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ETHICS CASE
How Do We Reward the Kind of Care We Want?
Commentary by Shivan J. Mehta, MD, MBA, and David A. Asch, MD, MBA

A quorum of physicians from the large, multispecialty King Practice Group have gotten together to consider a plan for changing the way they are paid. Members of the practice have been talking for months about reengineering the group's physician reimbursement method, moving towards one in which pay for specialty procedures and primary care clinical work is more equal. In prior discussions, group members had acknowledged that practices with fee-for-service payment and large disparities in charges by various specialists would be coming under scrutiny from Medicare and private insurers.

At this meeting, a task force selected by group members several months prior introduces a proposed plan that would address the significant income differences among the various specialties in the practice—from general internists who see fewer patients per day to those who are very specialized, see more patients in the course of the day, and do more procedures. In the end, the goal is to reward the value of care delivered rather than volume of care delivered.

Dr. Kellman, the group's president and task force chair, explained that, under the proposed plan, reimbursement for family practitioners in the group, who spend, on average, 50 hours a week providing health care maintenance and illness prevention along with general acute care and chronic illness management, would no longer be paid significantly less than that of a cardiologist or otolaryngologist who worked the same number of hours.

Making the plan fiscally sound called for some "leveling" of the pay. In other words, all practice members would not receive what the highest paid specialist had been receiving. The plan details were complicated, and a supermajority of the physicians would have to approve them in the end, but the pay for some specialists would come down as the pay scale for some primary care practice members rose.

While most of the practice members had agreed to the need for some sort of pay scale adjusting, some specialist practice members objected to the proposed plan when they heard it. "Don't those extra years and expertise acquired in a fellowship make some services more valuable?" a cardiologist asks. Other members grumbled to themselves that maybe they would take their skills elsewhere, where they would be appreciated and rewarded.

Commentary

The past several decades have seen many attempts to reform and update the physician payment system, but no "solution" has emerged, and every attempt has brought its own problems. This case highlights these ongoing issues, as it pits physicians against each other into factions competing for the same revenue. Recent interest in accountable care organizations brings these conflicts to the foreground, but the underlying tensions are not new.

We would argue that these problems are no different than those faced by any other organization that must allocate compensation for team activities, whether it is a not-for-profit organization or a for-profit partnership. They result from the incentives of the medical payment structure, which influence how physicians make decisions within organizations. Because payment structures so fundamentally determine the delivery of health care, an understanding of the history of medical payments in the United States, unintended consequences of the current system, and alternate payment systems is essential to evaluate issues of fairness and social welfare.

Medical Payments in the U.S.

In the U.S., specialty choice largely determines income: specialists who provide more procedure-oriented care get paid much more than generalists [1]. Popular opinion and the opinion of generalists argue that these disparities in income ought to be redressed, and over time there have been efforts to narrow these differences in income. For example, the Resource-Based Relative Value Scale, instituted by Medicare in 1992, assigned relative value units (RVUs) for each service provided, based on a formula of physician work, practice costs, and the cost of specialty training. This effort reflected an attempt to standardize Medicare payments to physicians [2], and many other payers followed Medicare's lead. Despite this attempt at standardization, however, income disparities between specialists and generalists have persisted for a variety of reasons, including increasing volume of procedures and weaknesses and political pressures within the Relative Value Scale update process that continue to favor the status quo [3]. The result is a system no more equitable than those of the past.

But this time, the goals and stakes are different. What is now being asked for is not payment based on resources used, which is fundamentally the structure of the Resource-Based Relative Value Scale. Instead what we want is payment based on what outcomes are produced—a concept of value-based pricing that is substantially more consistent with a patient-centered view of health care. The trouble is that, as hard as it is to compare the effort involved in a cardiac catheterization to the effort and time involved in developing a comprehensive plan of care with a new patient, it is still easier to compare these inputs than to compare their ultimate value. Procedures are time-bound and have steps that are quantifiable and part of the activity each time it is performed. Care, on the other hand, is ongoing, less quantifiable, and can take many forms. Pricing inputs is easier than pricing value, but in the end pricing inputs rewards the volume of effort over the value of outcome, when it is the outcome we value most. And if our pay scales make it more attractive

for graduating medical students to enter well-remunerated rather than needed fields, we should not be surprised when we find we don't have enough physicians for the care we want.

