

CAN MONEY BUY QUALITY? PHYSICIAN RESPONSE TO PAY FOR PERFORMANCE

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While pay for performance (P4P) has created a nationwide buzz among health plans, physicians and hospitals, most P4P initiatives are still on the drawing board, according to findings from the Center for Studying Health System Change's (HSC) 2005 site visits to 12 nationally representative communities. HSC focused on performance-based payment for physicians, finding that only two HSC communities—Orange County, Calif., and Boston—have significant physician P4P programs. In the other 10 communities, where almost no physicians have received quality-related payments to date, physician attitudes about P4P ranged from skeptical to hostile. P4P, a concept best suited to larger physician groups, may be difficult to implement in markets dominated by small physician practices. In spite of substantial barriers to initiating performance-related payment for physicians, most large health plans and Medicare are planning P4P programs.

Pay for Performance: Lots of Buzz, Little Action

Under existing payment systems, physicians typically receive the same payment regardless of the quality of the care provided to patients. To alter this equation, health plans and employers have embraced the idea of paying for performance. Typically, P4P programs refer to payment arrangements that offer financial rewards to physicians meeting specific goals, such as provision of certain preventive care, patient satisfaction, acquisition of information technology (IT) and cost containment.¹

Only two of HSC's 12 communities—Orange County, Calif., and Boston—have significant P4P programs for physicians (see Data Source). In the other 10 HSC communities, P4P programs targeting physicians are either minimal or nonexistent. Orange County and Boston are early P4P adopters in part because many physicians in these sites are organized into large medical groups, integrated systems or independent practice associations (IPAs). P4P is more difficult to implement in small physi-

cian practices that lack the resources and infrastructure to manage care systematically and track performance data. In all 12 markets, P4P has become a significant topic of discussion among health plan and physician leaders. Thus far, however, in most areas of the country, few performance-based dollars are flowing to physicians.

P4P Approaches Vary

The design of pay-for-performance programs can vary greatly. The following describe the main ways P4P programs are structured:

- Physician organizations pay their individual physicians bonuses for improved quality measures, without health plan involvement.
- Employers pay individual physicians for improved performance. The Bridges to Excellence program, sponsored by a few large employers, has instituted this model

in Boston and three other communities.²

- Individual health plans or Medicare pay individual physicians for improved performance. Physicians are rewarded only for the small number of patients with a particular medical condition who are enrollees of the sponsoring health plan, making these programs of limited interest—and small monetary reward—to physicians.
- Individual health plans or Medicare pay performance bonuses to physician organizations rather than to individual physicians. The physician organization may invest the bonus money in quality enhancement and/or distribute the money to member physicians.
- Health plans band together to coordinate payment to physician organizations for improved performance. This is the model pioneered by California's Integrated Healthcare Association (IHA).³



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Orange County, Calif.: Show Me the Money

In late 2004, major California health plans, in a relatively organized effort, paid physician organizations about \$40 million in performance-based bonuses. The physician organizations received funds for demonstrating improved clinical care (cancer screening, childhood immunizations, management of asthma, diabetes and cholesterol), patient satisfaction, and development of information technology. Physician organizations distributed a substantial amount of the money to individual physicians.

California's effort is led by the Integrated Healthcare Association, representing employers, health plans, health systems and the California Association of Physician Groups.⁴ IHA launched its pay-for-performance program in 2002 with a set of uniform performance measures. Seven health plans and more than 200 physician organizations involving 35,000 physicians participate in the IHA program, which is for HMO enrollees. Plans use the same performance measures but differ in how bonus payments are determined. Separate from the IHA, Blue Shield of California plans to roll out P4P programs for its PPO products in the near future, while Blue Cross of California is piloting a P4P PPO program that it expects to expand statewide over the next year.

IHA measured 2002 baseline data for physician group performance. Payments in 2004 were based on performance in 2003. While there was wide variation among physician organizations, 2003 performance overall improved compared with 2002.⁵ Performance measures can be derived from health plans' claims data or from data gathered by physician group clinical data repositories.

