

New Strategies for Aligning Physicians With Health System Incentives

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The spread of innovative payment models is driving health systems to engage physicians in providing high-value services. New reimbursement schemes are introducing health system-level incentives aimed at decreasing healthcare spending while improving quality—largely without changing the way individual physicians are paid for daily activities. For example, incentives at the system level are central to the Medicare Shared Savings Program, while individual physicians continue to submit fee-for-service (FFS) claims. The resulting misalignment of incentives at the front lines of patient care may hinder efforts to improve quality and control costs. CMS recently issued its proposed rule for the Medicare Access and CHIP Reauthorization Act of 2015, which will add complexity with a new Merit-Based Incentive Payment System that will adjust physician reimbursement based on quality, cost, clinical practice improvement, and advancing the use of electronic health records (EHRs).¹ The payment adjustments will be made at either the individual clinician or group levels. With increasingly complex, and sometimes opposing, financial incentives facing systems and individual physicians, health systems are tasked with a daunting challenge in creating alignment around value-based care.

Transmitting organizational incentives to individual physicians by using financial approaches, like performance bonuses, and nonfinancial approaches, such as actively managing them, is not a new problem. However, innovative payment models, increased physician employment, and network-affiliation all necessitate reexamination of the optimal approach. In the predominant accountable care organization (ACO) model, where gains and losses are shared equally by all participating physicians, financial gains for individuals may not be large enough to drive a shift from volume to value without complementary motivational strategies.² More stringent alternatives that hold individual physicians financially accountable for the total cost of their own patient panels create substantial risk. Moreover, physician attempts to decrease this risk potentially lead to unintended consequences, such as dumping high-risk patients.³ Although some

degree of risk sharing can provide a middle ground, it is clear that financial incentives alone can drive widely varying—even opposing—effects on practice patterns. Consequently, nonfinancial incentives should figure prominently in creating alignment.⁴

Importantly, the way health systems can meet this challenge is critically dependent on the structure of a health system's physician relationships. For example, systems with loosely connected physicians may not effectively use managerial tactics that systems with employed physicians deploy with great success. In this article, we highlight key issues for health systems in aligning their physicians through incentive programs tailored to the underlying structure of their relationships with other physician. We utilize a simplified framework for system-physician relationships to illustrate design principles from economics and psychology that emphasize nonfinancial elements of job design and contract terms, which can be used to complement financial incentives.

Aligning Physician Incentives With Organizational Models

Typically, 3 relationship structures prevail between physicians and a health system: employment-based with independent, self-governing medical groups and system-hired physicians, frequently part of large medical groups (employment-based); an integrated network of physicians, which may include both employed and independent physicians aligned through quality or clinical integration programs that extend beyond contracting (network-based); or contract-based between the health system and independent physicians, such as independent practice associations (IPAs) (contract-based).

In general, health systems possess more tools to influence care delivered by physicians in direct employment (employment-based) and less tools in contract-based relationships (contract-based). The relationship structure is important because it generally determines the system's ability to influence care delivery. Exceptions exist: for example, several IPAs in California have been successful in risk-based contracting since the 1990s and function more like integrated networks because of investments in

infrastructure and alignment. However, this framework enables a thematic understanding of the types of behavioral and financial incentives that may be most effective within 3 organizational environment archetypes.

Employment-Based Health Systems

In general, employment-based health systems benefit from a managerial relationship with employed physicians that enables extensive use of nonfinancial features in fostering alignment. These factors, which include job design, staffing, standardized processes, norms, and information sharing, become particularly important when organizations pay physicians salaries with little or no role for financial incentives related to productivity, quality, or cost control. Frequent interactions between physicians and leadership make these settings particularly suited to initiatives that create a culture of high-value care. For example, physician compacts can establish norms around mission, values, and organization-specific standards. Managers' personal performance reviews with physicians provide direct accountability and shared plans for improvement on quality and cost metrics.

