



NATIONAL
HEALTH CARE
PURCHASING
INSTITUTE



*The Growing Case for Using Physician
Incentives to Improve Health Care Quality*

**Bailit Health Purchasing, LLC
Sixth Man Consulting, Inc.**

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About the National Health Care Purchasing Institute

Mission: The National Health Care Purchasing Institute was founded to improve health care quality by advancing the purchasing practices of major corporations and government agencies, particularly Fortune 500 companies, Medicare, and public employers.

Objectives and Offerings: Our objectives are to help health care purchasers buy higher quality health care, save lives, and empower consumers to choose higher quality health plans and providers. We are also building the business case for effective, value-driven health care purchasing. Institute offerings include courses and workshops, technical assistance, convening of experts and working groups, research, and information on tools and best practices.

Sponsor: The Robert Wood Johnson Foundation (www.rwjf.org) sponsors the Institute through a \$7.7 million grant to the Academy for Health Services Research and Health Policy (www.academyhealth.org).

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About the Authors

A **Bailit Health Purchasing, LLC (BHP)** is a firm dedicated to assisting public agencies, private purchasers, and purchasing coalitions in the development and execution of effective health care purchasing strategies. BHP is driven by the belief that only sophisticated and demanding purchasing efforts can create accountability for quality, cost-effective care.

Sixth Man Consulting (6MC) is a health care consulting firm that helps physicians improve the productivity, clinical outcomes and market attractiveness of their outpatient practices. 6MC's services include the generation of performance cost curves from routinely collected data, comparisons with relevant peers, and coaching in performance management.

FOREWORD

Incentives are used successfully throughout business, government, and personal life to improve performance. Employers use bonuses to reward higher performers. Local, state, and federal governments pay highway contractors extra to finish projects early. Parents reward their children for better grades.

In the health care industry, however, there is little, if anything, that links physician reimbursement (salaries and/or bonuses) to providing quality care.¹ In its report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the Institute of Medicine (IOM) describes a dramatic and painful disconnect between evidence-based best practices and the actual practice of medicine by most physicians.

Incentives can and should link the natural motivational power of reimbursement and a physician's clinical performance. Incentives should also be an important component of any effort to improve quality in the American health care system. But, while it is arguably the ideal approach for structuring the health care



system, aligning physician incentives with the delivery of the highest-possible quality of care is a difficult task. As a result, incentive systems currently in place are more likely to be linked to productivity or utilization than to quality or quality improvement.

Nonetheless, purchasing innovators continue to wrestle through the challenges, and some have implemented incentive-based strategies to improve quality. To gain a sense of what has been tried and achieved thus far, the National Health Care Purchasing Institute (NHCPI) commissioned Bailit Health Purchasing, LLC (BHP) and Sixth Man Consulting, Inc. (6MC) to conduct a study of quality-focused, physician-level incentive strategies implemented to this point. In this report, NHCPI seeks to document the experience of innovators and leaders — highlighting successes, defining barriers, and offering lessons learned.

Kevin B. (Kip) Piper, MA, CHE
Director
National Health Care Purchasing Institute

¹ Dudley, R. Adams, Robert Miller, Tamir Korenbrot, and Harold Luft, “[The Impact of Financial Incentives on Quality of Health Care](#),” *The Milbank Quarterly*, Vol. 76, No. 4, 1998: pp.649-685.

EXECUTIVE SUMMARY

While the practice of using physician incentives to improve quality of care is not widespread, more provider groups, health plans, and purchasers are starting to recognize the need for, and the potential of, incentive strategies. Though some pioneering leaders, such as Aetna U.S. Healthcare, University of Michigan Health Services, and General Motors Corporation, are using quality incentives with individual physicians, most innovators are in the early stages of implementing physician-level incentive strategies to generate quality improvement.

To gain a more complete picture of the status of these efforts, the National Health Care Purchasing Institute (NHCPI) commissioned Bailit Health Purchasing, LLC (BHP) and Sixth Man Consulting, Inc. (6MC), to examine the extent to which such incentive strategies are being used. To supplement the findings in published literature, BHP/6MC conducted interviews and focus groups with health plans, health services researchers, primary care physicians (PCPs), employers, and disease management experts.

