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Provider Incentive Models for Improving Quality of Care

Bailit Health Purchasing, LLC

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, 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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For more information on the Institute, visit www.nhcpi.net.



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ABOUT THE AUTHOR

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.

EXECUTIVE SUMMARY

PROVIDER QUALITY INCENTIVES ARE AN IMPORTANT COMPONENT OF VALUE-BASED PURCHASING. THEY CREATE A BUSINESS CASE FOR PROVIDERS TO INVEST THEIR TIME AND EFFORT IN HEALTH CARE QUALITY IMPROVEMENT. OVER TIME, THE RESULT SHOULD BE IMPROVED DELIVERY OF HEALTH SERVICES AS WELL AS ENHANCED PATIENT HEALTH AND SATISFACTION WITH CARE.

The National Health Care Purchasing Institute (NHCPI) commissioned Bailit Health Purchasing (BHP), LLC to identify viable provider incentive models that could be applied by commercial insurers, employers, and employer coalitions contracting directly with providers.

Through their research and experience, BHP identified 11 such models. Each of them can be implemented by a wide variety of organizations and applied to a wide range of providers, medical groups, and health plans. The models were based on previously conducted research on quality performance incentives and a series of interviews with insurers, medical groups, medical management consultants, employers, and employer coalitions. The models were then tested in seven focus groups with primary care physicians, medical group practice administrators, hospital executives, insurers, and employer coalitions.

Key components of many of the models described have been put into practice to some extent in one or more health care markets. In other cases, the models have not been tested but reflect the latest thinking about the kinds of incentives that would most likely succeed in improving care.

The 11 incentive models are:

- | | |
|---------------------------------------|---|
| 1. Quality Bonuses | 7. Performance Profiling |
| 2. Compensation at Risk | 8. Publicizing Performance |
| 3. Performance Fee Schedules | 9. Technical Assistance for Quality Improvement |
| 4. Quality Grants | 10. Practice Sanctions |
| 5. Reimbursement for Care Planning | 11. Reducing Administrative Requirements |
| 6. Variable Cost Sharing for Patients | |

Some of the models are based on financial incentives, such as bonuses or increased fee schedules, while others use non-financial ones, such as technical assistance. Both forms of incentive can be effective in motivating providers to improve their performance, as can models that combine the two. An organization's decision about which incentive model to use should take into account the likely viability of the particular incentive model given the relative power structure across stakeholders, the type of providers to whom the incentive would be applied, and the quality measures targeted for improvement.

INCENTIVE MODEL DIMENSIONS

BEFORE IMPLEMENTING AN INCENTIVE MODEL,¹ ORGANIZATIONAL LEADERS MUST ASK THEMSELVES A NUMBER OF KEY QUESTIONS TO DEFINE THE SCOPE OF THEIR PROGRAM AND DETERMINE WHICH MODEL WILL WORK BEST FOR THEIR ORGANIZATION. THE FOLLOWING SEVEN QUESTIONS HIGHLIGHT THE MAJOR ISSUES THAT INSURERS AND EMPLOYERS SHOULD CONSIDER AS THEY BEGIN TO DESIGN THEIR APPROACH.

What level of providers should the incentive model target?

Incentive models can apply to individual physicians, medical groups, independent practice associations, hospitals, physician-hospital organizations, or health plans. In general, quality incentives are more effective if they relate to individual physicians rather than groups or organizations. Organizations may, however, need to base incentives on medical group performance to get sufficient, valid, and actionable data for certain quality improvement efforts.

Organizational leaders should also consider the extent to which different types of providers work collaboratively in the area targeted for improvement. For example, participants in the focus group of hospital representatives emphasized that quality incentives should apply at both the individual physician level and institutional level if they target performance areas where responsibility is shared between physicians and other hospital staff.

What type of group or provider should be targeted?

Incentive models have been most frequently applied to primary care physicians or groups. However, they can also be targeted to specialty or multi-specialty providers or groups, such as obstetricians-gynecologists, cardiologists, and surgeons. In a focus group conducted previously with primary care physicians, the participants recommended creating quality incentives that included nursing staff and, when appropriate, multi-disciplinary care teams, such as those focused on improving the health of patients with diabetes.

What area(s) of performance should be targeted?

Incentive models can address a wide range of clinical, administrative, access, and patient safety measures. Organizations developing incentive models should prioritize potential areas for performance measurement based on those that reflect the greatest opportunities for improvement, those for which there are sufficient data available, and those that are most likely to achieve buy-in from affected providers. Generally, incentive programs tend to be more effective if they target one performance area, or only a few of them, rather than many. Limiting the number of performance areas keeps the incentive model simple and straightforward for providers and the organizations administering the model.

Organizational leaders should also consider selecting the performance areas that providers most directly control. They should avoid areas where provider performance could be confounded by other factors or seek approaches to minimize the impact of such factors. For example, some providers have expressed concern over being evaluated on the basis of their preventive care screening rates because low screening rates may be related to patient non-compliance rather than a provider's actions. Incentive models perceived as penalizing providers for patient behavior may inadvertently create incentives for providers to drop non-compliant patients.

