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Raising the Bar on Quality Incentives in Physician Compensation

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The transformation to a value-based healthcare system is underway, as is the spread of programs that pay physicians for improving the quality of care. Whether called value-based payment, paying for quality, or pay-for-performance, such programs are becoming a more significant aspect of compensation for employed physicians and in co-management agreements—but they are not always used effectively.

Research by the Center for Healthcare Outcomes and Policy and others has concluded that the jury is still out on whether programs that pay for quality actually improve overall patient outcomes. When pay-for-quality programs set the bar too low, they not only are unlikely to improve patient care, but also can put participants at risk of regulatory actions where co-management arrangements are involved.

Improving outcomes requires well-designed incentive programs, which can be difficult to implement. We recently assessed an apparently robust compensation plan with many layers of quality performance metrics. Peeling back the onion revealed quality incentives that were of questionable efficacy: All 120 employed physicians earned 100 percent of the available incentive payment.

Incentives should be set so most physicians have to reach to achieve them.

A parallel situation with a co-management agreement could raise compliance questions. Quality measures in co-management must be set in a way that ensures the participating providers achieve something new and significant rather than simply maintain the current standard of care. Having one or two maintenance metrics is acceptable, but no arrangement can achieve the goal of improving patient outcomes if the organization or physicians already are meeting the metrics at the outset.

In any compensation plan that incorporates pay-for-quality, the goal is to demonstrate improvements measured against historical performance, either directly or in relation to national benchmarks. Incentives should be set so most physicians have to reach to achieve them.

Specifically, an incentive plan should:

- Recognize performance versus benchmarks, individual physician improvement over time, and performance versus peers (as applicable)
- Reserve a meaningful percentage of total compensation for quality incentives—at least $5,000 to $10,000, in our experience
- Ensure that quality targets are sufficiently challenging to require an improvement in quality for the majority of physicians
- Be designed so that the metrics change each year—or as areas in need of improvement are identified—so the organization is not repeatedly paying for the same improvement

An incentive plan is not an incentive plan if:

- All physicians meet the incentive metrics at the beginning of the measurement period
- Incentive compensation repeatedly is paid for achieving the same thing
- Low performers on a given metric receive the same payment as high performers

To the last point, paying for improvement is important, but so is rewarding superior quality. Using stratification in payouts can help meet both objectives.

Setting quality incentives is challenging, especially in an organization where quality of care already is high. However, physicians themselves often prefer at least some targets that make them stretch, and there is always something that can be done better. It's all about the metrics.

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