While a number of health plans and provider groups use financial incentives with physicians, the incentives are more likely to be linked to productivity or utilization measures, than to quality or quality improvement. Organizations that do use incentives for quality improvement at the physician level tend to rely on HEDIS rates and member satisfaction survey results to measure provider performance. Health plans and

purchasers attempting to improve quality of care by using external motivators often use both financial and non-financial incentives concurrently.

Research and experience suggest that financial incentives to improve quality of care are generally more influential than non-financial incentives, and incentive strategies are more effective when based on each individual physician's performance rather than at the group or plan level. Key factors that influence the extent to which an incentive strategy is effective in improving physicians' performance include the following:

- The level of trust between the physicians and the individuals and organizations implementing the incentives;
- The size of the financial incentive;
- The peer and/or consumer knowledge of individual provider performance;
- The perceived and actual accuracy of the data on which the incentives are based;
- The stimulus and need for change recognized among physicians;
- The level of support for the incentive program in the medical leadership;
- The practicing physicians' knowledge and understanding of the performance incentives/sanctions; and
- The simplicity and directness of the incentive program.

INTRODUCTION

Broad consensus exists that aligning physician incentives with quality improvement will yield a health care system that works better for all participants — patients, providers, and purchasers, alike — and some health plans, provider groups, and employers have sought to apply incentive strategies to achieve such an alignment. In the process these innovators have experienced both success and failure and have learned both where impediments lie within the system and what elements must be present for success. To document and analyze the efforts of innovators, the National Health Care Purchasing Institute (NHCPI) commissioned Bailit Health Purchasing, LLC (BHP) and Sixth Man Consulting, Inc. (6MC), to study the extent to which quality-focused, physician-level performance incentives have been implemented and how effective they have been.²

The experience and research documented in this study show that incentive systems currently in place are more likely to link to productivity and utilization reduction than quality, but leading provider groups, health plans, and purchasers are starting to recognize the need for, and the potential of, incentive strategies to improve quality of care. Still, the process of aligning physician incentives and quality is complex, and entrenched — sometimes contradictory — incentive and operating structures will continue to make the health care system resistant to change. The experience of those who have “gone first” thus becomes all the more valuable to those who would follow. This report seeks to aid prospective innovators by highlighting a few specific pioneers and recording the thoughts and lessons learned by many others.



² To determine whether research and practical experience have supported the effectiveness of incentive-based strategies in generating provider improvement in health care delivery, BHP conducted a literature review, and a series of interviews and focus groups, studying the experience and perceptions of health care executives, health services researchers, quality improvement experts, and practicing primary care physicians. Examining financial incentives, as well as non-financial incentives, BHP/6MC asked about barriers to quality improvement and the efficacy of different incentive strategies for improving care at the physician level. Similarly, the authors interviewed employers and disease management experts about their experience with creating incentives to motivate physicians and their perceptions about impediments to improving quality of care and patient health status.

EFFECTIVENESS OF PHYSICIAN INCENTIVES TO IMPROVE QUALITY OF CARE

Most studies of financial incentives conclude that incentives have a measurable impact on physicians' clinical decisions and resource utilization.^{3,4} While a few studies have reported that physicians are unresponsive to financial incentives, a number of researchers and other participants suggested that in these cases the financial incentives might have been too small. Research also suggests that financial incentives are more influential when based on an individual physician's performance.

Most of the health care executives interviewed for this study agreed with research findings indicating that the use of financial incentives is the most promising approach to change physician behavior. At the same time, some participants in the focus groups believed that financial incentives alone would not guarantee quality improvement at the individual physician level.