The three largest physician organizations in Orange County received substantial sums in the 2004 P4P payout and distributed a large portion of that money to their physician members. Some individual physicians in these groups received bonuses of \$5,000 to \$10,000. All three organizations had paid their physicians quality-based bonuses prior to the IHA program. The health plan P4P money was added to already-existing bonus pools, often result-

ing in larger bonuses for frontline physicians.

Medical directors are more enthusiastic about P4P than frontline physicians, who become more interested when they see real dollars at stake. Because payments come to medical groups rather than to individual physicians, medical groups have invested some P4P dollars in internal systems to improve performance and data collection, in addition to distributing the money to frontline physicians. One group distributed 50 percent of the money to physicians, while two groups distributed more than what they received in P4P payment to physicians, as new P4P payments were added to existing bonuses derived from other sources. Overall, Orange County shows that to gain physician acceptance, the first P (pay) in P4P is the key to success.

Despite the monetary benefit, physicians continue to have concerns about P4P. A key concern among physician organizations is the addition of quality measures by some plans, above and beyond the standard IHA measures, adding to the reporting burden. Leaders also worry that IHA is adding measures without adding money, increasing the work/reward ratio. Doctors with poor quality scores tend to blame noncompliant patients. Leaders recognize that, thus far, quality improvements reported by IHA are mainly improvements in documentation rather than in care itself.

Many medical leaders and frontline physicians believe that P4P payments are not new dollars, but represent a zero-sum game—a redistribution of existing payments. One respondent believed that health plans would reduce capitation payments to physician groups to allow P4P payouts. One health plan leader agreed that P4P payments represent a redistribution of payments, while another said the payments do represent new money.

A barrier to success is physician mistrust of health-plan-generated performance data. Physician organizations spend large sums to produce their own data, which favors sophisticated groups with clinical IT capability. Moreover, since large physician groups have funds for quality-enhancing processes, P4P could widen a quality gap between larger and smaller physician organizations. Health plan executives affirmed

that the money is going to larger and better-run medical groups and that smaller practices lack the infrastructure to make the program work.

Boston P4P Targets Efficiency

In Boston, the other HSC community with an established P4P environment, the three largest health plans include P4P arrangements in contracts with integrated delivery systems. Plans also have organized P4P programs for physicians practicing in groups and independently.

In contrast to California's IHA, which pays bonuses for improved clinical quality, patient satisfaction and IT development, some Boston health plans also target a portion of P4P money for cost-containment measures, such as percentage of prescriptions that are generic, utilization of expensive imaging services or hospitalization rates. In Boston, P4P payments are calculated from health plan claims data, chart review and provider-based registries or attestations.

While funds in California's IHA program are paid as a bonus on top of HMO capitation payments from health plans to physician organizations, Boston's P4P model includes both HMO and PPO products and the self-insured market. The adoption of pay-for-performance programs accompanied a significant change in physician payment methodology. As the use of capitation—or fixed per-member, per-month payments—to pay Boston physicians declined, performance-based payments became part of a revived fee-for-service reimbursement method. At Blue Cross Blue Cross Blue Shield of Massachusetts, 98 percent of the primary care physicians and over 80 percent of specialists in their managed care network are contracted under a P4P model.

Boston's P4P efforts include both large physician groups and small physician practices. In addition to the P4P activities of the three major health plans, some large employers are paying individual physicians quality-based bonuses under the Bridges to Excellence program.

Frontline physician awareness of P4P is limited; the concept is only beginning to “make its way out of boardrooms into office practices,” according to one respon-

dent. Frontline physicians seem more concerned about the stresses of medical practice than dollars. “Most of the rank and file is so busy trying to keep up with practicing medicine that they are not paying attention,” according to a physician respondent.

A concern of frontline physicians is that P4P means a little more money and a lot more work. Improving performance often involves identifying patients who are not receiving recommended care, such as mammograms or diabetes monitoring tests, and getting them to obtain needed tests.

According to physician leaders, health plan P4P contracts tend to withhold about 10 percent of reimbursement, which then gets paid to the practice if performance targets are met. Their view is that additional money has not entered the reimbursement stream, a view disputed by at least one health plan. Physician leaders worry that the amount of money required to make quality improvements may exceed the performance-based bonuses coming from health plans.

Mirroring the situation in California, small physician practices lack the infrastructure to make and document quality improvements, a situation that could widen the quality gap in favor of large groups.