What type(s) of performance measures should an organization select?

Organizational leaders can select among several types of performance measures, including standardized

measures, such as those in the Health Plan Employer Data and Information Set (HEDIS) or the Consumer Assessment of Health Plans (CAHPS), measures they create themselves, or a combination of the two.

Using standardized measures has the advantage of allowing organizational leaders to access performance benchmarks and comparative data from other provider groups. In some cases, however, there are no standardized measures that accurately capture the provider performance that an organization seeks to measure, so organizations may use a combination of standardized and unique measures, or modify standardized measures. In any case, they should link incentives to performance measures based on generally accepted clinical practice. Incentive models tend to be less effective if the measures change radically and frequently.

Should performance targets be quantitative or qualitative?

Organizations may establish quantitative performance targets, such as a goal number of annual eye exams for diabetic patients, or qualitative targets, such as target dates by which providers should complete certain steps in a diabetes quality improvement project. They may also decide that the best approach is one that combines quantitative and qualitative targets.

Organizations that use quantitative targets have the option of using absolute benchmarks of provider performance (e.g., national standards) or relative measures (e.g., providers in the 90th percentile of a specified peer group). Most insurers and providers in the focus groups conducted preferred absolute benchmarks to relative measures.

What method should an organization use to assess performance?

The methodology an organization uses to evaluate performance should be clear and meaningful to providers and other stakeholders. Providers should understand in advance:

- > What aspects of their performance will be evaluated.
- > How performance will be measured.
- > How the links between performance and the incentives are applied.

To assess performance, organizations must often create a methodology for taking various indicators into account. For example, they may develop a composite scoring approach in which providers' performance on a number of measures is weighted and calculated into a single score. The organization links the incentive to the overall score. An alternative methodology relates provider incentives to the number of targets a provider achieves. For example, an organization may assess whether a provider has achieved none of five, three of five, or all of five targets. Similarly, performance could be based on the number of targets a provider has achieved in a given time period.

What is the process for verifying provider performance?

An incentive model should include some mechanism for verifying provider performance. Physicians generally view performance data collected by insurers with skepticism, while insurers similarly question the accuracy of physician self-reported data. Organizations implementing incentive models can choose from a variety of approaches for verifying performance, including:

- > Directly collecting and analyzing data on provider performance.
- > Auditing a sample of data collected by providers.
- > Utilizing performance data audited by other organizations.
- > Using an independent vendor to collect and analyze performance data.

INCENTIVE MODELS

THE FOLLOWING SECTIONS DESCRIBE EACH OF THE 11 MODELS IN DETAIL. THEY ALSO HIGHLIGHT SOME OF THE DESIGN OPTIONS AVAILABLE TO ORGANIZATIONS IN APPLYING THE MODELS AND SUMMARIZE FEEDBACK ON THEM FROM OUR FOCUS GROUPS.² THE MODELS CONSIDERED TO BE THE MOST VIABLE WITH INDIVIDUAL PROVIDERS, MEDICAL GROUPS, AND HOSPITALS ARE HIGHLIGHTED, AS ARE MODELS GEARED TO PATIENTS, WHICH ARE INTENDED TO CREATE AN INDIRECT INCENTIVE FOR PROVIDERS TO IMPROVE THEIR PERFORMANCE.

The first six models include financial incentives and the remaining five describe non-financial ones. Organizations often combine financial and non-financial incentives into a multi-faceted model. For example, an insurer contracting with medical groups may link a financial performance guarantee with a non-financial incentive, such as publicizing medical group performance to improve delivery of preventive care services. Similarly, an organization seeking to increase compliance with clinical practice standards may use performance-based contracting to establish a minimum floor for performance, while at the same time reducing administrative requirements to encourage providers to reach high levels of performance. Competing employers or insurers may also choose to work together to create a series of common or complementary incentives for contracting providers or plans.

FINANCIAL INCENTIVES

Model #1: Quality Bonuses

Under this model, an organization offers providers an annual quality bonus. Providers are guaranteed to receive any applicable bonuses within an established period after performance is measured. Performance is evaluated based on a limited number of quality measures. Baseline performance for the measures is established for the involved providers using agreed upon data sources and methodologies.

The bonus represents at least 5 to 10 percent of a provider's total compensation. Bonuses are calculated by comparing a provider's performance to an absolute

threshold, not by assessing relative performance within a peer group. Bonus levels are determined on the basis of performance; they become gradually higher as performance improves. Providers rated below a minimal performance threshold do not receive any bonus. The target performance rate and the minimum performance needed to obtain a bonus are re-calibrated over time to provide ongoing incentives for improved performance.

Options

- > Bonus is a set dollar amount, rather than a percentage of compensation.

For example, providers receiving a sub-capitation payment from an insurer could receive an extra \$10 per member per month (pmpm) if at least 90 percent of eligible female patients received mammograms in a given time period, or an extra \$5 pmpm if at least 80 percent receive them.

