Using Physician Payment Reform to Enhance Health System Performance

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The U.S. health care system performs poorly on many key objectives. Services are overused, underused, and misused (McGlynn et al. 2003). Per capita spending varies widely across geographical areas in ways unrelated to need or quality (Wennberg and Fisher 2006; Fisher et al. 2003; Gold 2004). Although our nation expends more per capita on health care than any other country in the world, its outcomes are worse on many measures, health insurance coverage is spotty and unstable, and equity remains a concern (Davis et al. 2007).

One strategy to address these concerns involves reforming the system used to pay physicians, who are central to care delivery and drive a large share of national health expenditures. By design, financial incentives in a payment system will influence what physicians do, and will affect resource use and distribution. If we are not getting what we want from the health care system, changing payment methods can help align physician performance with broader goals for the system.

Well-designed changes in physician payment incentives can drive system change because physicians play a major role in determining use, content, and costs of services that others provide, including laboratory and radiology tests, hospitalizations, home health and skilled nursing care, and drugs and medical devices (see figure on page 2).

This brief builds on what we know and what we think we know about using physician payment to improve health system performance, suggesting that future priorities move beyond pay for performance of individual services and reward physicians for influencing totality of a patient’s care across all providers and settings. The goal of the brief is to help public and private sector leaders think about and set priorities for future physician payment reform.

Improving the payment system used to compensate and reward physicians will enhance the performance of our nation’s health care system. But attempts to improve the system must address the following operational constraints: (1) fragmented medical practices, (2) payments that reward volume and procedures, (3) erosion in incentives for providing primary care, (4) narrow and limited performance measures, and (5) factors other than financial incentives that influence physician behavior.

Research on physician pay-for-performance (P4P) to date has yielded valuable insights:

- First-generation physician P4P has produced marginal gains at best.
- The design of incentive programs is important and has influenced outcomes.
- Limited infrastructure in smaller practices providing a high proportion of care systemwide has limited P4P’s effectiveness.
- The structure of basic payment incentives has curbed P4P’s effectiveness.
- Physician support is critical to success.

In the future, attention must be paid to (1) moving beyond P4P for individual services to reward physicians for influencing totality of a patient’s care; (2) factoring in equity considerations; (3) enhancing the role of primary care and care coordination; (4) aligning incentives across providers; and (5) promoting “value” while recognizing the tensions associated with decisions about how to use limited resources.
Defining Desired Performance

Before physician payments are changed to enhance the performance of our health care system, it is important to articulate what good performance means. In its influential report on the health care “quality chasm,” the Institute of Medicine conceptualizes quality as a property of the health care system and calls for a safe, effective, patient-centered, timely, efficient, and equitable system (IOM 2001). Similar thinking underlies the Commonwealth Fund’s definition of a high performing system (Commonwealth Fund Commission 2007). Recently, the National Priorities Partnership (2008)—a collaboration of 28 major national public and private organizations convened by the National Quality Forum—identified six areas for immediate attention: (1) engaging patients and families in their care; (2) improving population health; (3) improving safety and reliability of the health care system; (4) ensuring coordination of care within and across organizations, settings, and levels of care; (5) guaranteeing appropriate and compassionate end-of-life care; and (6) eliminating overuse of services and delivering appropriate care.

If these concepts of quality reflect what we seek in our nation’s health care system, enhancing system performance will require more than upgrading how well individual services are performed and each provider behaves. Merely improving individual services can perpetuate care discontinuities, redundancy, and conflicting treatments that raise costs and lower quality and outcomes. Although there is debate over how to balance quality and cost to provide optimal financial incentives, they are intrinsically connected in a way that is fundamental to the desired, yet ill-defined, “value” in our health care system.
Operational Realities

**Fragmented Medical Practices.** Although physician practices are becoming more consolidated, they remain relatively fragmented. The number of physicians in solo and two-physician practices has declined, but a third of all physicians still practiced in such settings in 2004-2005 (Liebhaber and Grossman 2007). Large multi-specialty groups dominate markets such as California and the upper Midwest, but movement toward these forms of practice has slowed. More physicians now practice together in midsized multi-specialty groups, and more physicians operate in institutional or large group settings (Tu and Ginsburg 2006). While policymakers debate the importance of practice consolidation, communication is more complex when providers practice independently.

