Paying More Wisely: How Incentives Influence Physician Decisions at the Point of Care

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Objectives

- Provide a framework for understanding how incentives complicate point-of-care clinical decision-making
- Illustrate with examples from the "Choosing Wisely" program
- Consider advantages and disadvantages of payment reforms options
- Provide a strategy for better supporting evidence-based decisions at the point of care.
Inside the DC Beltway

- 65 miles surrounded by reality
- Beltway view of the current US Health Care System
Rates of Four Orthopedic Procedures among Medicare Beneficiaries

Source: Dartmouth Atlas
Policy problems for evidence based care

- “…little rigorous evidence is available about which treatments work best for which patients”
  - Solution: CER/PCOR

- And”…financial incentives … tend to encourage the adoption of more expensive treatments and procedures, even if evidence of their relative effectiveness is limited”
  - Solution: provider payment reform

Orszag and Ellis, NEJM, Nov 2007
Evidence-based, Affordable Health care

2009: ACA Investment in Effectiveness Research

AHRQ, HHS, PCORI
Infra-structure for CER

PCORI (AHRQ, NIH)
Comparative Effectiveness Research Studies
- Medications
- Medical devices and technologies
- Medical and surgical services,
- Behavioral change strategies,
- Delivery system interventions

PCORI, AHRQ, CMMI,
Research on using CER findings in practice
- Providers
- Patients
- Delivery Systems

Polices to promote using CER
- Payment and regulation
- Monitoring and feedback

Evidence-based, Affordable Health care
“...little rigorous evidence is available about which treatments work best for which patients”
   - Solution: CER/PCOR

And”...financial incentives ... tend to encourage the adoption of more expensive treatments and procedures, even if evidence of their relative effectiveness is limited”
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Orszag and Ellis, NEJM, Nov 2007
2013: Physician Payment Reform - the “Doc Fix”

- repeal the Medicare Fee Schedule SGR

- Recalibrate “overvalued” and “under valued” fees

- shift the basis of Medicare payment
  - from fee-for-service only (“rewards volume and intensity “)
  - to emphasizing “quality, effectiveness, and efficiency”

- encourage provider participation in “alternative payment models”
  - Bundled payment
  - “Shared savings” and other variations of global (population based) payment
"By God, gentlemen, I believe we’ve found it—the Fountain of Funding!"
Longstanding approach to physician reimbursement

Risks well recognized
- Code of Hammurabi, Heraclitus, Ben Franklin, GB Shaw

Physician as “seller of services”
- Buyer does not have physician’s specialized knowledge
- Buyer further disadvantaged by pain, anxiety, cognitive impairment

Principle-agent theory
- Physician contracts to act as patient’s agent
- Patients interests are advanced when the physician (clinician) recommends services with evidence of benefit

E Rich et al JCER. May 2013
The Clinical Decision Making Process

Access:
Patient makes appointment/visits physician

Problem Recognition:
Physician assesses/prioritizes problem(s)

Potential Health Concern:
Patient identifies concern or complaint

Diagnostic Testing Process:
Physician decides which tests to order

Response to Treatment:
Treatment does or does not address patient complaint or concern

Adherence to Treatment:
Patient gets treatment, with more or less physician oversight

Adherence to Testing:
Patient gets tests done, with more or less physician prompting

Diagnosis:
Physician makes diagnosis, using testing and other information

Treatment or Recommendation of Treatment:
Physician recommends treatment based on diagnosis

E Rich et al
JCER. May 2013
Complexity of Point of Care Clinical Decisions

- Patients seek physicians to address a broad array of health concerns
  - And want physicians to act to relieve their symptoms/distress

- Each patient encounter generates numerous decisions

- Physicians make these decisions in the face of extensive and conflicting relevant evidence
  - 23,000 clinical trials every year, few answers
  - CER/PCOR intended to help with this

- All diagnostic tests are imperfect
  - Inherent risk of over- and underdiagnosis
  - Multiple sequential tests do not help
FFS and Point of Care Decision-making