- > The organization offering the bonus establishes a bonus pool.

Under this scenario, a large amount of money is put aside in a bonus pool. Providers who reach established performance thresholds receive bonuses from the pool. The amount of each provider's bonus is dependent on the number of providers qualifying for a bonus in a given year. The distribution of provider performance also affects the bonus amount in models that retain the graduated bonus levels based on multiple performance thresholds. All funds in the bonus pool are paid out each year.

Feedback from focus groups

Physicians and medical groups generally like the bonus model concept, with a few caveats. Some physicians reject the idea of being paid differentially based on performance. They argue that providers should not receive additional financial compensation for meeting quality expectations because, on a philosophical level, all physicians should be expected to provide quality care. Others were skeptical that the bonus truly represented additional income to physicians; instead, they suspected it was simply redirected compensation.

Physicians also questioned the accuracy of using administrative data maintained by insurers to measure provider performance. Finally, most physicians were skeptical about whether insurers could collect enough data on each provider's practice patterns to make meaningful assessments at the individual level. Similarly, insurers and medical groups pointed out that large volumes of individual performance data would be needed to make valid conclusions about significant differences in performance.

When asked whether they would prefer absolute or relative measures of provider performance in this incentive model, physicians chose absolute measures. Providers wanted to have a clear performance goal established at the beginning of the incentive program and not what one participant described as “a moving target that I have no control over.”

Insurers strongly supported the concept of some providers not receiving a quality bonus, noting that if everyone were to get one, it would defeat the purpose of having an incentive program. Insurers also stressed the importance of having graduated bonus levels and re-calibrating the expected performance levels over time to create incentives for continued improvement.

Insurers were concerned that this incentive model may set them up to become victims of their own success.

The more successful the incentive program, the greater the required bonus payments. In addition, if a bonus is linked to increases in preventive care screening visits, the rises in medical costs that occur as a result of program success may not be offset by medical savings in the short term.

Physicians generally view performance data collected by insurers with skepticism, while insurers similarly question the accuracy of physician self-reported data.

Model #2: Compensation at Risk

In this type of program, a portion of a provider's compensation is placed “at risk” based on his or her performance on quality measures. In other words, the organization applying the incentive withholds some of the provider's total compensation — at least 5 to 10 percent — and retains it in an account where interest accrues.

Performance is evaluated based on a limited number of quality measures for which baseline performance has been established. An independent vendor verifies provider performance data and compensation calculations.

Providers receive the maximum additional compensation if they reach all of the identified targets and a portion of it if they partially achieve the targets. Providers rated below a minimally accepted floor of

performance do not receive any withheld compensation. The floor is established in consultation with providers and in light of available baseline data. The target performance rate and the minimum performance floor are re-calibrated over time to provide ongoing incentives for improved performance.

Option

- > Place providers' rate increases at risk based on performance.

For example, if an insurer agrees to a 20 percent rate increase for a physician hospital organization (PHO), the insurer could negotiate to place 15 percent of the additional compensation at risk. Similarly, when confronted with health plan rate increases, employers could consider an incentive model that would make rate increases contingent on the plan's meeting specified performance goals.

not be sufficient data available to implement such a program at the individual provider level. To address some providers' distrust of insurers, we amended this model to require an independent vendor to verify and calculate provider performance.

Model #3: Performance Fee Schedules³

In this model, an organization that directly contracts with providers creates provider fee schedules linked to performance. Local providers' practice patterns are compared with national standards. Based on this comparison, providers are designated to one of three performance levels. For example, highest quality physicians may be paid 115 percent of the Medicare fee schedule, while average quality physicians are paid 100 percent and the lowest performing providers receive 85 percent.

Model #4: Quality Grants

An insurer, employer, or a coalition of these organizations releases a request for proposals (RFP) to physicians, medical groups, hospitals, and PHOs asking them to submit quality improvement (QI) proposals. Providers are instructed to submit proposals for programs that could be completed within 18 months and at a cost below the maximum financial assistance level specified in the RFP.

Provider proposals are evaluated based on pre-identified scoring criteria that gauge their potential to improve performance in targeted QI areas and to be replicated by other providers. Proposals that involve significant capital expenses, such as new information systems, are not considered acceptable.

The organization that releases the RFP offers financial and administrative grant support to the winning providers or groups to pilot QI projects. In exchange for the grant, providers agree to furnish in-kind support to the sponsoring organization, such as dedicated clinical and operational staff time.

Individual physicians and insurers were skeptical that the quality grants model could lead to significant improvements in quality of care.

Feedback from focus groups

Medical groups and providers generally did not find this incentive model appealing due to the downside risk for providers. Insurers liked that the model could be budget neutral, but were skeptical about providers' and medical groups' willingness to accept risk-based compensation. As with the bonus model, some participants raised concern that there would

Providers also submit progress reports and data on an agreed upon time schedule, and present their findings in semi-annual meetings.

Option

A portion of grant funding is made contingent on providers' progress with the QI project.