Practice setting affects not only the way physicians operate but also the potential influence of financial incentives. Integrating quality improvement tools—such as electronic medical records, registries, and care managers—into small physician practices is challenging. Large group and institutional practices are likely to have both greater access to the capital required for technology investments and larger patient bases across which to spread the fixed costs. Furthermore, research links scale, cohesion, and affiliation of groups with quality (Tollen 2008).

Diversity in physician practice settings and variation across markets present challenges to changing performance. Shifting payment incentives, while unlikely in the short term, could ultimately alter economics of practice, encouraging larger and redesigned medical practices.

Existing payment systems that differ by physician practice setting also mean the same service may be paid in different ways when billed directly by a physician or included as part of payments to facilities. Medicare, for example, pays physicians using a fee schedule, with updates limited by total physician expenditures for category of service, while hospital outpatient services are paid using prospective payment to facilities (MedPAC 2007a, 2007b). Variability in payments does not necessarily encourage delivery of care in more efficient settings.

**Payment Systems Reward Volume and Procedures.** Physicians are paid in three fundamentally different ways: salary, capitation, and fee-for-service. Each creates its own incentives, with offsetting strengths and weaknesses (Town et al. 2004; Christianson et al. 2007). Paying physicians for each service provided encourages them to be productive by seeing many patients, but it may also promote services—whether needed or not—that are more highly compensated. Although capitation encourages physicians to see more patients, underusing, rather than overusing, services is the concern in this context. Salaried arrangements are volume-neutral but provide few incentives for physicians to be productive and see more patients.

To counter these limitations, supplemental payments can provide offsetting influences, such as productivity incentives for salaried arrangements or quality rewards for capitated physicians. But structuring incentives for individual physicians is complicated by the fact that payment may not be the same at the practice and individual physician levels. For example, in California, where large physician groups are common, 84 percent of group revenue comes from capitation, but most financial risk is retained at the group level (Rosenthal et al. 2002). If individual physicians are capitated, it usually is for only their own services.
Overlaying incentives on basic physician payment systems continues to reward productivity, or volume, over quality and cannot be expected to erase underlying flaws in payment policy.

Although changes in practice settings have made salaried arrangements more common, most physicians today continue to be paid on a fee-for-service basis. In 2004-2005, more than half of all physicians surveyed received no revenue on a capitated or other prepaid basis (CTSonline 2008). Fee schedules and other ways of determining payments for individual physician services have developed in a way that favors payment for procedures and tests over payment for direct physician services (that is, visits, or what Medicare calls “evaluation and management services”). This situation has also resulted in the use of more resource-intensive services (Newhouse 2005-2006). Over time, inequities have grown, with physician fees in both the public and private sectors increasingly lagging behind general inflation, while volume of services is rising (Tu and Ginsburg 2006).

Growth in use of technology, combined with current payment incentives, has led to a substantial increase in the quantity and mix of services provided (Maxwell et al. 2007). Medicare’s use of a sustainable growth rate has reinforced payment incentives favoring procedures. It has also limited growth in reimbursements for evaluation and management services (MedPAC 2007a, 2008b). Financial pressures from declining incomes have further reinforced these incentives. Studies of a randomly selected group of 12 markets nationwide in 2002-2003 indicate that physicians responded to declining income by increasing volume and revenue-producing services, both within and outside of their practices (Pham et al. 2004; Pham and Ginsburg 2007).