- FFS offers straightforward method to encourage delivery of services at the point of care
  - Patients have greater trust under FFS payment
  - Physicians prefer FFS to other payment models

- FFS may not provide consistent incentives to promote evidence-based practice
  - Poor calibration of fees—e.g., high margins for services of limited effectiveness; and vice versa

- Potential impact of FFS imbalance on point of care decisions
  - Over or under-testing, treatment
  - Over or under diagnosis
Over-testing: Imaging for Low Back Pain*

- High margin for imaging studies for back pain creates incentives for physician/clinician to ...
  - Promote increased patient awareness of medical services for the problem
  - Increase patient access for evaluation
  - Perceive higher likelihood of conditions that require testing
  - Provide services to help patients adhere to testing recommendation

* Overused service identified by “Choosing Wisely” program
Over-testing: Imaging for Low Back Pain*

- If imaging study is an efficient means of diagnosis candidates for a high margin treatment – then additional incentives for physician/clinician to ...
  - Diagnose the condition that warrants the high margin treatment
  - Provide services to help patients adhere to testing recommendation

* Overused service identified by “Choosing Wisely” program
Under-testing: PFTs in Asthma*

- FFS incentive for PFTs are modest (eg $35-60)
- Equipment availability and staff time needed for the test
- The patient's history and physical exam can seem quite informative
- Patients may not see the benefit of more of their time (and money) devoted to testing
- Therefore the FFS payment may be insufficient to overcome inertia and other barriers to testing

* Underused service identified by “Choosing Wisely” program
Over-RX: Antibiotics in Sinus infection*

- No direct FFS incentive of ABX RX (in US)
- FFS incentive to recommend an approach that satisfies patient expectations
  - ABX plausibly effective in addressing the likely diagnosis
  - Patients prior belief regarding ABX efficacy
  - Patient desire to avoid missed work/school
  - Patient preferences and shared decision-making
- Current FFS provides inadequate incentive to educate patients regarding risks and benefits
- Clinician efforts to discourage antibiotic use may complicate patient satisfaction

* Overused service identified by “Choosing Wisely” program
“Under-management” for GERD*

- Evidence-based care- GERD Rx “should be titrated to the lowest effective dose needed to achieve therapeutic goals”

- requires:
  - physician must contact asymptomatic patients on chronic therapy for GERD,
  - reduce medication dose as appropriate,
  - Follow-up on symptom response and further adjust medication

- Not easily rewarded via FFS

- May be viewed as unwelcome distraction by asymptomatic patients

* Underused service identified by “Choosing Wisely” program
“Oh! Four steps to the left and then three to the right! ... What kind of a dance was I doing?”
Payment reform options: potential impact on evidence-based care

- Revised FFS
- FFS + P4Q
- Episode-based payment
- Global payment (capitation)
Revised FFS: Description

- Revisions to make margins equal for all services
  - Increase payments for services with low margins
  - Decrease payments for services with high margins

- More ambitious goal: Set payments to provide higher margins for highly effective services
Revised FFS: Advantages

- If margins for services are high, physicians will increase use
- Increased payments can address underuse of effective services
- Strongly reward use of highly effective services
  - Bonus for stents for STEMI with door-to-balloon time <60 min
  - Reduced payments for stents in chronic stable angina patients with AUC <7

Stecker and Schroeder. Adding Value to Relative Value Units, NEJM Dec 2013
Revised FFS: Disadvantages

- Likely limited effects on overused services
  - Inertia, prior beliefs
  - Volume offsets
  - Unintended consequences

- Challenges in adjusting FFS payments based on evidence of effectiveness
  - Revising (and monitoring) the FFS codes
  - Pricing relative effectiveness
  - Responding to changing evidence base
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Bonuses or penalties based on performance on quality measures

