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### Physician Financial Incentives: Use of Quality Incentives Inches Up, but Productivity Still Dominates

Continuing concern about low-quality medical care has led both private and public payers to explore using financial incentives to encourage hospitals and physicians to improve their quality of care.<sup>1</sup> Many of these approaches, such as pay for performance (P4P), are motivated by the fact that existing payment systems compensate physicians equally regardless of the appropriateness or quality of care their patients receive.<sup>2</sup>

There has been little change since 1996–1997 in the types of practice-level financial incentives physicians practicing in groups of two or more face,<sup>3</sup> according to the Center for Studying Health System Change's 2004–2005 nationally representative physician survey. About one in four physicians (23.5 percent) in non-solo practice do not have their compensation tied to any explicit financial incentives.

Compensation based on individual productivity remained physicians' predominant financial incentive in 2004–2005, affecting 70.4 percent of physicians. In 2004–2005, 20.2 percent of physicians reported that quality measures were taken into account in determining their compensation, a statistically significant increase from 2000–2001, when 17.6 percent of physicians reported quality-based compensation.<sup>4</sup> Nevertheless, nearly all physicians with quality incentives also face productivity incentives.

Other incentives used by physician practices include tying individual physician's base compensation and/or bonuses to results of patient satisfaction surveys and profiling that compares a physician's pattern

of medical resource use to that of other physicians. In 2004–2005, 24.6 percent of physicians faced financial incentives related to patient satisfaction surveys and 13.9 percent had their compensation tied to profiling.

A closer examination of the 2004–2005 data illustrates the large gap between the importance of productivity-based and quality-based financial incentives. Nearly three in four physicians, who reported facing productivity-based financial incentives, or 52 percent of all physicians, view these incentives as a very important factor determining their compensation.

In contrast, 44 percent of physicians subject to quality-related incentives view these incentives as very important to their compensation, or just 9 percent of all physicians. A roughly equal number report that quality is moderately important to their total compensation. Even smaller proportions of physicians reporting financial incentives tied to patient satisfaction surveys or profiling regard them as very important to their total compensation.

### Quality Incentives More Common in Some Practices

Although productivity is broadly used to determine physician compensation across nearly all types of physicians and physician practices, the prevalence of quality-related compensation varies across specialties and practice type. Established quality indicators are most common in primary care and for the treatment of chronic conditions. Reflecting this, quality-related compensation is more common among primary care physicians than specialists.

Physicians in larger group practices — as well as hospital, medical school, or other institutional practices — are more likely to

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be compensated in part on the basis of quality than physicians in small- or medium-sized group practices. Physicians in group/staff-model health maintenance organizations (HMOs), who represent only 6 percent of physicians in non-solo practice, are at one extreme. Nearly two-thirds reported that quality measures affect their compensation, with more than one-quarter reporting that quality is a very important factor in determining their compensation.

The growth between 2000–2001 and 2004–2005 in the percentage of physicians with quality-related compensation was strongest among general internists and family/general practitioners, who experienced a 5.5 percentage-point increase, and medical specialists, who experienced a 3.3 percentage-point increase. Physicians in group/staff-model HMOs saw the largest growth in quality-based compensation arrangements. In contrast, there was no significant growth among physicians who practice in small groups with fewer than 10 physicians.

### **Rise in Quality-Based Incentives**

The percentage of physicians with quality-based compensation incentives in 2004–2005 was not significantly different from that in 1996–1997. The recent increase in quality-based compensation largely reversed a significant decline between 1998–1999 and 2000–2001, which most likely was associated with the sharp drop in capitation during this period. The percentage of physicians in practices that had capitated contracts with health plans dropped from 62 percent to 50 percent between 1998–1999 and 2000–2001. The use of capitated contracts has remained steady since 2000–2001, so increased capitation cannot explain the rise in the use of quality measures. Despite this, the greatest growth in quality-based compensation was seen among physicians in practices that receive a substantial portion of their revenue from capitation — greater than 20 percent of total revenue.

Another factor relevant to growing use of quality-based compensation is the trend of physicians moving to practice settings that are more likely to use this tool. Between 2000–2001 and 2004–2005, the percentage of physicians practicing in groups with 10 or more physicians rose from 14.7 percent to 19.4 percent. Moreover, the number of solo, self-employed practitioners has declined steadily for years, from 30.3 percent of patient-care physicians in 1996–1997 to 23.1 percent in 2004–2005.