Examples of non-financial physician incentives that were commonly cited included the dissemination of clinical practice guidelines, provider performance reporting, provider education, and championing change using local opinion leaders. One participant referred to his network's strategy as a "Hall of Fame" and a "Hall of Shame" approach for sharing performance data among medical peers and leadership. Research and experience indicate that each of these non-financial incentive approaches has been at least somewhat effective in changing provider behavior although some of the behavioral changes may be temporary.³ Ongoing personal and public

accountability and visibility, at least among peers and stakeholders, were considered essential to establishing effective, non-financial incentives with physicians to improve care. In contrast, sharing performance data where the physician identities are blinded was not found to be effective in changing behavior. Participants in the executive focus groups generally believed that non-financial incentives alone were not very effective unless they have some indirect financial consequences, e.g., a potential for increased or decreased patient volume.

The many ways in which organizations have combined financial and non-financial incentives for physicians made the research and evaluation of different incentives challenging. Different types of financial incentives have been used in combination and have been found to amplify one another.⁵ Similarly, non-financial incentives have been used as substitutes for, or complements to, financial incentives. A mixture of intrinsic rewards, reliable measures of performance, and feedback has been found to have a multiplicative impact on motivation. Overall, most focus group participants appeared to believe that a strategic combination of financial and non-financial incentives was the most effective approach to improve quality of care at the physician level. In addition, a number of participants postulated that quality improvement incentives for office staff, non-physician providers, health care executives, and patients could be effective as well.

3 Magnus, Stephen, "Physicians' Financial Incentives in Five Dimensions: A Conceptual Framework for Managers," *Health Care Management Review*, Winter 1999: pp. 57-72.

4 Goodpastor, Walter and Isaac Montoya, "Motivating Physician Behavior Change: Social Influence Versus Financial Contingencies," *International Journal of Health Care Quality Assurance*, Vol. 9, No. 6, 1996: pp. 4-9.

5 Dudley, R. Adams, Robert Miller, Tamir Korenbrot, and Harold Luft, "The Impact of Financial Incentives on Quality of Health Care," *The Milbank Quarterly*, Vol. 76, No. 4, 1998: pp. 649-685.

USING PHYSICIAN INCENTIVES IN PURCHASING

Although their application remains fairly limited, research and practical experience can make a case for the effectiveness of incentive-based strategies in generating provider improvement in health care delivery. Indeed, developing an interactive combination of financial and non-financial incentives at the provider level appears to be an effective strategy for purchasers to employ in order to improve the quality of care. This has different implications for different groups of purchasers. The majority of purchasers obtain health insurance through contracted health plans. For these purchasers, there is an opportunity to influence the manner in which their health plans contract with their providers. For example, Pacific Business Group on Health (PBGH) employers recently offered contracted health plans a bonus in an attempt to induce plans to reimburse providers differentially based on quality. While the PBGH bonus was insufficient to induce health plans to take on this reimbursement challenge, the employers and health plans remain in discussion about financial incentives at the provider level to improve quality of care. For the subset of employers who participate in direct contracting arrangements

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with physicians through a group or individually, there is an opportunity to apply quality incentives directly in contracting arrangements.

Prior to implementing physician incentives either through contracted health plans or directly with providers, it is essential that purchasers thoughtfully determine the priority and the appropriate order for those aspects of performance to which they seek to attach incentives. There are more opportunities for improvement in the quality of care that patients receive than any one organization could undertake at a given time.



Purchasers should carefully evaluate the potential for specific physician incentives to be effective before developing an incentive-based strategy. The size and demographics of the target population, variation in provider performance, and current performance data limitations were all cited as key factors to consider. In selecting a quality improvement initiative with which to link incentives, this study's findings suggest that purchasers:

- focus on quality improvement efforts likely to affect a significant number of patients;
- identify clinical care areas where clear provider performance measures exist;
- select performance measures for which clinical guidelines are widely accepted by the provider community;
- carefully consider the role of individual physicians in the identified quality improvement area compared to the role of patients and other providers, and
- determine the priority of areas for which an opportunity for improvement has been established according to baseline data that identify where variable provider performance exists compared to an identified and accepted benchmark.

