

Compensation for Quality: The Next Inevitable Step

Medical Groups Respond to Provider Payment Reform

BY ALICE G. GOSFIELD, J.D.

The advent of pay for performance (P4P) is only one manifestation of increased demands by policy-makers, regulators, and the market for improved quality performance among physicians. To date, the results of P4P programs are equivocal.¹ We don't know the extent to which we are getting the same quality of care we were getting before, even though now we measure it and pay for it; or if physicians are actually changing their behavior in response to the P4P incentives.² We do know that those who were doing well before continue to do well, but we don't know if the bottom of the class is actually moving up.³ Often, this is because many of the programs never established a baseline when they launched their P4P programs.⁴

Another factor that may be contributing to the lack of robust results is that so far, P4P programs are incremental in their scope, sitting on top of payment systems in which the fundamental incentives are inconsistent with quality goals. Fee for service rewards overuse, and capitation rewards underuse. If either was capable of producing the quality we desire, P4P would never have arisen.

Against this background, one is led, inevitably, to ask whether the limited results from P4P also are tied to our uncertainty about what happens to the P4P money when it gets to physician groups. Do individual physicians realize personally the economic effect of their performance? This question leads to the broader

one of whether physician groups pay their physicians differentially based on quality performance. This article offers a brief description of traditional compensation approaches and then offers examples from medical groups of compensation models that have a quality performance component. The examples were obtained from a simple e-mail survey sent by the American Medical Group Association (AMGA) to the chief executive officers of its member groups. Looking at the new forms of provider payment reform on the horizon, the article addresses inevitable and necessary responses.

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Traditional Compensation Formulas

In order to understand the degree of movement and the scope of the efforts of medical groups reported here, it is useful to reflect upon traditional approaches to compensation, which rarely and barely recognize quality as a component of compensation to an individual physician. Typically there are two fundamental forms of payment: per capita compensation, and payment that takes into account productivity. Some groups still pay per-capita-

equal amounts. This is far more typical in single-specialty groups. Multispecialty groups, by definition, incorporate physicians with widely varying resource-consumption profiles. High-technology specialties draw far more on the resources of the group in terms of technology, supplies, and support staff, than specialties that are predominantly cognitive or visit-based. On the other hand, physicians who render a substantial portion of their services in the hospital present a different expense profile than those whose practices are office-based.

Most multispecialty groups use some base compensation modified by measures of productivity. How expenses are allocated plays into the ultimate compensation received, but approaches to expense calculation are not the critical issue for our consideration here. Productivity, a way to capture work effort, can be measured in many ways, including gross revenues, net revenues, and RVUs. To reward physicians who engage in administrative work for the group, work at the hospital, or conduct research, modifications to the basic formulas are often adopted.

In today's world, it is hard to imagine any group succeeding with a purely quality-driven compensation model because the payment systems providing the revenues distributed as compensation are disconnected from quality. Capitation rewards under-service. Since the group gets paid whether anyone uses its services or not, the lower the expenditure

of time and resources in delivering care, the greater the group's financial margins. The group gets paid only the fixed capitation amount, regardless of the clinical complexity of the patients treated or the quality of care provided. Productivity measures in capitation models sometimes take into account patient panel size, but most commentators agree this is not a useful measure of work. On the other hand, fee for service pays more money for more services rendered, regardless of the appropriateness or outcome of the services. This model is the predicate for the RVU approach to measuring productivity, since higher RVUs yield more revenues. Neither of these payment models measures or rewards quality performance.

In light of today's quality-discordant payment systems, it is noteworthy that physician groups that seek to deliver better care to their patients have used—some for a relatively long period of time (8-10 years)—compensation methods that explicitly pay their physicians for their performance related to measures of quality.

What Do We Know?

To take a snapshot of the phenomenon of groups compensating physicians, at least in part, on quality performance, in the fall of 2007, the AMGA distributed a simple, 7-question e-mail survey, authored by myself. The survey was sent to the CEOs of its 345 member groups, and responses were received from 14 groups. The answers are neither scientific, nor statistically valid, nor likely representative of the totality of groups that engage in these efforts. Because of variability in the responses, in some instances the information is not even comparable. Some respondents answered all questions and others didn't. That said, the answers tend to fall into three groups characterized by the longevity of their pay-for-quality program. Longevity also tracks to the amount of compensation at risk

for quality performance. The longer the history of the program, the greater is the proportion of compensation that turns on quality. Groups become more comfortable with tying compensation to quality measures over time.

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Variations

Almost all of the programs put between 5 percent and 10 percent of the physician's compensation at risk for quality performance, although two groups base 15 percent of compensation on quality and one is moving as high as 20 percent. At least three of the respondents had just begun their programs, and several have revamped earlier programs with refinements.

The simplest form of quality compensation is a year-end bonus stipend of up to \$5,000, determined at the discretion of the board based on its assessment of participation in quality programs within the group. One group (PriMed) sets aside 3 percent of its revenues as a bonus pool to allocate based upon adherence to process standards for treatment of hypertension. The program began in 2004 with no payment impact and simply reminded physicians of the standards; it progressed in 2005 to posting scores for the whole group; and now it has 5 percent at risk based on meeting the standards, yielding a potential per physician bonus up to \$10,000. Integrated Health Associates (IHA) pays stipends of \$1,000 to divisional top performers based on satisfaction surveys, and has recently added individual performance bonuses of \$125 per physician with appropriate satisfaction scores. Healthcare Partners Medical Group in California bases part of its compensation on the same

metrics applied by payors in the Integrated Healthcare Association P4P program.

