Incentivizing Primary Care Physicians: Opportunities and Challenges

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Many healthcare business "experts" would say that there is one simple way to incentivize physicians. Give them money! We would respectfully disagree. While financial incentives are one way of impacting physician behavior, they are not the only way. Furthermore, in order to pass muster with both our profession and society as a whole, financial incentives must either maintain or improve the quality of care. This concept has led to the focus of moving from "volume to value." One of the problems in moving from "volume to value" in the care of older adults is that value has yet to be adequately defined. For example, in someone nearing the end of life, is not a comfortable death of greatest value? Maintaining a bed-bound, demented nursing home resident in a nonfunctional state is certainly not considered to be something of value. The challenge of defining value in the frail older population has significant implications for all ongoing attempts to move the Medicare program in this "value"-driven direction. And this is only one of the issues that we face when addressing this topic.

There are a number of fundamental problems with financial incentives. The first is the actual need for clinicians to be susceptible to such incentives. Granted, there are some physicians who do very well with volume-based incentives, particularly those that have gravitated to procedurally based specialties. On the other hand, there are those physicians that have landed in more cognitively based specialties, geriatric medicine being a prime example, who do not respond well to financial incentives. This, I would posit, has been one of the reasons for the lack of success demonstrated by geriatricians practicing in today's fee-for-service world!

Senior Care of Colorado, PC, was founded in 2001 by Dr. Don Murphy and myself (Michael Wasserman). We were founded as a primary care geriatric practice

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functioning completely in a fee-for-service world. We started with six physicians and two physician assistants. When we sold our practice 10 years later, we had 30 physicians, 35 nurse practitioners and physician assistants, and 3 social workers. Over that period of time, we had extensive experience in what it took to incentivize our clinicians. Money was rarely at the top of the list for the majority of them. In fact, a focus on financial gain often turned off many of these dedicated professionals.

When Senior Care was founded, we originally developed contracts that paid our physicians a percentage of the revenue that they brought in. We quickly discovered that our doctors wanted security and didn't function well with this method. This was our first clue that geriatricians were different in relation to traditional volume-based incentives. We changed to a salaried system with incentives based on work value units. Similarly, we provided salaries for our nurse practitioners and physician assistants and developed a similar bonus system based on work value units. While there were a few clinicians who had no trouble focusing on productivity and worked diligently to gain bonuses based on their visit volume, we found that most of our clinicians were turned off by this approach. At the heart of our care model was the "geriatric approach to care." This person-centered approach often meant spending more time with patients and their families in order to provide the necessary care. That approach would certainly be at odds with a volume-driven productivity model, especially since the CPT coding system rewards clinicians for a higher number of shorter visits.

The practice struggled under this work value unit methodology. This led us to develop a metric called patient care units, or PCUs. PCUs were developed with the idea that clinicians would be rewarded for the total amount of care they delivered in a day. Hence, there was concomitant value awarded for spending more time with patients. The key to the success of the PCU system was that clinicians were encouraged to fully document all of the care they delivered over the course of a day and to properly code for that care. Hence, a nurse practitioner might only see eight patients in a day, and if they spent 1 h with each patient, their PCUs would reflect that. We also took the initiative to educate our clinicians on the proper use of "time-based coding," so that their time delivering care could be effectively captured. This was particularly critical as we had calculated that "time-based coding" provided an acceptable degree of revenue production for our practice to at least break even.

On the back end of the PCU system was a crosswalk to the revenue production that each PCU would generate. From a practice perspective, we could adjust PCUs to reflect certain needs for the practice, such as higher PCUs for time-consuming home visits. We also took great pains not to create disincentives to spending more time with patients. This ran counter to traditional CPT codes, which tend to pay less per minute for longer visits. Our number one priority was to assure that our clinicians received credit for all of their patient care time delivered over the course of a day. This system worked very well for the vast majority of our clinicians. We did have a few who worked very hard and endeavored to receive a higher number of PCUs in order to get a bonus. On the other hand, most of our clinicians were happy to find that the practice was quite satisfied if they were documenting that they actually spent 8 h caring for their patients. It is not in the realm of this chapter to quantify how we strategically adjusted PCUs in order for the practice to

flourish overall. Nor is this chapter a treatise on the effective use of time-based coding. Both of these topics have been covered elsewhere [1].

In the frail older population, the population that drives the brunt of Medicare expenditures, reducing costs by reducing visits can be counterintuitive. On the other hand, reducing unnecessary care could be beneficial both from a quality and cost perspective. The devil is in the details. In taking a "high-touch, low-tech" geriatric approach to care, increased visit volume might prove to be helpful. At Senior Care of Colorado, we had a very robust house call program. We targeted patients with severe congestive heart failure for weekly home visits and had excellent results in reducing hospitalizations. Of the 30 physicians in our practice, over half were board certified and fellowship trained in geriatric medicine. The rest, as well as the nurse practitioners and physician assistants, were influenced by those of us with geriatric training. The practitioners tended to follow the core elements of the GeriMed philosophy of care (Table 15.1) [2].