When developing physician incentive strategies to improve care, purchasers working with health plans and/or physicians, should also identify barriers that physicians face in improving care. By investing in good systems, good data, and effective use of support staff, health plans and purchasers can make physicians' jobs easier and

help to overcome some common impediments to quality improvement efforts. Physicians in the focus groups also encouraged purchasers to consider the patient's role in quality improvement and to explore whether incentives or cues for patients are needed to supplement or parallel a provider incentive strategy.

Once purchasers have selected priority areas for quality improvement, they should get consensus with their health care contractors (i.e., plans and/or providers) on reliable, understandable performance data at the provider level.

Purchasers and their contractors should phase in physician incentive programs by first requiring data and providing feedback before tying financial awards or penalties to physician performance. To the extent possible, incentives should be attached to individual physician performance rather than to group practice performance if the incentives are to have maximum impact.



UNDERSTANDING WHY INCENTIVES ARE NOT MORE WIDESPREAD

Offering thoughts on the limited presence of effective quality-focused incentive structures in the health care system, focus group and interview participants cited an array of impediments as well as evidence of progress and ideas for getting past certain barriers. At the most basic level participants from a variety of perspectives observed that physicians are simply not rewarded for investments in quality improvement. In fact, provider financing is typically divorced from patient outcomes, and some physicians noted that the financial incentives they face often conflict with practice changes that could promote improvements in quality of care for patients.

There was consensus that physicians generally want to do the right thing for their patients but face impediments to improving care. Participants cited the need to address the limitations of the traditional medical model and the expanding job description for primary care providers (PCPs) in order for substantive quality improvement to occur at the practice level. According to some

participants, external motivation and technical assistance are necessary to enable physicians to keep abreast of the latest clinical guidelines and implement practice changes. A number of participants also noted that physicians need to be part of a supportive quality improvement environment in order for individual practice patterns to change.

Some participants suggested that organizations could address barriers by developing complementary financial and non-financial incentives for individual providers to improve care delivery. Participants also noted that incentives are less likely to be effective in overcoming barriers where individual physicians may have less control, such as with patient non-compliance or fragmentation of the insurance market.



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Despite all the impediments noted, certain physicians, physician groups, and managed care organizations have been successful in promoting quality improvement, and better patient outcomes are being achieved. The experts interviewed mentioned the Institute for Clinical Systems Improvement (www.icsi.org) in Bloomington, Minnesota, and the Institute for Healthcare Improvement (www.ihi.org) in Boston, Massachusetts, as examples of organizations successfully applying quality improvement techniques with providers and provider organizations to achieve better patient outcomes.

Key factors that influence the extent to which an incentive strategy is effective in improving physicians' performance include:

- level of trust between the physicians and the individuals and organizations implementing the incentives;
- size of the financial incentive;
- peer and/or consumer knowledge of individual provider performance;
- perceived and actual accuracy of the data on which the incentives are based;
- stimulus and need for change recognized among physicians;
- level of support for the incentive program in the medical leadership;
- practicing physicians' knowledge and understanding of the performance incentives/sanctions, and
- simplicity and directness of the incentive program.



PERVASIVENESS AND SIZE OF PHYSICIAN INCENTIVES

ne of the earliest examples available of a health plan using financial incentives to promote quality of care is the Quality Care Compensation System (QCCS) for primary care providers, implemented in 1987 by U.S. Healthcare⁶ (now Aetna U.S. Healthcare). [See sidebar below for more details.] Early results — prior to U.S. Healthcare’s merger with Aetna — demonstrated improvements in immunization rates and mammogram screening rates.⁷ While recent data on the effectiveness of

the physician incentives is not publicly available, Aetna U.S. Healthcare continues to use a mix of standardized measures, like Health Plan Data and Information Set (HEDIS), and customized measures of performance to identify and reward primary care providers for quality care. While there may be alternative explanations, the longevity of this program could mean Aetna still considers this incentive system effective.

6 Hanchak, Nicholas MD, Neil Schlackman MD and Sandra Harmon-Weiss MD, “U.S. Healthcare’s Quality-based Compensation Model,” *Health Care Financing Review*, Vol. 17, No. 3, Spring 1996: pp. 143-159.