Other misplaced incentives appear in the current payment system. After a review of Medicare payment policy, the Medicare Payment Advisory Commission (MedPAC March 2008b) concluded that current payments result in distorted incentives favoring overuse of some services and underuse of others. To ensure accurate prices, MedPAC recommended addressing overvalued and misvalued services, adequacy of practice expense values, and aspects of the conceptual basis of the relative value schedule (Hackbarth 2007).

Although P4P as recently implemented introduces supplemental incentives into fee-for-service payments, P4P covers a variety of potential arrangements (Christianson et al. 2007). Overlaying incentives on basic physician payment systems continues to reward productivity, or volume, over quality and cannot be expected to erase underlying flaws in payment policy. For example, incentive payments may encourage use of preventive care, but will do so weakly if this care is not covered by insurance or entails substantial cost sharing.

National surveys show little change since 1996-1997 in practice-level incentives for physicians in groups of two or more (Reschovsky and Hadley 2007). Such incentives involve payment beyond the underlying form of payment (for example, fee-for-service). Incentives can be structured positively, in the form of bonuses, or negatively in the form of withholding. In 2004-2005, 70 percent of physicians had some incentives tied to productivity; in contrast, 20 percent had incentives tied to quality, almost always in addition to those for productivity. Quality incentives were much more common in primary care than specialty care and in large group and institutional practices. Incentives were also three times as likely in practices receiving a substantial part—that is, 20 percent or more—of their revenue from capitation. They also were more likely in group/staff HMOs. These findings are consistent with other studies showing a relatively strong emphasis on fee-for-service payment. They also suggest that the penetration of P4P efforts to date has been relatively localized and on a small scale nationally.
Eroding Incentives for Primary Care. The income gap between primary and specialty physicians is widening—recent surveys show that median income has increased much more slowly for primary care physicians than for specialists. Furthermore, fewer doctors in training aspire to practice primary care (Bodenheimer et al. 2007). Generalists practicing family medicine, general internal medicine, and general pediatrics provide half of all ambulatory care visits, but the number of recent graduates in these areas is declining. In addition, future supply may not be adequate to meet the needs of an aging population (Colwill et al. 2008). These concerns led MedPAC to recommend efforts to promote primary care, including enhanced, budget-neutral payments for a subset of evaluation and management services that constitute primary care, a medical home pilot demonstration, and Medicare subsidies for teaching hospitals to promote primary care (MedPAC 2008a).

Limits of Existing Physician Performance Measures. The American Medical Association, Centers for Medicare & Medicaid Services, National Committee for Quality Assurance, National Quality Forum, and others have led the way in encouraging development of accepted measures of physician performance (NQF 2007; Physician Consortium for Performance Improvement 2008). Available measures have moved beyond prevention and primary care, but most still center on underuse of recommended services. There is a dearth of measures capturing overuse, efficiency, care coordination, and outcomes of care, though many are actively working on ways to overcome these gaps.

In addition, existing measures focus on what individual physicians or practices do, rather than how effectively the system as a whole performs in meeting patient needs (IOM 2006). However, effective ways of measuring these dimensions of performance remain under study, and concerns exist about how to handle accountability for outcomes that span multiple providers and types of care. There also are tensions over the statistical feasibility of attributing care to individual physicians and identifying levels of aggregation that best reflect accountability for outcomes.

There’s More to It Than Money. Although economists focus on financial incentives, research in other disciplines highlights the diverse forces that influence physician behavior. Physician practice involves decision making under uncertain conditions, in which patients, illnesses, and outcomes vary (Town et al. 2004). In recommending treatment, physicians take risk into account and aim for “regret avoidance.” They may react differently to positive and negative incentives, as well as to the way in which a given incentive is structured. Professional norms influence physician performance. Behavior is also shaped by competitive forces operating implicitly or explicitly in a practice group, depending on its interdependence and the nature of ownership. The fact that physicians typically provide services for multiple payers, using a variety of arrangements, also limits their response to incentives. For example, a California P4P program failed to engage physicians in responding to incentives, in part because of the multiple, uncoordinated health plan interventions and communications that they faced daily (Teleki et al. 2006).
Lessons from Experience

First-Generation P4P Yields Marginal Effects. Recent efforts at P4P typically overlay performance incentives on an existing, basic form of payment to providers. Physicians may receive a bonus over and above their regular payment if they improve care on specified measures. They also may be rewarded for using certain tools, such as registries, that improve care. While P4P is considered an innovation, it is similar to the incentives used historically to reward physician practice, especially in HMOs (Reshovsky and Hadley 2007; Gold et al. 1995; Gold 1999; Christianson et al. 2007).

