VIEWPOINT

Value-Based Purchasing and Physician Professionalism

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Supplemental content

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There is broad consensus among US policy makers that payers should move toward value-based purchasing (VBP), but less agreement about how programs should be designed or about their effect on physician professionalism. Value-based purchasing can be defined as payment models in which clinicians and health care organizations are held accountable for the quality and cost of care instead of being paid based on the volume of services they deliver.

There are 3 fundamental requirements for VBP to succeed: supporting physician professionalism, providing financial rewards for medical groups and hospital systems to invest in systematically improving care, and explicitly designing each program for the context in which it occurs. These contexts can be categorized by 3 combinations of who provides the incentives and who receives them: (1) incentives provided by an external entity (typically a payer, such as Medicare or a health insurer) to a health care delivery organization such as a medical group or hospital; (2) incentives provided by an external entity to individual physicians; and (3) incentives provided internally from a health care delivery organization to its own physicians (eFigure in the Supplement).

In 1963, Arrow[1] argued that professionalism, understood as placing patients' welfare above personal self-interest, is essential because there is information asymmetry between physicians and patients. Despite efforts to measure physician performance, patients and policy makers will never be able to observe or evaluate most physician behavior. Many essential tasks and actions physicians perform are not measured by VBP programs, and may never be adequately measurable (eg, making accurate diagnoses, coordinating care, and identifying and addressing issues beyond the patient's chief concern). Professionalism is needed because it motivates physicians to do the best they can for patients in the many areas in which performance cannot be measured.

Physician professionalism can be conceived as the intrinsic motivation to become a better physician and to place patients' interests above the physician's own interests. If a VBP program weakens professionalism, it may improve performance in the areas it measures but have the unintended consequences of worsening performance in unmeasured areas and of incentivizing physicians to avoid patients who may lower their scores in measured areas. For example, the British pay-for-performance program for primary care practices resulted in small, short-term improvements in certain aspects of asthma and diabetes care, but this trend was not sustained, and quality on measures not associated with an incentive declined.[2] Continuity of care decreased, possibly because a patient's access to any clinician within 48 hours was tied to an incentive, but access to a patient's own physician was not. Another study found that public reporting for percutaneous coronary intervention was associated with decreased odds of receiving the procedure, with larger reductions for high-risk patients.[3] Physicians are typically the target of VBP programs, but professionalism among other clinicians, such as nurses, is also important.

But professionalism alone is not enough. The professionalism of physicians will not systematically improve care for the entire population of patients for which a health care delivery organization is responsible. Such improvement requires investment in organized processes, such as identification of high-risk patients and use of care managers to coordinate care and help patients learn to manage their diseases. These processes are expensive to create and maintain. Medical groups and hospitals will not make substantial investments, year after year, without incentives that give them a reasonable expectation that if they improve care, they will receive some return on their investment.

The contexts for VBP are defined by 3 combinations of the source of incentives and the target of incentives (eFigure in the Supplement). The incentives likely to be effective and to minimize unintended consequences (including reducing physician professionalism) vary across the 3 contexts. In the first VBP incentive combination, a payer provides incentives to a large health care delivery organization (eg, from Medicare to a hospital or accountable care organization [ACO]). The primary purpose should be to give the organization a potential return on investment for creating systematic processes to improve care. Payers can measure global areas of performance (eg, ambulatory care admissions, readmissions, complication rates, and risk-adjusted costs of care) because the number of patients cared for is large enough for statistically reliable measurement. Payers can place large health care delivery organizations at sizeable financial risk and shift from fee-for-service payment to individual physicians toward global payment to organizations. Global payment and robust performance measurement could incentivize organizations and physicians to collaborate to create programs they believe will help patients, instead of strategizing ways to generate revenue from fee-for-service payments. Organizations and physicians could develop a suite of services they believe best meets patients' needs, including for example, email, telephone, and video communication, without seeking payment for each individual service.