7 Schlackman, Neil MD, “How One Health Plan Gets Doctors to Improve.” *Medical Economics*, February 12, 1996, pp. 237-241.

AETNA U.S. HEALTHCARE’S QUALITY CARE COMPENSATION SYSTEM

The Quality Care Compensation System (QCCS) includes a quality factor and a level-of-care factor as defined by Aetna U.S. Healthcare.

Primary care provider (PCP) performance measures included in the quality factor are:

- member satisfaction survey results;
- performance on preventive care measures such as immunizations and cholesterol screenings;
- the number of members who change to another doctor; and
- how well the physician manages the care of patients with chronic illness, (e.g., asthma, diabetes, and congestive heart failure).

The PCP level of care factor includes the following measures:

- the number of hours a week the PCP’s office is open;
- “extra” services the PCP may provide in the office, such as stitching cuts or removing moles;
- whether the PCP has participated in certain educational programs;
- whether the PCP is caring for more seriously ill patients;
- whether the number of Aetna U.S. Healthcare members choosing the PCP increased; and
- whether the PCP goes to the hospital to take care of patients.

Source: Aetna U.S. Healthcare “Primary Care Doctors and the Quality Care Compensation System,” on the website: www2.aetnaushc.com/docfind/pcp_qual_comp.html; May 24, 2001.

A 1997 survey of California PCPs helps quantify the sense that while health plans' use of financial incentives for physicians is common, the application of these incentives to improve quality is comparatively rare. Almost 40 percent of the respondents reported facing some type of financial incentive in their health plan contracts while only 18 percent reported facing financial incentives linked to quality of care.⁸ Further, these California physicians were three times more likely to report facing quality incentives if they were practicing in a group or staff model health plan. Recent newspaper articles suggest that health plan's use of financial incentives linked to quality measures may be increasing.⁹



California physicians surveyed were three times more likely to report facing quality incentives if they were practicing in a group or staff model health plan.

Where they do exist, financial incentives for quality improvement vary along a number of dimensions, such as the percentage of a physician's income at stake, the organizational level at which the incentive is applied, and the relationship and synergy between multiple financial and non-financial incentives.¹⁰ The size of the financial incentives used by health plans and medical groups tends to range from 1 to 20 percent of a physician's total compensation, with many incentives clustered in the 5 percent range. The size of the incentive varies partially in relationship to the type of organization applying the incentive. For example, physicians in staff or group model health plans tend to face financial incentives that account for a greater portion of their overall compensation. In an independent practice association (IPA), however, where the health plan may only have 30 percent of the provider's overall business, any financial incentive applied by that IPA is likely to account for much less than 10 percent of a provider's total compensation.

8 Grumbach, Kevin MD, Dennis Osmond Ph.D., et al, "PCP's Experience of Financial Incentives in Managed Care Systems," *The New England Journal of Medicine*, Vol. 339, No. 21, November 19, 1998: pp. 1516-1521.

9 Boodman, Sandra G, "Paying Docs to Do the Right Thing," *The Washington Post*, July 3, 2001, p. HE07; Appleby, Julie, "HMO to Pay Bonuses for Good Care," *USA Today*, July 11, 2001, p. 3B.

10 Magnus, Stephen, "Physicians' Financial Incentives in Five Dimensions: A Conceptual Framework for Managers," *Health Care Management Review*, Winter 1999: pp. 57-72.

CASE STUDIES ILLUSTRATE SUCCESS AND BARRIERS

EMPLOYERS AND COALITIONS HAVE PIONEERED PHYSICIAN LEVEL EFFORTS

While a number of employers and employer coalitions interviewed use incentives in their health plan contracts, most have not used incentives at the physician level. However, evidence did show that a number of employers and coalitions, such as General Motors Corporation in Michigan, the Tri-River Health Care Coalition in Ohio, and the Employers' Coalition on Health in Illinois, are beginning to focus incentives at the provider level, including medical groups.