Few studies have included a rigorous evaluation of P4P, and most studies conducted to date focus on early efforts. In a review of published, peer-reviewed empirical studies of paying for quality in health care, Rosenthal and Frank (2006) found six that met minimal quality criteria. Five involved narrowly targeted measures centering on individual physicians. Only two studies found positive results, and these were not the studies with the strongest designs. A 2003 review of P4P found 37 separate incentive plans involving 31 payers, most related to physicians (Rosenthal et al. 2004). In a 2006 followup, most programs were still in place, with early adopters expanding the number of measures, pool of money available, and sophistication of measurement (Rosenthal et al. 2007). However, few programs had been evaluated; their support was sustained by belief rather than evidence. Authors concluded that existing P4P studies tend to have limitations, although improvements typically have occurred in at least one measure of quality (usually based on HEDIS measures).

Recently, a study of 79 physician groups in Massachusetts found that practices with a P4P incentive for a measure were more likely to have taken a specific quality improvement action to improve on that measure (Mehrotra et al. 2007). But the incentive and its association with improvement were modest; most physician group leaders said that incentives of 5 percent of revenue or more would be necessary to increase emphasis on quality improvement. Groups with salaried employees and larger groups were more likely to have taken these actions than groups with other payment arrangements and smaller groups. Massachusetts also reports physician group-level quality measures publicly, so the study findings likely reflect a combination of the modest financial incentive (average of 2.2 percent of revenue) and concern about public reaction.

Design and Implementation Strategy Matter. The structure of an incentive system will influence the outcomes most likely to be achieved. System designers need to think through what performance goals they seek to realize and construct features consistent with these goals. The box summarizes lessons from key design and implementation issues and approaches that may facilitate or impede success.
### Lessons from Experience with Physician P4P

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<th>Lessons Learned</th>
<th>Facilitators</th>
<th>Barriers</th>
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<td><strong>Match terms of payment to desired outcomes.</strong></td>
<td>Identify who P4P rewards in terms of performance by comparing (1) against peers, (2) against absolute performance targets, or (3) against prior performance (Trude et al. 2006). The first option rewards high performers, the second pays only for desired performance, and the third pays for improvements. Those rewarded will differ under each scenario, so think through application and match measurement to goals.</td>
<td>Rewarding improvements has conceptual merit but is used less than other approaches because improvements take time and data lag. Rewarding high achievers may give most money to those already performing well at the start, providing limited incentive for improvements (Rosenthal et al. 2005).</td>
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<td><strong>Use a broad and balanced set of measures.</strong></td>
<td>Physicians are likely to give priority to performance improvements that are measured (Young et al. 2007c). Early adopters of P4P have broadened and diversified measures they use (Rosenthal 2007).* Selecting measures that provide the right incentives can avoid narrow efforts and promote broad quality improvement (Epstein et al. 2004). Mature incentive programs measure both quality and cost and recognize connections between the two to address clinical and purchaser concerns (Rosenthal et al. 2007).</td>
<td>There may be a limit to the number of measures—and areas for improvement—that can be accommodated (Town et al. 2004; Christianson et al. 2007).</td>
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<td><strong>Anticipate physician reaction and work for trust.</strong></td>
<td>Using accepted performance standards that physicians see as important will increase support (Felt-Lisk et al. 2007). Physician support is important; measurement issues include risk adjustment, using measures that reflect sufficient physician volume and accountability (medical home), and acknowledging role of patient compliance in performance (Christianson et al. 2007).</td>
<td>Patients and physicians distrust incentives they think will lead to less care (Gallagher et al. 2001; Epstein et al. 2004).</td>
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<td><strong>Incentive size is important.</strong></td>
<td>Programs that cover a large share of a practice are more likely to draw provider attention and be significant, and often involve large payers and coalition efforts (Rosenthal et al. 2004).</td>
<td>The small size of many current incentives is one reason for their limited effects (Rosenthal et al. 2005; Rosenthal et al. 2004; Felt-Lisk et al. 2007). Physicians think that P4P means “a little more money and a lot more work” (Bodenheimer et al. 2005).</td>
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Lessons from Experience with Physician P4P (continued)