MedStar Physician Partners is an example of a longer-standing program with broader metrics, including HEDIS measures and guidelines compliance. Allina Medical Clinic has for three years paid their physicians in part based on quality measures, focusing on diabetes care and depression management. For about six years, Camino Medical Group has used a single, blended score based on peer review data and patient satisfaction scores.

Based on those scores, physicians are tiered, and top performers are awarded stipends of \$1,000-\$3,000. The Billings Clinic, with program duration varying from six years to just a year, has let its specialty divisions develop their own measures of quality for 5 percent to 10 percent of physicians' compensation. The Duluth Clinic also has used, over six years, section-specific metrics based on achievement of section service, clinical, and operational excellence goals. The distributions, which are explicitly distinguished from bonuses, are based on team metrics, since leadership and culture are the primary drivers of the organizational processes, with compensation serving as support. Partners Community HealthCare has used quality compensation in small measure since P4P arrived in Boston. However, the organization is no longer paid a bonus, per se; rather, plans withhold part of their payment to be released only if agreed-upon performance targets are met. The physicians are measured in accordance with the metrics in the P4P programs, although some of their payment hinges on the use of infrastructure (CPOE) rather than on pure quality performance.

The oldest reported programs were at the Everett Clinic, Sutter Medical Group, Geisinger Health System, and HealthPartners in Minneapolis. At the Everett Clinic,

quality compensation is based on the percentage of unique registry patients who are up-to-date for needed services. Primary care physicians (PCPs) can earn up to \$15,000 for their performance. Everett has begun rewarding specialists with smaller stipends of \$1,500. The Sutter Medical Group began its quality compensation program eight years ago with 10 percent of salary for PCPs at risk based on factors including patient satisfaction, HEDIS measures, meeting attendance, and use of electronic infrastructure (e.g., EMR, CPOE). The group has increased the percentage at risk to 15 percent for the 2007-2008 compensation year.

Geisinger's program has been in effect for seven years. The base salary reflects expected productivity. Incentive compensation is between 10 percent and 20 percent of the physicians' compensation, and 35 percent of incentive payment is now based on quality measures. In 2005, an article⁵ in this publication reported the organization's success with the program. Today even more compensation is at risk for quality and results are even better in terms of both quality measures and productivity of physicians than what was reported in 2005.

HealthPartners had the oldest program to report, going back to 1994 for primary care physicians. Over time, measures have become increasingly outcome-focused, with approximately 15 percent of the physicians' compensation at risk based on quality measures, and the group is moving toward 20 percent.

Lessons Learned

All respondents reported common lessons learned. The groups with longer-running programs report their quality performance has indisputably improved. They do not attribute the improvement to the compensation model, per se, because in the systems reported on here, the compensation model was not the only quality initiative, but was part

of broader strategic measures to improve quality.

From the longstanding struggle for payment reform, new models are emerging.

All respondents reported that programs were rolled out gradually with considerable education and measurement preceding a link to payment. Transparency of results within the group was cited more than a few times as a contributor to improved performance. Some groups claimed better results with fewer measures. Some have found that specialty/division/section-specific programs work better. All have some measure of productivity at their base to assure a revenue stream, but how they handle the set-aside for the bonus pools varies.

What Do New Payment Models Reward?

From the longstanding struggle for payment reform, new models are emerging. The Medical Home and Advanced Medical Home have been proposed to reward primary care physicians for maintaining and utilizing infrastructure and processes to coordinate care, using evidence-based guidelines with measuring and reporting of performance.⁶

Another proposal, the PROMETHEUS Payment[®] model, was recently awarded a \$6 million grant from the Robert Wood Johnson Foundation to pilot its approach in four markets. It is based on case rates generated by science-based clinical practice guidelines for specific conditions, risk-adjusted to accommodate co-morbid conditions. In this model, physicians do not win on throughput, RVUs, large panels, or secret, lowest price schemes.⁷ The program rewards those who score well based on whether they delivered the salient elements of the clinical practice guideline (CPG) which provides the basis for the case rate for all providers treating a specific

patient, the patient's experience of care, outcomes, and the efficiency in delivering care. Because 70 percent of the score is based on what the provider does and 30 percent on what everyone else does for the patient, clinical collaboration, even among otherwise independent providers, is rewarded. The PROMETHEUS Payment model is designed to encourage what providers should be doing anyway, even in the absence of payment reform.⁸

Conclusion

Traditional compensation models within groups reflect existing payment systems that generate revenues. It is the effect of those systems that has led to calls for both enhanced quality and payment reform. Groups that have made a strategic commitment to significantly improve the quality of patient care have begun to use individual physician compensation to support and propel their efforts. As new payment systems evolve, traditional compensation approaches will be far less relevant—and that is the point. As the system moves to support the process results we want, physician groups will have to consider how to move to an individual compensation model that will better support their overall goals for quality.

Editor's Note: This article is based on work described in a broader and deeper examination of these issues, including contract issues and Stark; see A. Gosfield. 2008 *Physician Compensation for Quality: Behind the Green Door in Health Law Handbook*, Gosfield ed. (2008 Edition). Eagan, MN: West, A Thomson Company. <http://gosfield.com/PDF/gosfield.2008%20HLH.articlewithcoverpage.122807.pdf>.

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Tell Your Story

Does your group have its own approach to paying physicians for quality? To aid in compiling meaningful data to research on this topic, contact the author at the address below:

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