In the second VBP incentive combination, a payer provides incentives to individual physicians or small practices. This approach differs from the previous context because individual physicians and small practices lack

the scale to be measured on important but uncommon outcomes (eg, ambulatory care admissions) or to assume large amounts of financial risk.[4] Historically, most VBP programs that involve payers providing incentives to physicians have been pay-for-performance programs for individual physicians. These programs have focused less on rewarding investments in care improvement processes and more on the assumption that physicians need to be motivated to try harder by the lure of small rewards for small actions.

Professionalism may be decreased when physicians perceive that VBP programs focus on relatively unimportant measures, are unnecessarily complex, increase administrative burden, lack the statistical power to reliably measure performance, rely on checking of boxes (eg, documenting that a patient was asked about smoking), penalize physicians who care for socioeconomically disadvantaged or complex patients, or incentivize inappropriate care (eg, prescribing antihypertensive medications for a patient for whom risks exceed benefits).[5] More broadly, behavioral economics research suggests that providing financial incentives to individuals may undermine intrinsic motivation[6] and that nonfinancial incentives may be more effective when intrinsic motivation is important.[7] Professionalism is a quintessential form of intrinsic motivation.

The design of VBP approaches in which the payer provides incentives to individual physicians remains controversial, as evidenced by the Medicare Payment Advisory Commission's (MedPAC) recent recommendation that the MIPS (Merit-Based Incentive Payment System) be eliminated.[8] At least 4, nonmutually exclusive, options could be considered. First, small practices could join together to participate in VBP programs that involve incentives from payers to health care organizations. For example, these practices could participate in ACO programs through independent practice associations, through virtual groups (as suggested by MedPAC), or assisted by companies that create networks of small independent practices. Second, payers could reward performance without relying on providing small rewards for small actions. Physicians and small practices that perform extremely well over a 2-year interval might be rewarded with an exemption from prior authorization or other reporting requirements. Those performing extremely poorly could be subject to additional review and mandatory coaching, or excluded from caring for the payer's insured patients if poor performance persists. The small sample size problem would be less important because the goal would be to identify clear, persistent outliers rather than distinguish small differences across physicians. Third, payers could experiment with innovative incentive and technical assistance programs, such as Medicare's Comprehensive Primary Care Plus initiative, to help small practices create care improvement processes.[7] Fourth, they could collect and publish patient experience reports. These would include not only star ratings, but also patient narratives, which could be useful to patients trying to select a physician and to physicians hoping to understand how patients believe they could improve.

In the third VBP incentive combination, a health care delivery organization, such as a medical group, hospital, or ACO, offers incentives to its physicians. These internal incentives can differ in important ways from those offered by payers.[9] Health care delivery organizations can codevelop performance measures with their physicians. Within the organization, it is relatively easy for physicians to appeal (eg, a physician may explain that his or her generic prescribing rates are low because of a high proportion of patients with hepatitis C); however, this is unlikely to be successful with external payers. The possibility of appeal also reduces the incentive for physicians to avoid patients who may lower their performance scores. In addition, health care delivery organizations can more easily use nonfinancial incentives (eg, peer recognition) in addition to, or instead of, financial incentives. Policy makers and researchers have given relatively little attention to incentives that health care organizations provide to their physicians even though leaders of these organizations are well aware of their importance.

Given the complexity, heterogeneity, and entrenched financial interests of the US health care system, the shift toward meaningful VBP remains challenging. But current VBP efforts also are hampered by lack of clarity about the context in which a program is being deployed and lack of attention to the intrinsic motivation of physicians. The goal of VBP should not be to incentivize physicians to work harder. The vast majority of physicians already work hard. Failure to recognize this may result in physician resistance, decreased professionalism, and unsuccessful VBP programs. A VBP program is more likely to succeed if it supports physician professionalism and if it is designed specifically for the context in which it exists.

ARTICLE INFORMATION

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