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<td>Information infrastructure will influence effectiveness.</td>
<td>To address constraints information infrastructure imposes on ability to generate P4P measures, some initiatives go beyond performance incentives. For example, CMS demonstrations and other P4P programs pair quality performance incentives with incentives for practices to use electronic medical records. In Bridges for Excellence, physician offices can receive a bonus of up to $50 per patient for systems like registries and following up with at-risk people (Epstein and Hammel 2004).</td>
<td>Pending widespread system improvements, limitations in information system infrastructure detract from the effectiveness of P4P. For example, they were a major barrier to achieving performance goals in the Rewarding Results demonstrations (Young et al. 2007c).</td>
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<td>The feasibility of P4P varies across markets and practice settings.</td>
<td>Potential is greater where large groups and integrated delivery systems exist since they have more resources to support infrastructure for quality measurement and improvement (Mehrotra et al. 2007). Substantial variation exists across markets in physician practice; available information infrastructure; relative leverage of physicians, hospitals, and health plans; and willingness of providers to participate and employers to exert influence (Trude et al. 2006). Even within markets, perspectives on care management and quality improvement likely to differ across types of practices (Rittenhouse et al. 2004).</td>
<td>Providers’ willingness to participate or employers’ motivation to help improve health information technology varies across markets (Trude et al. 2006). Solo physicians or small groups may not have sufficient scale or patient volume to support valid measurement, except for preventive services and/or the most common chronic conditions (Bodenheimer et al. 2005; Rosenthal et al. 2006).</td>
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<td>Physician engagement is critical.</td>
<td>Surveys of primary care physicians in Massachusetts and California (where P4P is most advanced) found many reacted positively to the concept of payments based on quality but lacked understanding of features affecting them (Young et al. 2007b). In a 2005 national survey of general internists, Casalino et al. (2007a) found strong support for P4P but concern about accuracy of measures and possible unintended effects if physicians avoid high-risk patients or fail to improve in important but unmeasured areas.</td>
<td>Providers’ lack of engagement has been a major barrier to the success of P4P (Rosenthal et al. 2007).</td>
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In California’s Integrated Healthcare Association program, for example, member health plans pay physician groups based on a consolidated scorecard that includes clinical measures, patient ratings, and use of information technology. Measures for efficiency and care coordination recently have been added (Epstein et al. 2004).

Source: Authors’ analysis of relevant studies and analysis reported in the literature.
Attention Required

Key areas for future attention include:

- Moving beyond P4P of individual services to reward physicians for influencing the totality of care
- Factoring in equity considerations
- Enhancing the role of primary care and care coordination
- Aligning incentives across providers
- Prioritizing incentives that promote “value” while recognizing the tensions associated with decisions about resource use

Some efforts in this direction are under way (see table on page 12) but more is needed. Moving forward will require addressing technical challenges, such as developing payment models that effectively align incentives across providers, and financial challenges, such as supporting interoperable electronic medical records. More fundamental challenges involve confronting complex and value-laden issues and trade-offs. How these differences are resolved will determine what incentives are embedded in the health system of the future.