Organizations offering the QI grants could elect to withhold a portion of the funds (e.g., 15 percent) to be awarded based on the progress of the project over the course of the first year. The remaining funds would be disbursed to providers that have implemented their QI projects in good faith and have met the timelines and expectations originally established for the project.

Feedback from focus groups

This model was a favorite among medical group representatives. However, some of their enthusiasm can be attributed to their belief that providers could receive funding for information systems enhancements and other large capital expenses—which we did not exclude from the initial description of the model. Such expenses were later ruled out in a focus group with insurers, who said that costly new systems would not be replicable to all providers.

Many physicians and insurers believed that the grant model would favor large academic health care organizations with experience responding to RFPs and large medical groups with support staff who could help them develop a proposal. Independent physicians and those in small group practices said they would not have the time or resources to put together a feasible proposal. A few physicians said they would not even know what kind of QI project they would propose.

Individual physicians and insurers were skeptical that this model could lead to significant improvements in quality of care. One physician commented that, “I



doubt this model would be very effective, and it would take money away from other activities that could do more to promote quality.”

Insurers considered the idea of soliciting quality improvement proposals from providers “intellectually stimulating,” but perhaps “too idealistic.” They also viewed the model as administratively difficult and resource-intensive for the organization offering the grant awards. A more optimistic insurer reflected that the grant model could be an effective way to pilot approaches, identify successful QI projects, and then roll them out to the rest of the plan.

Model #5: Reimbursement for Care Planning

In this model, providers receive additional reimbursement for completing care planning tasks for people with chronic conditions, such as diabetes, asthma, congestive heart failure, and high blood pressure. Individual providers receive a small fee (e.g., \$50) for completing an annual health risk assessment or developing an action plan for each patient with a chronic condition. Providers directly

bill the insurer or employer offering the incentive using special codes to obtain the fee-for-service reimbursement. Non-physician providers may assist in developing the care plan and risk assessment as long as doing so is within their scope of practice. Members with chronic conditions are identified through claims data, lists of disease-management program participants, and referrals.

Option

- > Providers are reimbursed for preventive care screens. Physicians receive a small check every year for each member with a chronic condition to whom they provide specific preventive care screenings.

Feedback from focus groups

Some insurers and providers thought that the immediate financial reward for providers, and the direct link between care planning and individual physician behavior, would make this an effective incentive model. Other focus group participants believed that the financial incentive is too small to produce significant behavioral change among providers, particularly if the insurer or purchaser does not represent a substantial portion of a physician's business. Participants also commented that it would be difficult for insurers and providers to accurately identify patients with chronic conditions.

Insurers wondered whether this model might result in providers being reimbursed for care they would have provided anyway. Physicians suggested that the model would be more effective if patients with chronic conditions were also given an incentive for seeking care-management services, such as a gift for scheduling and completing risk-assessment appointments.

Model #6: Variable Cost Sharing for Patients

Insurers or self-insured employers offer insurance products with three-tiered patient deductibles and co-pays for hospital admissions and for medical

office visits (e.g., a \$100, \$500, or \$1,000 deductible for non-emergency hospital admissions, and a \$10, \$25, or \$50 co-pay for medical office visits). The deductibles are determined on the basis of the provider's combined score on clinical quality and patient safety measures, such that patients seeing physicians who score highest have the lowest cost sharing, and those who see the lowest-scoring providers have the highest.

Multiple-tier cost-sharing applies only in non-rural areas where patients have a choice of hospitals and medical offices within a reasonable travel distance. In addition, it is used only for providers for which the insurer or employer has sufficient volume or access to all-payer data to assess performance. Provider performance is based on the most recent two years' worth of data. Performance data are collected and analyzed by an independent vendor acceptable to the insurer and the providers.

Options

- > Organization applies other provider performance measures.

In addition to clinical quality and patient safety measures, organizations could include other performance measures, such as patient satisfaction, administrative services, and cost of care. To retain the quality focus, cost accounts for no more than half of the total performance evaluation.

- > Organization applies tiered deductibles to specific admissions.

Three-tiered cost-sharing is implemented for specific types of high-volume, high-cost admissions.

Feedback from focus groups

Insurers and employer coalitions with the most experience using quality incentives found this model intriguing. Medical groups, individual physicians, and insurers with little experience with incentives

commented that they would find it difficult to administer variable hospital deductibles and co-pays related to provider performance.

Most participants also believed that it would be hard to explain the model to members and providers. Some thought that members would choose the highest-cost providers in the mistaken belief that high cost translated into providers with better, rather than worse, performance track records. One medical director of an insurance company cited an ethical concern with the model. In his view, “The insurer has passed down decision-making to the member, who is not prepared to make these judgments; the insurer is ‘copping out’ on its network responsibilities.”

Participants also questioned whether this model would affect provider referral and admission decisions in a meaningful way. They said that physicians with multiple insurer contracts may not really change their referral patterns unless this model was implemented by a dominant insurer or group of insurers in a market.

