter Medical Group, IHA, PriMed Physicians, Healthcare Partners Medical Group, Geisinger, HealthPartners, First Health Physician Group, Baystate Medical Practices, and ThedaCare.

Lessons Learned

The lessons learned are very similar to those reported in 2007. First, involvement of the affected physicians in selecting the measures is critical. Education without financial impact for a year enhances implementation. Some reported that transparency of results within the group was useful, although others report that only when group-wide metrics are at issue does the inherent competition that comes from transparency within the group help.

Almost all reported that making the measures achievable mattered. Limiting the number of measures to no more than 10 in a well-evolved program will focus the physicians' attention on what needs to be done. Non-controversial, evidence-based measures are important. Education regarding appropriate documentation to demonstrate the measures achieved was cited several times as important. Periodic feedback during the year enhances the impact.

Those who have been doing it awhile stated that change takes time, and very clear communication about the goals and the reasons for the program are essential. Staying the course with refinement over time to align these compensation approaches with organizational goals results in a program that is consistent with overall strategic goals and becomes a completely accepted part of the group's culture.

Overall Observations

The groups reporting here are basing some of their compensation on quality and increasingly on value. They are a self-selected group already focused on quality improvement and measurement. Even among those who said they were doing nothing today, several say they will move in that direction. Other than in one or two instances, none cited external payment models as the primary reason for even initiating these programs and certainly all said external payment models have not been the reason to sustain these efforts. Rather, the compensation models reflect either the deeper culture of the groups regarding quality improvement or, among the newer adopters, are part of moving to a more desirable culture. Still, some are eyeing the Medicare value-based purchasing physician program as something that could affect their

current approaches.

Some groups have already used their data with payors and almost all expect to. While the initial groups in 2007 reported that there must be 5%-10% at risk to motivate a change in behavior, as it turns out, these incentives are often linked with other measures that are not purely quality measures but can influence whether quality measures can be achieved group-wide. These include measures of citizenship, participation in meetings and committees, and effective documentation.

When asked about value, many respondents cited their emphasis on productivity. But productivity is not necessarily "value" to third parties, if it is volume of work RVUs alone. One pioneer group did observe that productivity enhances patient access to physicians. This is a view of productivity that certainly is not the traditional compensation model under fee for service. While several respondents indicated that paying for quality in individual compensation is not easy, and productivity is far easier to measure, at least one group indicated a move away from individualized achievement for bonuses to sub-group (specialty or locational) performance as a whole for eligibility. Fewer use their data to market to the public, but those that do report a positive response.

Conclusion

The Medicare value-based purchasing modifier will draw attention to specific measures of performance and will affect group revenues, up or down. The attention to bending the cost curve ought to motivate physician groups to look inward to becoming more efficient in their delivery of care, while producing improved quality outcomes. Commercial payors will generate the same pressures. Today, the outside world of payment has been a relatively minor factor in these compensation programs, although there is a sense that we may well be on the cusp of something different. That more groups are starting these initiatives and that long-term players will sustain them speak to the changing environment.

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Survey Questions

1. For how long has quality performance been a factor in determining physician compensation in your group?
2. Please describe your current approach or attach a written description used in the group.
3. If your approach has evolved over time, please briefly describe the stages your group went through to get to the program/metrics that you use now.
4. How much of the physician's compensation turns on these metrics? How has that evolved?
5. Do you consider "value" as a factor in compensation (e.g., bonuses or additional payment for less resource-intense services, shorter lengths of stay, use of less-expensive treatments first)?

   a. If Yes, for how long has this been a factor in compensation?

   b. If Yes, what percentage of the compensation turns on value performance?

   c. If Yes, please describe the metrics and approach or attach what you use within the group.
6. Have you ever terminated a physician for not having achieved threshold performance on your quality or value metrics?
7. Please describe the impact of these programs in changing physician behavior or performance results of the group.
8. What lessons did you learn in implementing these types of programs?
9. Have you ever used the existence of these programs or their results in marketing to the public or your patients? Please describe.
10. Have you ever used the results of these programs or their existence in payor negotiations? Please describe.