With P4P in Boston facing the additional barrier of no standardization of performance measures across insurers, the Massachusetts Health Quality Partners coalition is working to unify quality goals. However, physician organization medical directors—who overall embrace P4P—remain concerned about the lack of a unified P4P effort. As one physician leader explained, “You can perhaps get a physician to engage with one program, but once you introduce three programs, you get zero engagement with all three.”

Physicians: Supporters, Skeptics and Resisters

Physicians in the 12 HSC communities are divided among P4P supporters, skeptics—wait-and-seers—and resisters. In several communities, physician leaders are concerned that the amount of money at stake will neither justify extra work for frontline physicians nor cover extra expenses of physician organizations. Physicians often believe that health plans are not putting

additional dollars into P4P, but are taking money from some providers to pay others. P4P opponents may see the programs as “no pay for no performance”—a health plan strategy to pay physicians less.

Some physician leaders are getting ready for health plans in their area to roll out P4P programs. Others are pressuring plans to get P4P going. Yet others refuse to sign health plan contracts with performance-based payment clauses. Physicians in one HSC community complained to their medical society, which forced a health plan to retract its P4P plan. One academic health system objected to P4P, arguing that academic physicians do not need money as an incentive to practice high-quality medicine.

While frontline physician attitudes toward P4P vary widely, many physician leaders find P4P acceptable if all health plans have the same program. The prevailing model of physicians facing different measures and rules from different plans is seen as an untenable option.

P4P: Will It Spread?

While many health plans intend to implement P4P, the barriers, as enumerated by plan executives, are considerable. For each health plan to have its own measures, rules, payment method and payment target (physician groups, individual physicians, primary care physicians, specialists) creates major administrative hassles. In many markets, most physicians do not belong to physician organizations. In those cases, the numbers of patients with a particular condition enrolled in a particular health plan seeing a particular physician are so small that quality measurement is virtually meaningless and payments per physician will be too small to gain physician acceptance and influence practice patterns.

Physician acceptance likely will be determined by the extent to which health plans commit new funds to reward improved quality. In a 2004 report, the American Medical Association echoed physician discomfort, writing that P4P is a “tsunami building offshore in a sea of stakeholder unrest, threatening those who are not prepared.”⁶

P4P has flourished in California



Data Source

Every two years, HSC conducts site visits in 12 nationally representative communities as part of the Community Tracking Study to interview health care leaders about the local health care market and how it has changed. The communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. From January through June 2005, HSC interviewed 30 health plans and 19 physician organizations in the 12 HSC communities about P4P, including discussions with leaders of three health plans and three large physician organizations in Orange County and with leaders of three health plans, two integrated delivery systems and two independent physician organizations in Boston.

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because visionary leaders brought health plans to the table and because California has a history of strong physician organizations, some of which already paid quality bonuses to their physicians. Boston also has a tradition of large physician groups with a focus on quality. These conditions do not exist in most health care markets.

Adoption of P4P will accelerate if mandated by government programs. In early 2005, the Centers for Medicare and Medicaid Services (CMS) launched a P4P demonstration project; 10 physician group practices will receive extra Medicare payments based on quality measures and cost reduction. CMS has expressed support for Congressional efforts to integrate P4P into Medicare physician payments. Should Medicare adopt P4P, private plans and Medicaid programs could well decide to adopt Medicare's measures, which in turn would reduce the problem of lack of standardization. Whether physicians like it or not, if the giant payers decide to put money into P4P, it will happen.

Policy Implications

What do the early observations on physicians' response to P4P tell policy makers? P4P thus far is a program for larger medical groups, and P4P has not yet touched the majority of the nation's medical practices, which have fewer than five physicians.

In at least one area—preventive services for Medicare patients—quality in small practices is inferior to that in larger groups.⁷ To the extent that improved performance requires data repositories, chronic illness registries, and other quality-enhancing innovations, small physician practices will not be able to keep up with larger groups.

A danger lurks that a gap will widen between larger high-quality groups and smaller lower-quality practices. On the other hand, P4P could become a catalyst for physicians to join larger groups that can make the investments necessary to improve performance and reap P4P funds.

Notes

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