Some insurers noted the challenges presented in this model based on the geographic distribution of providers and hospitals and their relative rankings. One insurer questioned whether high-performing medical groups would be able to handle the increased patient volume that would result from implementing the model. Similarly, physicians pointed out that increased patient volume was not an effective incentive for providers with closed patient panels and hospitals operating at capacity.



Providers, insurers, and employers emphasized the importance of profiling as a building block for a wide variety of incentive models.

NON-FINANCIAL INCENTIVES

Model #7: Performance Profiling

Organizations offering this type of incentive have access to performance data for a wide range of providers, such as hospitals, medical groups, individual primary care providers, surgeons, etc. They compile data on each provider, either by collecting it themselves using a standardized approach to assess performance or by accessing it through a database on provider performance measures that is maintained by an independent entity. The performance data may relate to access-to-care measures, clinical quality, patient satisfaction, patient safety, or patient outcomes.

Performance is compared across similar providers, taking into account significant differences in volume and characteristics of patient populations that might affect provider performance. Providers with insufficient volume to support an assessment are excluded from the profile report.

Provider performance is evaluated using both relative and absolute measures of quality. Results of performance comparisons are presented in a graphic format that can be easily understood by providers. The profile reports are designed for physicians, not patients or stakeholders.

Feedback from focus groups

Providers, insurers, and employers emphasized the importance of profiling as a building block for a wide variety of incentive models. The first step in rewarding

good performance is being able to measure and recognize it, they said. Most focus group participants also felt that provider profiles would create an effective provider incentive if they were presented in an understandable format using valid performance data.

Physicians in the focus groups generally liked this incentive model and viewed profiling as a valuable quality improvement tool. Currently, however, most physicians indicated that they do not have access to comparative performance data that they view as meaningful. Physicians and other providers emphasized that performance data would need to be complete, accurate, and timely for this model to work.

Physicians cited problems with the performance profiles that are currently in use, noting that they often receive multiple profile reports, each from a different insurer, on a relatively small number of patients. Physicians recommended that insurers and purchasers collaborate to develop common profiling measures and reports to address the issue of low patient volume. They also noted the problems they have had with interpreting performance data because different insurers use different data sources, methodologies, and formats for profiling performance. In addition, many providers were generally distrustful of data used by insurers to profile providers.

Some insurers recommended that performance profiles show provider performance over time and compared to absolute benchmarks. A few insurers felt that performance profiles should be linked to financial incentives or publicly distributed in order to create a meaningful and lasting provider incentive. Employer coalitions generally believed that information distribution alone was not a sufficiently powerful motivator.

Model #8: Publicizing Performance

In this model, organizations publicly distribute information on provider performance and inform providers of their intent to do so in advance. Potential positive or negative publicity is used to motivate providers to improve performance. The public release of performance information may be through a published report, a press release, a website, an award ceremony, or a combination of efforts.

Organizations develop publicity strategies designed to educate members about variations in provider performance and influence their choice of providers.

In some cases, provider results are made public for a large number of providers, such as all medical groups in a geographic region, whether they perform well or not. In other publicity strategies, organizations may choose only to promote providers identified as having the best practices.

Option

> Performance results are presented at stakeholder meetings.

Organizations can create new public forums to hold providers more accountable for their performance. One option is to have providers make semi-annual or annual presentations on their performance to stakeholders.

Feedback from focus groups

Providers and insurers supported publicizing performance results. As one physician emphasized, “You get the value of peer pressure when performance is publicized, not blinded.” Participants in all focus groups agreed that peer pressure and market forces create strong incentives for providers to improve. The potential to gain or lose patients and market share was particularly powerful in competitive markets and among providers who were not operating at maximum capacity.

Insurers that had experience publicizing performance data for medical groups noted that such groups respond well to this model. Insurers and employers both believed that this approach is even more effective when applied to individual physicians. Both insurers and providers noted that local medical leaders would need to support the model—by endorsing the validity of provider information, for example—in order for it to be effective.

Potential positive or negative publicity is used to motivate providers to improve performance.

Model #9: Technical Assistance for Quality Improvement⁴

The organization using this type of incentive model offers technical assistance to hospitals, medical groups, or individual providers to help them achieve quality improvements. Provider outreach is targeted to high-volume providers that have relatively low performance on selected quality indicators. The organization offering the technical assistance meets with low-performing providers to identify potential reasons for their performance. The organization identifies best clinical or administrative practices among providers’ peer groups, shares examples of best practices, and brokers meetings between low- and high-performing peer groups.

Options

> Organization applies non-clinical quality improvement assistance.

Employers and insurers could offer hospitals and

larger medical groups technical assistance in non-clinical performance areas, such as customer service, information technology, and billing procedures.

> Organization reduces malpractice premiums.

As an incentive for providers to improve, large purchasers or insurers work collaboratively with providers to obtain reductions in malpractice premiums for provider organizations that make demonstrated improvements in patient safety measures.

One physician emphasized,
“You get the value of peer pressure when performance is publicized, not blinded.”