Moving Beyond Individual Services. Health care expenditures are highly concentrated. Chronic conditions and episodes of need drive a disproportionate share of spending and disease burden. To align with overall performance goals, physician performance incentives should account for the range of services patients receive from a variety of providers and encourage physicians to be concerned about performance on measures reflecting the total patient experience, including care they do not provide directly. The IOM’s 2006 report on aligning incentives in Medicare recognized this need. Yet providing incentives of this scope is challenging and potentially controversial.

Moving from fee-for-service to more bundled forms of payment can shift incentives (Schoen et al. 2007; Ginsburg 2008). One such approach involves measures that account for episodes of care for particular conditions. Work is under way on how to attribute care to particular physicians and identify providers accountable for care in an episode (MedPAC 2006). Another approach, global payments that cross multiple providers as well as hospital and nonhospital settings, is more challenging to implement but aligns well with goals involving care coordination and efficiency (Shih et al. 2008).

The Medicare Physician Group Practice demonstration is one effort under way to create broader performance incentives for physicians. It began in 2005 and involves 10 large physician groups that continue to receive regular fee-for-service payments, as well as an annual performance payment based on aggregate Medicare spending for their patients (Kautter et al. 2007). The intent is to encourage coordination across hospital and physician services, invest in administrative structure to enhance efficiency, and reward physicians for improving health care processes and outcomes (see table on page 12).

Features of current practice deter physicians from thinking beyond individual services. HIPPA has many positive features but also limits ability to share clinical information across unaffiliated or loosely affiliated providers. This is particularly problematic for smaller practices facing...
barriers to sharing information or supporting the costs of electronic medical records. The lack of standards for interoperability also limits physicians’ ability to monitor care patients receive and curbs payers’ ability to develop clinically relevant measures of performance.

**Equity and Resource Allocation Considerations.** Patients are not all the same—some are more healthy, medically literate, financially secure, or responsive to physician advice than others. Differences often correlate with socioeconomic variables and make treating disadvantaged patients more difficult. Although enhanced cultural competence can make physicians more effective in treating diverse patients, patient and nonmedical factors beyond their control remain important to health outcomes.

These considerations warrant attention if performance measures are expected to provide incentives consistent with societal perspectives on improving health care (Casalino et al. 2007b). The payment system needs to recognize how patients differ in ways that influence key outcomes. In current physician service-oriented P4P programs, most performance measures relate to process of care and are not “risk-adjusted,” as is common for outcome measures. For example, physicians should be able to encourage all their patients to receive timely preventive services, but payments typically do not factor in differences in the effort a physician might need to exert on patients with the same condition, but considerably different circumstances, to affect outcomes.

Determining how to respond to these concerns creates challenges in designing payment and incentive systems, not the least of which is how to identify patients or physicians that may incur higher costs due to these factors. Existing administrative data often do not support such adjustments. Future testing of adjustments and research on the role socioeconomic factors play in care practices and medical outcomes also warrant consideration if equity is the goal.

**Enhancing Primary Care and Care Coordination.** Current payment incentives diminish the role of primary care, to the detriment of system performance. Adding new performance incentives without addressing this problem will limit success. MedPAC (2007a, 2008b) has recommended modifying the way in which Medicare sets and updates physician payment rates, but more is likely to be needed. Enhanced payment rates, such as those associated with medical home demonstrations, or provider recognition awards, such as those offered by NCQA for care for diabetes, back pain, or heart disease/stroke and used in the Bridges to Excellence program, are basic incentives that could reinforce the importance of primary care and physicians who coordinate care. Modifying the way graduate medical education is financed and shifting the current pattern of income differentials across specialties could also help encourage a workforce well-suited to enhancing physician performance.