Measures of process or outcomes
“Why, yes...we do have two children who won't eat their vegetables.”
Advantages-
- Monitor/reward better chronic care management (e.g. GERD management)
- Monitor/reward appropriate use of test or treatments (e.g. back imaging, antibiotic use)

Disadvantages
- Focus P4Q on high priority services
  - physicians make numerous decisions per encounter, 1000s of decisions per day
- Rectify conflicting P4Q signals from multiple payers
- Assuring salience to real-world decision-making
  - Attribution to the correct clinician decision-maker
  - Patient risk adjustment, benchmarking
- Quality measures ≠ evidence-based practice
Quality measures ≠ evidence-based practice

- Less than 20% of AHA/ACC heart disease management recommendations are based on a high level of evidence; over 40% are based on the lowest level of evidence
  - Pierluigi, et al JAMA 2009

- Dichotomous performance measures don’t take into account heterogeneity of patient risk factors or patient preferences
  - Hayward AJMC 2007
Diagnostic Error: Another challenge to Evidence-based Practice

- CER and PCOR is only informative when patients actually have the condition under study.

- Misdiagnosis rates of 10 to 15% across a variety of clinical settings and conditions.

- Advanced diagnostic technology not a panacea
  - Eg Scans detect findings of unclear clinical salience
  - Problem ranges from critical care to prevention

- Interpreter incentives may diagnostic accuracy (sensitivity/specificity tradeoffs)

- Quality metrics have not addressed diagnostic errors.

E Rich JCER. Nov 2013
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Episode-Based Payment: Description

- Bundled payment for all services needed during an episode of illness or care
- Removes “piecework” incentive of FFS within the episode
- Incentive for constraining volume of services during an episode
Who Gets the Episode Payment?

Practice environment and clinical decision-making

“Physicians don’t just work for money”

- **Do good-**
  - Solve substantive clinical problems
  - Provide impactful clinical services

- **Do something important with their work time-**
  - Minimize “administrivia”
  - Work with talented clinical staff
  - Access to excellent equipment, facilities etc
  - Earn the respect of their professional peers

- **Do what they want with their life-**
  - Controllable lifestyle
  - Fulfill family obligations
  - Educational leave, travel, etc
Einstein discovers that time is actually money.
Changing the Employed Clinician’s “Margin”

**Compensation**
- Physician incentive plan
  - Productivity measures
  - Quality metrics
  - Patient satisfaction
  - Organizational financial performance

- “Perks”
  - Education and travel funds

**Work environment**
- Workload
  - Work assignments
  - On-call responsibility
  - Admin “hassles”

- Support staff /space
- Ease/difficulty obtaining tests, services

- Recruitment /retention

- Professional culture
  - Leadership
Who Gets the Episode Payment?

- Most physicians will not receive episode-based payment directly
- Larger provider entity will receive and distribute the bundled payment
- This larger entity will have incentives
  - And will be motivated to influence clinical decisions at the point of care.
WHICH 'UNNECESSARY PROCEDURES' WOULD YOU BE REFERRING TO?

DO YOU WANT US TO MISS SOMETHING?
Can reduce some overused services when designed correctly
  – Over testing example:
    • Imaging for back pain during an episode represents higher cost, not additional revenue
    • Business case for lower cost alternatives

Can address under-diagnosis
  – Create episode payments initiated by diagnosis
Episode-based payment: Disadvantages

- Discourages evidence-based testing and treatment during an episode of illness
  - PFTs in asthma
  - Drug management in GERD

- Episode-based payments tied to diagnoses
  - Potential incentive for over-testing to find episodes
  - Potential incentive for over-diagnosis from test results

- Episode-based payments often tied to high cost services (like surgical procedures)
  - Potential incentives for over-Rx

- P4Q can help
  - Same limitations as FFS
"Oh, if only it were so simple."
Global Payment (Capitation): Description

- Fixed payment for all services needed by a patient during a year
- Removes “piecework” incentive of FFS
- Incentive for constraining volume of all services for patients
- “Shared Savings” incentives for ACOs are a variation of global payment
Global Payment: Advantages

- Provides incentive to reduce any overused services, especially those that are high cost
- Incentives for prevention of disease or exacerbation of disease ("HMO")
Incentives for Prevention?