In January 2001, General Motors (GM) and the University of Michigan Health System established a direct contracting relationship that includes a series of financial incentives for providers to improve patient care. Under this new initiative, referred to as Activecare, GM directly reimburses providers for performing patient health risk assessments. In addition, Activecare provider groups meeting target rates for a number of process measures will receive a bonus at the end of the year. Target rates have been established for measures such as the percentage of patients with completed care plans and the number of patients enrolled in for disease management programs. According to the GM representative interviewed, over time, GM intends to link financial incentives for Activecare providers to more outcome-oriented data on quality of care.

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The Tri-Rivers Healthcare Coalition in Dayton, Ohio also began offering providers financial incentives to improve patient care in early 2001. A quality council comprised of purchasers, providers, health system representatives, and consumers govern the Tri-Rivers initiatives. The quality council determines the provider performance areas on which to focus and the targets for performance. GM is one of the purchasers in the coalition, and the Tri-Rivers financial incentives are similar to the Activecare initiatives described above. Provider bonuses are financed by a \$2 per member per month contribution from each of the purchasers. (See Sidebar on page 12 for more details.)

The Employers' Coalition on Health, (ECOH), represents 37,000 covered lives in Rockford, Illinois. In collaboration with three area health systems, ECOH developed a diabetes management program that incorporates incentives for physicians to monitor diabetic patients closely and to ensure that they receive appropriate preventive care.

TRI-RIVERS HEALTHCARE COALITION

In January 2001, the Tri-Rivers Healthcare Coalition in Dayton, Ohio, began offering providers financial incentives to improve patient care. The financial incentives for the Tri-Rivers Healthcare Coalition include the following characteristics:

- Providers are paid fee-for-service and can receive a direct reimbursement for completing an annual health-risk assessment and action plan for each patient. Providers that complete the care plan can directly bill for this service using a special code.
- Provider groups are eligible to receive portions of a bonus pool if they meet or exceed the targets established by a coalition quality council. The exact bonus percentages are proprietary at this time, but the four performance areas in which providers can obtain bonuses are as follows:
 1. Completing health action plans for 50 percent of their patients.
 2. Attaining global financial targets based on demographics and previous cost experience, as well as negotiation of reasonable improvement.
 3. Meeting stretch goals for identified disease management areas, including enrolling patients in disease management programs and developing care plans. In the first year, the four areas for disease management focus are diabetes, smoking cessation, hypertension and cardiac management.
 4. Developing a website to be used as a tool for patient education. In the first year, providers can receive a portion of the bonus pool for developing a website that provides specific service information as well as direct links to important sites. In the future, the quality council may consider creating incentives for physicians for on-line patient communication (e.g., e-mail). There are, however, some concerns in the provider community regarding liability and privacy.

Claims data indicate that providers are developing care plans and using the unique codes in their claims submission, but it is too early to identify whether providers will reach the 50 percent threshold to obtain the related bonus payment. Similarly, providers are enrolling members in disease management programs, but it is not clear whether the providers will meet the targets required to obtain the bonus. Preliminary evidence suggests that most providers will receive the portion of the bonus pool assigned for website development.

ECOH created significant financial incentives for physicians to meet negotiated performance standards for diabetic care over a three-year period. Previous ECOH provider contracts had incentives for patient satisfaction and diabetes management but ECOH had little direct contact with physicians and insufficient provider buy-in. By actively involving the physicians in determining the diabetes management performance thresholds, ECOH appears to have obtained physician buy-in to the new incentive strategy. ECOH will evaluate the impact of its diabetes initiative by comparing claims data from 2001 to 2003 with baseline data from January 1999 through June 2000. (See Sidebar on page 15 for more details.)

These examples of employer purchasing incentives at the provider level are in the early stages. There is not yet conclusive data on the incentives' effectiveness on improving quality of care. However, the Tri-River Health Care Coalition in Ohio has some preliminary data that suggests their financial incentives have been at least somewhat effective in motivating providers to complete health action plans, enroll patients in disease management programs, and develop a website to be used as a tool for patient education.