> Organization conducts outreach to members for preventive care services.

Insurers or medical groups use administrative data to identify patients on a primary care provider’s panel who are overdue for preventive care services. The organization offers to assist physicians in conducting outreach to these members via mail or telephone. Outreach activities could target women who need mammograms and Pap smears, children requiring immunizations, diabetic patients overdue for eye exams, or patients with heart disease needing a physical exam, for example. Providers and insurers suggested that this type of technical assistance would be a significant incentive for physicians to increase their outreach to patients overdue for preventive care.

Model #10: Practice Sanctions

In this model, an organization that contracts directly with providers measures provider performance on selected quality indicators annually. After the initial measurement period, the organization establishes a minimum performance level for contracted providers to meet in targeted areas. Providers not meeting the minimum thresholds are required to implement quality improvement initiatives.

If a provider’s performance remains below the minimum threshold in the following year’s measurement, the provider faces sanctions ranging from practice limitations to non-renewal of the contract. All providers below the minimum performance level must meet the performance standard within a specified time (e.g., two years) in order to remain in the network.

Feedback from focus groups

Providers generally found this model to be too punitive, and expressed significant concern over signing contracts that included a minimum performance threshold. As one provider noted, the model is “too much stick and not enough carrot.”

Insurers thought provider sanctions could help create a floor for acceptable performance. However, they weren’t convinced that provider sanctions could have a significant impact on improving quality of care, or at least not within a short period of time. They noted that providers would likely need more than one year to improve their performance before a contract could be terminated. Insurers and employers also questioned whether insurers would truly be willing and able to terminate contracts if providers did not meet the established thresholds.

Model#11: Reducing Administrative Requirements

This model is implemented by an organization with administrative requirements for providers. The organization evaluates the performance of providers on targeted measures. Those who meet a best practice threshold are not required to meet existing administrative requirements. The requirements that are waived relate to the performance being measured, and the waiver remains in effect unless a more recent measurement indicates that the provider's performance has fallen below the best practice threshold.

For example, a dominant insurer could exempt an obstetrician-gynecologist from pre-certification requirements if the physician's performance data demonstrate that the provider practices according to nationally accepted clinical guidelines for hysterectomies. However, if the insurer becomes aware of a potential negative change in the provider's performance on hysterectomy guideline compliance, the insurer reserves the right to reinstate the administrative requirement.



Feedback from focus groups

Most providers and insurers thought this model was a strong incentive. However, a few participants suggested that reducing administrative requirements may be a greater incentive for office staff than for physicians. Some insurers noted that they have already eliminated many of the administrative requirements related to pre-certification and utilization review and wondered what else they could do to ease providers' administrative burden. One hospital executive pointed out that, if administrative requirements could be waived, perhaps they aren't really necessary in the first place.

RESEARCH METHODS

BHP BEGAN WORK ON THIS PROJECT BY REVIEWING THEIR PREVIOUS RESEARCH AND ANALYSIS ON THE APPLICATION OF QUALITY PERFORMANCE INCENTIVES TO PROVIDER CONTRACTING.⁵ THEY CULLED FROM THAT RESEARCH A DESCRIPTIVE LIST OF THE VARIOUS QUALITY INCENTIVE MODELS (FINANCIAL AND NON-FINANCIAL) THAT HAVE BEEN APPLIED TO PROVIDERS AND PROVIDER ORGANIZATIONS. IN ADDITION, THEY USED PRIOR RESEARCH AND PRESS ARTICLES TO GLEAN KEY “LESSONS LEARNED” ON INCENTIVE PROGRAM DESIGN AND IMPLEMENTATION AND TO IDENTIFY ORGANIZATIONS INITIATING NEW QUALITY INCENTIVE APPROACHES WITH PROVIDERS.

To supplement the research, the authors conducted 15 telephone interviews; most were with insurers and large employers or employer coalitions that had used quality incentives in some form. They also interviewed large medical groups that were either known to be using provider incentives or considered likely to be using them, based in part on surveys conducted by the Medical Group Management Association. Finally, they interviewed a few medical management consultants cited in recent articles on physician incentives. Because earlier research depended in significant part on focus groups in two metropolitan areas (Boston and the Twin Cities), this study focused on other areas of the country, including California, the Pacific Northwest, and parts of the Midwest (other than the Twin Cities).

During the interviews, the authors solicited detailed information on specific provider quality incentive models. They asked about the use of financial and non-financial incentives with physicians, medical groups, and hospitals. They also inquired about the type of incentive offered, the quality measures used, the process for establishing performance targets, the amount of financial awards (if any), and the distribution of provider performance results. Interview respondents discussed their experience with incentive models that had been tried in the past and models that are currently operating, as well as models that are in development or under consideration.

The authors synthesized the findings and identified incentive models that appeared to be both independent of one another, and, if not proven to be effective, then at least potentially viable. They defined viability as models that were believed administratively feasible and attractive to providers and insurers/purchasers. In addition to models that have already been tried, the authors described some that had not been tested but appear to have merit based on our experience and judgment.

