Paying for Quality in Integrated Health Systems: Concepts, Empirical Evidence, and Lessons from the Field

Final Project Report to the Industry Advisory Board,
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Executive Summary

Research Questions

This project poses three specific research questions:

(1) What are the effects of financial incentives on the development and implementation of quality improvement initiatives and care management systems in provider organizations (medical group practices and hospitals)?

(2) What are the effects of financial incentives on the adoption of specific care management practices by individual physicians?

(3) Which of the two levels of incentive has the greatest impact on the adoption of quality-related care management practices of individual physicians?

Major Findings

First, both the key informant interviews of hospital senior executives and medical group leaders reveal that financial incentives based on clinical quality and patient satisfaction are at a relatively early stage. The *practice penetration* of quality-based financial incentives is still relatively modest, with approximately 3% of total practice revenues coming from incentive features other than straight fee for service (FFS) or various forms of capitation and less than 3% of the typical primary care physician's total compensation based on any incentive feature (except for individual productivity). Productivity-based incentives are indeed predominant. Our interview data and survey cross-tabulations suggest that there may be a positive association between the use of quality-based financial incentives and the adoption by medical groups of such care management practices as the use of chronic disease registries and systematic assessments of patient health. But these impressions must be validated with larger sample sizes and with analysis of individual physicians' reported use of these evidence-based care management practices and perceptions of their ability to deliver high-quality care.

The available evidence from this study does not imply substantial differences in the implementation of care management practices attributable to organization-level incentives, as compared to incentives applied to individual clinicians. The evidence from other studies, including two recent ones (Escarce et al. 2003; Ettner et al. 2004), suggests that both levels of quality incentives are associated with improved processes of care and that differences associated with both levels of incentive are of roughly comparable magnitude. But more definitive answers will come only from longitudinal, large sample studies capable of distinguishing causation from correlation. Our key informant interview data reveal that *non-financial incentives* based on quality are relatively minimal at this point: neither channeling of enrollees to preferred providers based on clinical quality, nor tiered cost-sharing based on quality (lower co-payment or coinsurance for patients of preferred providers), is prevalent in the study markets. The predominant models of plan payment and individual physician compensation remain productivity and FFS-based.

Using the evidence from this empirical study and the best of the previous literature, we offer a set of *design principles* for quality incentive development and implementation. These principles are intended to assist executives and clinicians as they craft new quality-based contracting arrangements between and within organizations.

Who will use these findings?
The results of this study should be of direct value to medical group and hospital leaders. In particular, the findings of our key informant interviews regarding the significance and particular role of organizational culture, specific aspects of incentive implementation, infrastructure requirements for quality improvement, quality measurement, financial stability, and the place of strategy and organizational structure should be helpful to strategic planning, compensation committees, contracting officers and managed care directors, and to medical and nursing executives involved in the design and implementation of quality improvement and incentive programs.

How will these findings be applied in management and organizations?
We propose that the major lessons of this research are directly applicable to (a) the choice of contracting and payment arrangements between health plans and provider organizations, (b) the design of quality measures and specific forms of incentive contracting by health plans and provider organizations, and (c) the form and pacing of implementation of quality incentives between plans and providers and within provider organizations.