According to the purchaser representatives interviewed, the initial reaction of the provider community has been very positive. Specifically, providers perceive that these purchasers are interested in rewarding quality and not just reducing utilization. The providers recognize that the purchasers are providing additional funding to reward quality (as opposed to withholding a percentage of premium). Additionally, providers seem to appreciate that they were asked to participate in the development phase and that the measures were not imposed on them without their input.

MEDICAL GROUPS AND HEALTH PLANS REPORT MIXED RESULTS

As reported in focus groups and interviews, the experience of medical groups and health plans with implementing financial incentives for physicians has ranged from success to retraction. Two plans stopped using financial incentives. Meanwhile, two other plans experienced positive results and remain committed to their incentive strategies.



One health plan specifically noted that non-financial approaches alone did not work.

Those That Re-grouped

Two health plans that participated in this study have discontinued their network-wide financial incentives for individual providers linked to scores on HEDIS measures even though they continue to measure and report on provider performance. These plans changed their quality improvement approach because they found the on-going impact of the efforts to be too marginal to justify investing the operational resources required for implementing financial incentives at the provider level and managing the additional tension created between the plan and physicians. One of the two plans, an IPA, previously offered a \$3 per member per month bonus if PCPs met goals on immunizations, adolescent counseling visits, breast cancer screening rates, and member satisfaction survey results. In the initial year, the determination of the physician awards was very contentious and lawyers got involved. Neither the plan nor the providers were satisfied with the quality of the data used for the incentives. The second year was less controversial because the plan made awards at two levels and included half of the providers. In addition, during the second year, the award thresholds were related to the community norm rather than to absolute benchmarks.

Those That Have Succeeded

On the positive side, one health plan observed dramatic improvements in five areas as a result of significant financial incentives for practices to improve their performance. This health plan specifically noted that non-financial approaches alone did not work. They shared data, provided feedback, held up certain practices as models, and nothing changed the practices' performance for years until they tied the additional compensation to performance at the group practice level.

Anthem Blue Cross Blue Shield (BCBS) has had success using financial and non-financial incentives in two small pilot programs, one with PCPs and the other with obstetrician-gynecologists (ob-gyns). In both instances, the providers are paid fee-for-service, and the financial incentives are offered as a year-end bonus. These incentive pilots are ongoing, and the health plan intends to expand them to additional providers.



EMPLOYERS' COALITION ON HEALTH

In the summer of 2000, the Employers' Coalition on Health (ECOH) in Rockford, Illinois, developed a methodology for improving care for their diabetic population over a three-year period. ECOH identified three components of the project:

- include incentive language in primary care provider contracts to promote compliance with the diabetes initiatives;
- use claims data indicators to measure the impact of the quality improvement initiative; and
- develop appropriate educational materials and workshops to advance the understanding of the disease and the steps that can be taken to prevent severe episodes.

As part of contract negotiations, ECOH and the health systems agreed to use the Illinois Foundation for Quality Health Care's "Project in a Box" (the Project) as the basis for measuring physician treatment of the ECOH diabetic population. The Project is designed to move local practice patterns toward a "best practice" model as determined by clinical research. The Project requires physicians to complete a diabetes care flowsheet on each diabetic encounter and to provide intervention suggestions and key literature reprints for the patient.

Specifically, physicians in the ECOH incentive program obtain additional compensation if they achieve a 95 percent flowsheet completion rate and maintain 60 percent of their diabetic patients at Hemoglobin A1c level of 7.5 or less in the second year of the project. In the third year, physicians must maintain 65 percent of their diabetics at or below a Hemoglobin A1c level of 7.5 in order to receive the incentive payment. These ambitious performance goals were developed in conjunction with the physicians who will be measured against them. The amount of the incentive or method for calculating it has not yet been determined.

ECOH has also negotiated with care systems to require health care professionals to conduct a variety of health education initiatives for employees, including blood screening for the detection of diabetes. The ECOH Board of Directors is simultaneously reviewing recommendations from its Primary Care Provider subcommittee to broaden the coverage of preventive care and education for diabetics by amending the benefit packages of ECOH member companies.