• For some chronic conditions - near-term financial gains through improved chronic disease management.

• For many patients - evidence-based care has near term costs, with savings many years in future (or not at all)
Global Payment: Disadvantages

- Can encourage reduced access and under-diagnosis

- Can discourage evidence-based testing and treatment
  - PFTs in asthma
  - Drug management in GERD

- P4Q can help
  - Daunting limitations
    - How to properly measure and reward myriad decisions at the point of care
Capitation Incentives for Care of Low Back Pain

- Reduce patient access to expensive clinical services
- Perceive a lower likelihood of conditions that require costly testing or treatment
- Convince patients of the risks of additional imaging studies or interventions
- Promote patient adherence to low cost options
- Discourage adherence to costly interventions like advanced imaging or surgery
## Summary of Payment Reform Options

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Lake, Rich et al  JCER. May 2013
Insights for Designing Payment Reform

- No one payment reform addresses all problems with current FFS
- Some payment reforms are better than others for addressing certain problems
- “For every complex problem there is an answer that is clear, simple, and wrong.”
  - HL Mencken
Behavioral Economics and Professionals

- Economic incentives change behavior through extrinsic motivation
  - Clinicians have an intrinsic motivation to act in their patient’s best interests. Berenson, et al RWJF Health Policy Analysis May 2013

- Behavioral economics research
  - Tangible rewards can undermine motivation for tasks that are intrinsically interesting or rewarding
  - The negative effects for financial incentives appear strongest for complex cognitive tasks. Woolhandler and Ariely, Health Affairs Blog 2012

- “Rewards should reinforce, not undermine, intrinsic motivation to pursue...health system quality.” Cassel and Jain, JAMA 2012
Considerations for Provider Payment Reform

- Patients seek clinicians they can trust to recommend “what is best”
- Professional societies and policymakers want clinicians to recommend evidence-based services
- Payment reform that does not reward evidence-based care will prove unacceptable to both patients and clinicians
The Path Forward- for Payment Policy

- Recalibrate FFS to recognize physician costs at the point of care

- Monitor patterns of care relative to highly effective services
  - Overused and underused tests
  - Overused and underused treatments
  - Undermanagement of chronic conditions
  - Over- and under-diagnosis

- Targeted approach to overall payment reform to reward more evidence-based decisions at the point of care
The Path Forward- for Educators and Clinicians

- Identify under-use of highly effective tests or treatments

- Address professional issues
  - Knowledge of current evidence
  - Diagnostic skills
  - Conflicting interpretations of evidence or professional standards
  - Access to credible knowledge resources and decision support
  - Awareness of practice relative to peers (feedback)
The Path Forward- for Educators and Clinicians

- When highly effective services continue to be underused
  - Re-evaluate for mis-calibrated physician financial incentives
  - If productivity rewards look balanced consider
    - Compensation reform
      - Increased FFS type payment (to jumpstart increased use for highly effective services)
      - P4Q incentives to increase awareness and rewards for appropriate use
    - Work environment adjustments
      - Workload and Support staff
      - Ease of ordering/obtaining the underused service
      - Professional culture
      - ??Reminders (recent surveys show reminder burden)
For over-used tests or treatments

- **Address professional issues**

- **If overuse persists consider**
  - Compensation plan
    - Eliminate production incentive for this service
    - Add incentive based on expected utilization
  - Work environment
    - Ease of ordering/obtaining
    - Referral process
    - Workload, Support staff
    - Professional culture
Objectives

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Final page of the Medical Boards

BONUS QUESTION:
(50 points)
What's the name of that thing that hangs down in the back of our throats?
 There are many mechanisms for paying physicians;
 some and good and some are bad.
 The three worst are fee for service, capitation, and salary.
  – James Robinson