In addition, changes to system infrastructure, such as implementing evidence-based default care pathways, can be effective in avoiding unintended consequences of salary models (eg, underprovision). For example, The Permanente Medical Group (TPMG) ensures patient access via default scheduling practices to establish appointment lengths and offer more appointments per day than needed for average patient demand, encouraging practice efficiency. Another powerful application of defaults is use in EHR order entry, where standardized order sets and defaults to generic medications dramatically reduce errors, low-value care, and cost. Partners Healthcare, another employment-based system, effectively uses EHRs to track quality and link action directly with feedback by using unblinded dashboards that enable comparisons among physicians.⁵

Network-Based Health Systems

Network-based systems with programs and infrastructure that tie physicians together beyond contracts may rely more heavily on individual financial incentives because structural and cultural alignment is more challenging than in employment-based systems. Financial incentives are most effective when they are sizable, matched to the level of effort required to achieve desired results, and can be delivered through methods that enhance salience. They should also align with physician values to minimize the likelihood of displacing internal physician motivation.³ Group incentives aimed at interdisciplinary teams can be used effectively to supplement individual incentives and promote coordination as both TPMG and Advocate Physician Partners (APP)

TAKE-AWAY POINTS

The use of physician incentives to create alignment with organizational objectives depends critically on the structure of a health system's relationship with its physicians.

- ▶ Explicitly designed nonfinancial incentives are important to being able to modulate the effect of the conflicting incentives that are facing physicians today.
- ▶ Network-based models, such as clinically integrated networks, and employment can effectively utilize nonfinancial incentives to intensify effects of monetary rewards.
- ▶ Employment-based, network-based, and contract-based physicians must have access to performance feedback—not just incentives for quality—to provide high-value care.

have done.⁶ Gain-sharing models, where shared savings or losses are distributed across all participants, work better within formal networks where cohesion among physicians overcomes the incentive to free-ride and administrative infrastructure lowers the costs of teamwork. APP, for example, utilizes a combination of financial incentives at the group and individual levels, including a gain-sharing component to fund the incentive pool.⁵ Limiting metrics to those with significant variation, and matched to gaps in care, avoids information overload in feedback.

Network-based systems may also use complementary nonfinancial strategies. For example, social norming, implemented through unblinded performance-based comparisons among groups of physicians and individual physicians within practices, can improve performance, particularly when financial incentives include a component based on group performance. Payments should track directly with unblinded rankings and employ multiple thresholds to engage lower-performing physicians. Selecting the group of physicians to include in comparisons and shared financial incentives should be deliberate; calibrating incentives and comparisons to peer groups with whom physicians readily identify maximizes the benefits of social competition. It also minimizes the risk of learned helplessness that could develop when comparing physicians with distant colleagues without a shared professional connection.⁷ Other program features may similarly intensify the effects of financial incentives. For example, APP delivers separate checks around tax day in a public ceremony to increase salience and reports unearned dollars to invoke loss framing.⁶

In employment- and network-based systems, the ability to track and report practice patterns on a physician's entire panel can be leveraged in incentive design. For example, availability of EHR data can enable the use of value-based metrics, including in-network emergency department visits, ambulatory-sensitive condition admissions, readmissions, specialist referrals by condition, and postacute care use. In particular, metrics of coordination and integration, such as referral of high-need patients to care management programs and timely postdischarge care, should be emphasized. These measures may be unavailable due to missing data from other providers or unreliable due to inadequate sample size in contract-based systems.

Contract-Based Health Systems

In contract-based systems, financial incentives will have limited effect if they apply only to a small portion of a provider's patient panel, and nonfinancial incentives are difficult to implement due to fragmentation. Thus, providing robust quality profiling may be the only way to empower financial incentives to work and prevent crowd-out of intrinsic and reputational motivation. Quality metric feedback, at the smallest reliable unit (eg, practice site)—including information on patient-reported experiences, access to care, and use of low-value care—should be routinely provided to the extent possible. These groups may benefit from maximizing overlap in pay-for-performance incentives across payers and limit the number of metrics to optimize economic value and salience. Gain-sharing models and total cost of care incentives, while being tested at some IPAs participating in ACO programs, are less likely to succeed because of the high likelihood of free riding without existing robust infrastructure, which is characteristic of some exceptional IPAs. In general, the emphasis should be on providing rich, timely information on value-based care performance and facilitating practice transformation.

CONCLUSIONS

As FFS payment alternatives grow, it is imperative that the “micro incentives” provided to physicians in their daily work are tailored to organizational structure and align consistently with value-based care. Many organizations have not yet taken this step.⁸ Regardless of setting, high-quality feedback on value-based performance can facilitate the effectiveness of financial incentives in improving care. The combination of recent advances in health information technology, analytics, digital technology, and quality measurement make this robust individual feedback possible. Although traditional and behavioral incentive design techniques cannot fix perverse incentives, thoughtful application to financial and nonfinancial incentives can greatly improve the effectiveness of new payment models in achieving organizational objectives and value-based care.

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