In the PCP pilot which is associated with approximately 35,000 covered lives, Anthem BCBS pays primary care physicians a bonus for reaching target rates for designated HEDIS childhood immunization and breast cancer screening rates. For example, if at least 70 percent of the eligible children are immunized, the PCP receives \$56 per eligible child in the physician's panel. The health plan pays providers a higher rate, \$98 and \$140 respectively, for meeting 80 percent and 90 percent thresholds. Both the immunization and breast cancer screening rates improved during the time period of the pilot for providers facing incentives according to the Anthem BCBS representative interviewed.

In the ob-gyn pilot, a group of 15 ob-gyns are rewarded for specific performance on preventive care screening rates, patient satisfaction survey results, compliance with hysterectomy guidelines, and utilization ratios for generic drugs. The health plan offers the ob-gyns a bonus representing a percentage of their total fee-for-service reimbursement and eliminates pre-certification and concurrent review requirements for high performing ob-gyn providers.



Anthem BCBS has seen an improvement in all five areas targeted by the incentives, and the combined payments to all ob-gyns in the pilot have been close to the \$50,000 maximum bonus. Based on HEDIS specifications for preventive care screenings, the ob-gyns in the pilot are achieving Pap smear and postpartum screening rates of 100 percent of eligible women, well above the mean rates of 72 and 81 percent respectively among other ob-gyns in the plan. According to the health plan, 90 percent of the hysterectomies performed by ob-gyns in the pilot met the guideline criteria.

Research also yielded two positive examples of innovative approaches to create care-improvement incentives that extend beyond individual physician incentives. For example, one medical group in Minnesota allots bonus money it receives from health plans to all employees in the group — not only to the physicians. Employees at this group are reportedly “very involved” and “very excited” about the performance incentives as a result.

A health plan in Boston solicits proposals from physicians to make a change in their practice that will result in better quality health care. This plan awards funding to selected physician groups to implement system and infrastructure changes needed to support widespread quality improvement. This quality award program has been well received by physicians and promotes a collaborative approach between the health plan and large provider groups seeking quality improvements.

THOUGHTS ON APPLYING LESSONS LEARNED

The experience and findings collected in this report echo an article by John Meerschaert¹², which suggests that in designing a physician incentive strategy, organizations should pursue the following advice:

- Identify minimum quality standards.
- Strike a balance between simplicity and rigor.
- Focus on a limited set of quality measures.
- Make a direct connection between physicians' daily actions and resulting reimbursement.
- Offer bonuses for providers with above-average quality rankings; consider graduated bonuses for higher levels of performance.
- Make the quality component of an individual physician's compensation meaningful.
- Develop and implement suitable quality measures for different provider types.
- Ensure adequate information systems and provider reporting capabilities.

Purchasers and their health care contractors can complement an incentive strategy with a variety of quality improvement activities. For example, some health plan executives suggested interviewing high performers to understand best practices and showcasing best practices at physician meetings and to advisory boards. Similarly, one focus group participant recommended that the medical leadership conduct peer meetings and individual meetings with low-performing physicians to obtain buy-in for quality improvement efforts.

In addition, participants in our study offered the following recommendations for purchasers and their health care contractors developing financial incentives to improve quality of care:

- Link financial incentives to physician performance, but recalibrate performance thresholds over time to keep provider interest and attention.
- Be aware of tradeoffs physicians may make if you are using large financial incentives targeted to a few performance targets, i.e., “what else is not getting done?”
- Do not let poorly performing or outlier physicians drive the organization to create financial penalties that could be interpreted as punishing all physicians.
- Create financial incentives for physicians to attend clinical discussions of quality improvement efforts and, by doing so, recognize their time constraints and opportunity costs.

Incentives provide leverage for creating an environment in which continuous quality improvement thrives. Purchasers should work collaboratively with health plans and physicians to structure and align financial and non-financial incentives so that providing quality care is recognized and rewarded.



¹² Meerschaert, John D. ASA, MAAA, “Uniting Quality and Health Care With Quality-based Reimbursement,” *MGM Journal*, September/October 1999: pp. 8- 12.





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