The tension boils down to this: some kinds of care produce attractive financial margins. Doctors and hospitals make money doing these services, and so they will do a lot of them. Some kinds of care produce good outcomes for patients. These are the kinds of services we want done more. In the U.S., the kinds of care that produce high margins are not necessarily the same as the kinds of care that produce high value. Our reimbursement system does not create incentives for what we want, and it won't until the margins reflect the social value.

Is There a Better Way?

We know that any payment system will have unintended consequences. Fee-for-service, capitation, and salary all have their advantages and disadvantages, and none of them provides accountability for the outcomes patients care about. There is reason for optimism because accountability for quality is advanced by increased use of electronic medical records. More robust information systems bring greater opportunity to measure quality and outcomes and therefore greater opportunity to deploy payments to align incentives with those goals. Indeed, one reason that payment systems have so far not rewarded quality is that the measurement of (and hence payment for) performance has only recently come within reach. But quality-based payment or outcome-based payment does not yet seem within reach.

Outcome-based payment aligns payments more closely with what patients want, which is better health rather than more health care [4]. But, despite their appeal, these approaches remain challenging to implement in the overall population [5]. There are so many clinicians and clinical situations that it would be difficult to fairly measure quality for all specialties in a meaningful way. The Medicare Value Based Purchasing initiative takes a step in this direction by attempting to reward physicians when they meet certain standards for high-quality care. However, expected changes in payments may not be big enough to impact care delivery [6]. These approaches also carry the same concerns of "teaching to the test"—whereby the elements of care that are rewarded are performed to the exclusion of elements of care that, while also important, are not rewarded. And to date there is limited evidence of improvement in quality of care—evidence that is essential for moving forward. But while that evidence is gathered, these approaches offer conceptual appeal.

So, how should the King Practice Group reevaluate clinician payments? Just thinking about this is a step in the right direction, since any well-functioning organization should continually reevaluate how its implicit and explicit incentives affect its functioning and goals. But the practice faces a challenge: not only is this multispecialty group a microcosm of the broader world of physician reimbursement and all the challenges of that world, but it is situated in that world and affected by it.

They can redistribute practice income any way they want, so long as they are inclusive and considerate in their deliberations. And so they may decide to take some of the money derived from the higher fees that currently go to the orthopedists and redirect that money to the general pediatricians. Or maybe they will not pay physicians as much for services that provide low value to patients (some spine surgery performed by those orthopedists) even though they are highly reimbursed by payers, and will instead pay more to pediatricians or nurses for counseling on childhood obesity.

Of course physicians care about more than just money—they want to take good care of their patients and be contributing members of their community. But they also care about money, and physicians can take good care of patients and be contributing members of their community in practices other than King Practice Group. So, to the extent that redistributing income in a practice is a zero-sum game, the practice may have a hard time retaining those highly paid specialists if their internal redistributions redirect too much of the income the external market provides. It is hard to distribute money internally one way when the external world distributes it a different way. In all industries, it is hard to fight the market.

Does that mean that individual practices have no responsibility for their payment structures? Certainly not. Just as two wrongs don't make a right, so it is that practices have a responsibility to ensure that their internal financing—or any of the elements of their internal operations—don't get in the way of important goals. But we should recognize that their leverage is limited by external market forces that they cannot individually control.

So, what is to be done? The real targets are external and require broader action. It is pointless to sustain a financing system that rewards volume, and only certain kinds of volume at that, rather than one that rewards good clinical value and health. While we wait for that external system to change, perhaps King Practice Group can adopt an "all-of-the-above" approach. Since the current payment system is, at its core, fee-for-service, this element is hard to overcome. However, the practice can consider aligning patient care goals with physician incentives at the margins. They could provide some incentives for patient activity that may not result in direct reimbursement, such as coordination in care, phone calls, or virtual visits. They could provide additional payment for administrative or quality improvement activity. They could reward panel management that privileges the number of different patients who receive quality care, rather than just the number of patient encounters.

We all know the saying "you get what you pay for." In most settings, it is meant to suggest that if you pay too little, you don't get enough. In health care the saying works equally well in both directions. We get lots of what we pay for in health care, and not enough of what we don't pay for. Given that reality, it is time for us to pay for what we actually want.

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