### **Implications**

Although P4P is often thought of as a new innovation, roughly one in five physicians outside of solo practice is already compensated on the basis of their quality of care, a percentage that has changed little over the past decade. Moreover, nearly one in 10 physicians reported that quality incentives are a very important component of their compensation. These incentives are at least partially a reflection of financial incentives physician practices currently receive from public and private payers.

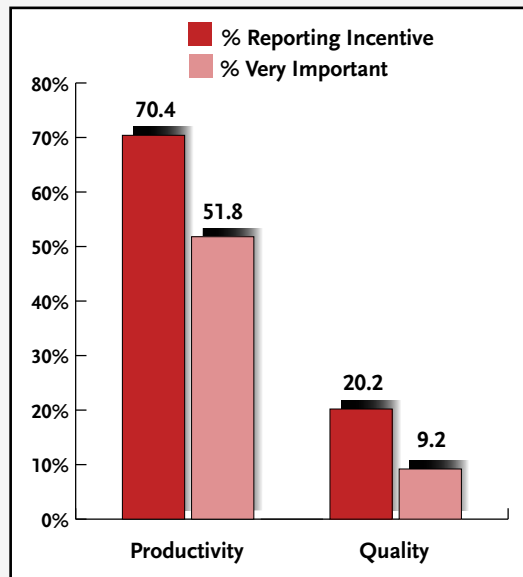
If public and private payers seek to significantly expand quality-based physician compensation through P4P or quality reporting, it is important to understand why the past use of quality measures in physician compensation has been both uneven and relatively uncommon. One likely factor is the lack of a broad and consistent range of important clinical care process and outcome measures that physicians accept as valid. So far, the number of acceptable measures is relatively small and drawn mostly from primary care. Expanding quality-based compensation to many medical and surgical specialties will require developing measures relevant to the conditions those physicians treat and determining accurate methods to attribute which physician is responsible for providing what care to individual patients.

Quality-based compensation also may be limited by the fact that a majority of physicians practice in solo and small-group settings where they typically treat relatively small numbers of patients with conditions

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**MARKET WATCH**

**PHYSICIANS REPORTING COMPENSATION-BASED PRODUCTIVITY AND QUALITY INCENTIVES, 2004-2005**



Note: Sample excludes full owners of solo practices.

Source: Community Tracking Study Physician Survey as published in Issue Brief No. 108, January 2007, James D. Reschovsky and Jack Hadley. Issue Briefs are published by the Center for Studying Health System Change ([www.hschange.org](http://www.hschange.org)).

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covered by any particular payer’s quality/performance measures. The “small number” problem makes it difficult to apply quality/performance measures with the statistical reliability crucial to their acceptability. Using common measures and sharing data across public and private payers may be one way to address this limitation.

If there are natural limits to the use of quality-based physician compensation, then policymakers should consider developing additional policies to complement P4P programs’ efforts to improve the quality of care, such as development and promotion of more clinical guidelines and/or subsidies for

the adoption of electronic medical records and disease management programs. In the meantime, physicians will continue to be compensated primarily on the basis of their productivity, an incentive that has uncertain implications for quality of care but which likely increases the cost of care by encouraging the provision of more services to patients.<sup>6</sup>

Source: Reprinted with permission of the Center for Studying Health System Change, Washington, D.C. [www.hschange.org](http://www.hschange.org). Issue Brief No. 108, January 2007, James D. Reschovsky and Jack Hadley. NOTE: This article has been edited due to space constraints. To view the article in its entirety, including its notes section where footnotes are listed, please go to <http://hschange.org/CONTENT/905/>.

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October Resident Reach ***	10/11/07	9/21/07	All specialties — about 100	Final-year residents and fellows
November Resident Reach	11/8/07	10/19/07	All specialties — about 100	Final-year residents and fellows

\*Please refer to the above chart for specifics on audience and specialties for each special issue. Each booklet will be mailed to over 30,000 physicians, and an e-mail will be sent to over 7,500 physicians in conjunction with each special issue. In order to have your ad appear in all three booklets, you must run a paid print ad in each designated issue of the NEJM. Direct mail and e-mail counts are based on counts provided by the AMA and are subject to change.

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**Congratulations to Jim & Jan-Marie!**

Jim Murray, NEJM senior account representative, married Jan-Marie Belliveau on Saturday, May 26, 2007, at the Brookmeadow Country Club in Canton, Massachusetts. The newlyweds will honeymoon in Hawaii for two, fun-filled weeks before returning to Waltham, Massachusetts, where they currently reside. Congratulations and best wishes to Jim and Jan-Marie!