**Aligning Incentives Across Providers.** Because so much health care involves physicians, hospitals, or both, better alignment of incentives across these providers could encourage the outcomes desired from a well-performing health system. Studies show that, even in integrated systems, where organizational and financial ties exist between physicians and hospitals, alignment may not occur because conflicting payment incentives, inconsistent policies, and other forces result in limited, competing, or few incentives to promote quality (Budetti et al. 2002). In a national survey, 39 percent of hospital quality improvement directors rated lack of physician interest or involvement as a major barrier to improving their hospitals’ quality performance scores (Laschober 2006). Burns and Muller (2008) suggest that bundled payments, where hospitals
share financial gains from improved performance with physicians, may have potential. But better alignment of economic and clinical incentives may not be possible without changing the infrastructure of practice and the culture of medicine.

**Promoting Value and Acknowledging Tensions.** Current geographical variations in practice and spending show that more care is not necessarily better care; services may be underused, overused, or misused. A key policy goal must involve creating performance and payment incentives that encourage the “right” or most appropriate care and minimize or eliminate unsafe or unnecessary care. Providers should be encouraged to think carefully about using care for which appropriateness is uncertain or unclear.

In response to these concerns, efforts have been made to restructure the debate on performance from one involving trade-offs among cost, access, and quality to one aimed at improving the value of performance in the health system. Focusing on value versus volume of care highlights the importance of the outcomes sought from health care spending. Concern for value provides an impetus for enhanced research on effective treatment and the cost effectiveness of alternative strategies. These studies are important because technology growth has increased health care spending (Ginsburg 2008).

Operational constraints in the health care system impose barriers and technical challenges to using payment system change to spur providers to act. For example, as CMS (2008) considers how to transition Medicare physician payment to focus more on value, it is asking for feedback on how to accommodate different practice arrangements, levels of accountability, and contributions of health care system members in a performance-based payment system. It is also seeking feedback on how to get the data needed for this change without undue burden or cost.

Finally, and perhaps more fundamentally, it is debatable whether a focus on value alone will resolve tensions over resources and priorities for health care spending. Effectiveness research may help to better target resources, but medical practice is likely to continue to involve judgment about how best to apply research on groups of patients to individuals, each with his or her unique needs and characteristics. While some treatments have the potential to generate more returns than others, many have some value, at least marginally, in improving care for individual patients. These circumstances make it challenging to determine how scarce resources should be allocated, what insurance should cover, and how ability to pay should influence access to care. In the face of diversity in values, it is appealing to let the market decide, but it is unclear whether this path will provide an equitable outcome.
### Selected Work by Key Organizations

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<th>Initiative</th>
<th>Key Features</th>
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| **CMS Value-Based Purchasing Demonstrations Related to Physician Services** | *Medicare Care Management Performance (MCMP) Demonstration (July 2007–June 2010).* P4P to nearly 700 enrolled small to medium-sized physician practices in AR, CA, MA, UT. Annual per-patient bonus based on performance on 26 clinical quality measures pertaining to preventive services, diabetes, heart failure, and coronary artery disease, plus bonus for electronic submission of data. (Mathematica is the evaluator.)  
*Electronic Health Records Demonstration (June 2009–May 2015).* P4P and pay for use of EHR functions within a CCHIT-certified EHR, for small to medium-sized physician practices. Randomized design with up to 1,200 treatment and 1,200 control practices across 12 sites. Includes progressive incentives over time, moving from pay-for-reporting to P4P. System use incentive is based on responses to detailed survey; P4P is based on performance on the same 26 clinical quality measures and conditions as the MCMP demonstration. (Mathematica is the evaluator.)  
*Physician Group Practice (PGP) Demonstration (April 2005–March 2009).* Financial incentives in the form of shared savings for improving quality while achieving savings to 10 large multi-specialty groups with strong information infrastructure. By the end of the second year, groups improved quality scores on diabetes measures by an average of 9 percentage points, 11 percentage points for heart failure, and 5 percentage points for coronary artery disease, with 19 of 27 clinical measures improving. Four also achieved savings, receiving a total of $13.8 million in performance payments.  
*Medicare Health Quality Demonstration (five years in length, not yet started).* Next generation of the PGP demonstration. Will evaluate effect of factors such as appropriate use of culturally and ethnically sensitive health care delivery on quality. Defines “health care groups” as regional coalitions, integrated delivery systems, and physician groups; allows groups to incorporate approved alternative payment systems and modifications to Medicare FFS and Medicare Advantage benefit packages. For more, see www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp |
| **CMS Gainsharing Demonstration** | Determining if aligning incentives by allowing physicians to share in savings associated with inpatient stay and period following discharge can improve quality and efficiency. Three-year project began January 2007 with six hospitals. |
| **CMS Work on Resource Use Reports** | CMS Physician and Hospital Resources Use (PHRU) Workgroup is working to support CMS goal of enhancing efficiency through value-based purchasing. Part of this effort involves using Medicare FFS claims and commercial episode grouper products to create resource use reports for individual physicians treating patients with eight high prevalence, high cost conditions. Reports being pilot tested with the goal of considering using a scaled-up version nationally. (Mathematica is the contractor.) |
| **MedPAC Recommendations for Payment Reform and Medical Home** | Payment adjustment on the Medicare physician fee schedule for primary care services. Much larger medical home pilot in Medicare (quadruple the size of the current effort); participants would receive P4P incentives; must include use of health information technology for active clinical decision support, 24-hour patient communication, and rapid access. Pilot test of feasibility of bundled payment for services around hospital episodes for selected conditions, incorporating accountability for quality. |
### Initiative: NQF Frameworks