Having developed a group of incentive models, they then solicited reactions from various stakeholders in seven focus groups:

- > Two focus groups with primary care physicians (Indianapolis and Minneapolis).
- > One focus group with medical group practice administrators (Arlington, VA).
- > One focus group with hospital executives (Philadelphia).
- > Two focus groups with insurer executives (Atlanta and Los Angeles).
- > One focus group with direct contracting employer coalitions (via telephone).

Dr. Richard Hughes of Sixth Man Consulting coordinated the two physician focus groups. Dr. Hughes also co-led the focus group in Indianapolis with BHP staff and independently led the Minneapolis focus group. The physician and insurer focus groups were

split so that one of each would be situated in a market in which quality incentives were in wide use, and one of each would be hosted in a market in which quality incentives were not in wide use. Provider and insurer focus groups took place face-to-face, while the employer coalition focus group was conducted via conference call due to the geographic dispersion of direct contracting employer coalitions.

The purpose of the focus groups was to critically assess the models and determine which were most viable from the perspective of those who might apply them (e.g., insurers) and those who might be subject to them (e.g., physicians). In the focus group with medical group practices, we considered both incentive models that might be applied to a medical group as well as models that the group might apply to contracted physicians.

During each focus group, we discussed four or five different models, soliciting participant reactions to different combinations of incentives and different options within models. For example, with medical groups we asked about incentives that a health plan or purchaser might apply to the group, as well as how the medical group might apply a similar type of incentive to individual physicians.

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Participants' reaction to incentive models, and to specific components of these models, often varied across focus groups. However, there was general consensus among the different groups of purchasers and providers on a number of important aspects. The authors used participants' feedback in those areas to modify their model designs and drop features that were widely perceived as unattractive or not feasible. They designed each incentive model to be an independent building block that could be implemented in isolation or in combination with other compatible models.

INFORMATION ON CURRENT INCENTIVE PROGRAMS

VARIOUS ORGANIZATIONS PARTICIPATING IN QUALITY INCENTIVE PROGRAMS SHARED INFORMATION ABOUT THE TYPES OF INCENTIVES THEY USE, THE PROVIDERS THEIR INCENTIVES TARGET, AND THE INDICATORS THEY USE TO MEASURE QUALITY. THE AUTHORS ALSO EXAMINED HOW SPECIFIC PROGRAMS EVOLVED OVER TIME AND THE EXTENT TO WHICH VARIOUS STAKEHOLDERS VIEWED THE PROGRAMS AS SUCCESSFUL IN IMPROVING QUALITY OF CARE. FINALLY, THEY INQUIRED ABOUT INCENTIVE PROGRAMS DESIGNED TO IMPROVE THE QUALITY OF CARE FOR PATIENTS WITH CHRONIC CONDITIONS AND THOSE TRYING TO QUIT SMOKING.

Organizations using quality incentives often use a multi-faceted approach that combines financial and non-financial provider incentives. Consequently, organizations using quality incentives and researchers studying them often have difficulty quantifying the relative effectiveness of different incentives. Many organizations start by offering one type of incentive and later add another to stimulate continued improvement. Some organizations initially use incentives designed to help providers better understand their performance and how they compare with achievable benchmarks. They may then decide to distribute comparative performance data to stakeholders, members, and other providers to exert market pressure on providers to improve. Numerous focus group participants noted that peer pressure was a powerful means of changing physician behavior.

Prevalence of quality incentives

Quality incentives for providers are primarily implemented by dominant insurers, large employers, and employer coalitions. Consistent with our previous research, we found that quality-based incentives are less common than productivity incentives for providers. Among the medical groups we identified as most likely to be using provider incentives, only a few reported using such incentives for quality improvement.

In a number of markets, there appears to be growing interest in using provider incentives for quality improvement, particularly among insurers and large

public and private purchasers. For example, one large insurer recently increased the level of quality-related bonuses available to large medical groups. The maximum quality bonus is now equal to 10 percent of a group's total capitation. In addition, criteria for determining the amount of the bonus include whether the medical group has an effective system for measuring how individual physicians perform on quality measures, and whether the group offers quality bonuses to high-performing physicians. Previously, the insurer's bonuses for medical groups represented a much smaller percentage of a group's capitation and were primarily based on utilization review and productivity measures.

Types of providers and quality measures

Insurers, employers, and employer coalitions using quality incentives primarily report having models that apply to medical groups, rather than to individual physicians or hospitals. Common types of incentives include bonuses for medical groups and the publication of comparative rankings of medical group performance on a number of quality or patient satisfaction measures. Quality incentive models being used by insurers and employers focus mainly on standardized measures relating to primary care, and, to a lesser extent, on member or patient satisfaction survey results.