By developing a definition of coordinated care, NQF hoped to help facilitate measure development. The five domains are:

1. **Health care “home”** that functions as central point for coordinating care around patient’s needs and preferences;
2. **Proactive plan of care and followup**, including goal-setting with patients and joint management of plan of care;
3. **Communication** with all team members, including patients and family;
4. **Information systems**, using standardized, integrated electronic information systems with functionalities essential to care coordination;
5. **Transitions or hand-offs** between settings of care; ensuring these are coordinated and safe.

Will soon release measurement framework for assessing “value” associated with episodes of care for chronic conditions, with funding from the Robert Wood Johnson Foundation and Commonwealth Fund. Working to apply framework to develop more comprehensive measures for diabetes care.

### Initiative: Medical Home Principles, Recognition, Pilots/Demonstrations

Joint principles for a medical home issued in 2007 by the American Academy of Family Physicians, American College of Physicians, American Academy of Pediatrics, and American Osteopathic Association. NCQA operates a patient-centered medical home recognition program built on these principles.

CMS demonstration in all or parts of eight states will provide new reimbursement in the form of a care management fee (about $40 or $50 per beneficiary per month, risk adjusted) for services of a “personal physician.” “Typical” and “enhanced” medical homes are defined and qualify based on the Physician Practice Connections/Patient-Centered Medical Home instrument. Payment period is January 2010 through December 2012.

In the private sector, 32 BCBS companies committed to medical home demonstrations in 2008; pilots sponsored by United Healthgroup, and jointly by Group Health and Health Insurance Plan of New York, also exist. The latter includes randomized design and evaluation.

Many state Medicaid agencies pay a primary care case management fee to a beneficiary’s chosen primary care provider; some efforts have evolved to encompass more functions desired from a medical home.

### Initiative: State Reforms—Minnesota

Legislation calls for a single statewide system of quality-based incentive payments by July 1, 2009, for public and private payers, to include payments for health care (medical) homes.

Legislation requires defining at least seven “baskets” of health care by mid-2009 (cutting across providers) for certain conditions (such as all services needed for knee surgery). Standardized quality measures are to be established; beginning January 2010, providers offering baskets will establish their own prices. Consumers would have ability to compare cost and quality. Bundled payment and transparent quality approach are expected to promote provider innovation around quality.

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References


Mathematica strives to improve public well-being by bringing the highest standards of quality, objectivity, and excellence to bear on the provision of information collection and analysis to our clients.