A few large insurers and purchasers apply quality incentives to hospitals. The number of organizations initiating or contemplating incentives in this area

appears to be increasing. The Leapfrog Group, a consortium of purchasers, is promoting hospital quality incentives to improve patient safety in three specific areas: 1) having a computerized order entry system for prescriptions; 2) using evidence-based hospital referrals, and 3) having intensive care units staffed by a physician certified in critical care medicine. In addition to measuring provider performance in these areas, some Leapfrog purchasers distribute patient safety information to consumers and reward hospitals with outstanding performance on patient safety.

One large insurer requires hospitals to submit all-payer data on selected quality measures. The insurer provides detailed confidential feedback on comparative performance to each facility and eliminates hospitals scoring below 70 percent from its network. In another example, a large health plan recently tied a multi-year rate increase for a dominant physician hospital organization to a series of quality measures related to hospital and physician performance, including diabetes management and patient safety.

Medical groups using quality incentives with their individual providers include primary care groups, as well as a few cardiology and surgery groups. In general, the incentives used by medical groups appeared to be based on less rigorous measures of quality than incentives applied by insurers or employers. Examples of physician incentive models applied by medical groups include programs based on physician-reported measures of quality, qualitative assessments of physician performance by medical group leadership, and physician's successful completion of tasks related to quality of care.

Incentives related to chronic conditions

In telephone interviews and focus groups, the authors inquired about the use of quality incentive models focused on caring for patients with chronic conditions and on smoking cessation programs. They did not identify many models applied to these areas. The only chronic condition targeted by incentive models mentioned by multiple insurers, purchasers, and a few medical groups was diabetes. A few organizations

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also mentioned provider incentive programs that had at least one quality component related to asthma or coronary heart disease.

A number of respondents indicated that some provider incentive models used for other quality initiatives could potentially be modified to apply to chronic conditions. Respondents were generally less optimistic about the potential for creating meaningful provider incentives targeted to smoking cessation. A few organizations using provider incentives reported considering, but ultimately rejecting, incentives related to smoking cessation. Reasons cited for abandoning models included confounding factors such as patient non-compliance and the limitations of available provider performance measures.

CONCLUSION

PROVIDER INCENTIVES CAN BE AN EFFECTIVE WAY TO IMPROVE HEALTH CARE QUALITY AND DELIVERY, AND ORGANIZATIONS HAVE A RANGE OF VIABLE MODELS FROM WHICH THEY CAN CHOOSE. WHILE FINANCIAL INCENTIVE MODELS MAY BE THE MOST WELL KNOWN TYPE, ORGANIZATIONS SHOULD NOT OVERLOOK NON-FINANCIAL MODELS, PARTICULARLY THOSE THAT LEVERAGE THE POWER OF PEER PRESSURE AMONG PHYSICIANS. ORGANIZATIONS CAN ALSO EFFECTIVELY COMBINE INCENTIVE MODELS TO CREATE STRONGER MOTIVATIONAL FORCES FOR CHANGE.

Through research, interviews, and focus groups, the authors identified characteristics that many viable provider incentive programs share:

- > Performance measures are focused on areas that are priorities for the organization offering the incentive.
- > Incentive approaches are relatively easy to understand and administer.
- > Providers recognize the performance indicators as valid measures of quality that are within their control.
- > Actionable provider performance data are available in the targeted areas.
- > The organization offering the incentive collaborates with providers to obtain and retain buy-in.
- > Stakeholders agree on the source of the data and the methodology for calculating provider performance.
- > Incentives for providers to reach performance targets are challenging but achievable in the established time frame.

- > Incentives are promptly applied and providers receive timely feedback on their performance.
- > Incentive models are evaluated regularly and modified as needed.

Not all provider incentive models are appropriate for all providers or in all health care markets. In a market with relatively little experience with provider incentives or performance profiling, for example, an aggressive risk-based compensation model linked to provider profile results would be difficult to implement. However, such a model may be the next appropriate step in markets that have experience analyzing and publicly reporting on provider performance. Organizational leaders can find the model that works best for them by reflecting on the 11 options outlined in this report and how they might fit with their organization's current structure, needs, and goals.

Endnotes

- 1 The authors define a quality incentive as any mechanism used to influence a change in provider behavior for the purposes of improving quality of care, including rewards for improving care as well as sanctions for poor performance.
- 2 In the focus groups with insurers, hospitals, medical groups, primary care physicians, and employer coalitions, BHP described four or five incentive models to test participants' reactions to different incentives. For discussion purposes, they combined some of the 11 models. They also modified some model descriptions after receiving feedback from focus groups. Two of the 11 models—the Performance Fee model and the Technical Assistance model—were not tested in focus groups.
- 3 BHP did not test this model with the focus groups. This model is based on a physician incentive program currently being implemented by the Central Florida Health Care Coalition.
- 4 BHP did not explicitly test the technical assistance model in the focus groups. Some insurers did discuss the importance of technical assistance as a component of all provider incentive models. A number of employers and insurers currently offer technical assistance to providers, but the assistance is not typically designed as an incentive model.
- 5 Bailit Health Purchasing and Sixth Man Consulting, "The Growing Case for Using Physician Incentives to Improve Health Care Quality," the National Health Care Purchasing Institute, December 2001.



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