On the other hand, clinicians following a "classic" internal medicine approach to care, diagnose, treat, and cure might easily coalesce around a more volume-driven type of practice. Recent literature has finally started to call the traditional internal medicine approach into question in the oldest old. A recent study from Britain questions the aggressive treatment of diabetics in relation to blood sugar, blood pressure, and cholesterol [3]. They found increased mortality in patients over the age of 80 who were treated most aggressively. Similarly, another recent study questioned the value of statins in older adults hospitalized for coronary events [4]. Evidence like this, in addition to previous studies such as one that questioned aggressive treatment of prostate cancer in older men, may be the tip of the iceberg [5].

This discussion brings us to the heart of a bigger issue. If we are to financially incentivize clinicians for value rather than volume, we have additional questions that must be answered. What is value? What is quality care? Do financial incentives work to drive value-based quality care? This approach requires that there is clear financial reward for well-defined outcomes and that there is clarity on how to achieve those outcomes. In a healthcare world where many clinicians still try to

Table 15.1 GeriMed philosophy of care

• Focus on function
• Focus on managing chronic disease(s) and developing chronic care treatment models
• Identify and manage psychological and social aspects of care
• Respect patient's dignity and autonomy
• Respect cultural and spiritual beliefs
• Be sensitive to the patient's financial condition
• Promote wellness
• Listen and communicate effectively
• Patient-centered approach to care, customer-focused approach to service
• Realistically promote optimism and hope
• Team approach to care

aggressively treat blood pressure, blood sugar, and cholesterol in older diabetics, it is difficult to see how this type of incentive system can work. Coupling that with the fact that many geriatricians and primary care physicians just want to "do the right thing," rather than focus on getting a bonus, creates a conundrum.

Let's pause and consider the latest focus of the Centers for Medicare and Medicaid. It has shone a light on the "quadruple aim," a concept first developed in 2007 by Dr. Donald Berwick and the Institute for Healthcare Improvement (IHI) as the "triple aim" [6, 7]. The four dimensions of the now "quadruple aim" are improving the patient experience of care (including quality and satisfaction), improving the health of populations, reducing the per capita cost of health care, and, now, the fourth goal of improving the work life of healthcare providers, including clinicians and staff. Partly in response to this approach, the new Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 legislation endeavors to bring about a value-based model of care delivery. This sounds great, but one has to wonder what physicians have been trying to do for the past century. As professionals, do we not expect physicians to be working to provide quality care? Managed care organizations have presumably been trying to accomplish these same goals for the past 40 years. Unfortunately, the literature on the success of these types of incentives is mixed [8]. Why this "new" approach through MACRA is supposed to finally bring about such change is confusing, to say the least.

Calling something a "quality program," doesn't make it so. At the heart of MACRA is MIPS, or the Merit-based Incentive Payment System. This program will combine four areas: quality, improvement activities, advancing care information, and cost into some type of composite score. The data will be collected during a calendar year, and then the clinician will be bonused (or possibly penalized) over a year later. How this forms any type of effective incentive remains to be seen. There are also the challenges already alluded to. What type of quality metrics are truly pertinent in the frail older adult population? What type of clinical decisions truly impact the overall cost of care in this population? Clinicians can choose to avoid this approach by joining an "Advanced Alternative Payment Model." These models presently include the Comprehensive Primary Care Plus program, Next Generation ACOs, and Medicare Shared Saving Programs [https://qpp.cms.gov/docs/QPP_Advanced_APMs_in_2017.pdf]. The criteria for Advanced Alternative Payment Models have recently been defined by three criteria: require participants to use certified EHR technology, provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of the Merit-based Incentive Payment System (MIPS), and either be a Medical Home Model expanded under CMS Innovation Center authority or require participating APM entities to bear more than a nominal amount of financial risk for monetary losses. At the heart of these programs is some type of shared risk [ibid]. These models tend to reward and penalize clinicians based on the overall cost of care.

There has been a push to add more advanced payment models so that physicians can avoid the MIPS program. In some ways, this could be looked at as a "bait and switch," insofar as CMS is aware that the advanced payment models are capitated, with the intent of limiting overall Medicare expenditures. Similarly, the MIPS

program is intended to be a "zero-sum" program, which creates its own challenges, as bonuses will ultimately need to be evened out by penalties or cuts in reimbursement elsewhere. Solo practices, or small group practices, often run on very narrow margins. It remains to be seen how these programs will impact such practices, although the industry has clearly been moving toward consolidation of physician practices into larger groups or having physicians employed by hospitals and health systems [9].

There is also the question regarding the ethics of adding the cost of care to the equation of clinical decision-making. What are the implications of how a clinician will make decisions in such settings? Perhaps even more important is how effectively a clinician can predict the overall cost of care based on a particular approach. Trying to save money by not ordering tests or delaying treatment might ultimately be more costly. Similarly, aggressive initial treatment might ultimately save money. Is this what consumers really want their physicians to be thinking about when they make health care decisions? Furthermore, as the system is presently structured, physicians will not get feedback on the actual cost of care for well over a year after the end of the calendar year the care occurred. How this can possibly influence physician behavior in an effective manner remains to be seen.

Let's go back to our original question. What type of outcomes do physicians, nurse practitioners, and physician assistants want to provide for their patients? These answers are fairly clear in younger patients and in single system diseases that occur in the younger population. Clinicians are looking to make a diagnosis and develop a treatment plan in hopes of finding a cure or at least to significantly curtail the disease. In frail older adults, these questions become quite muddled. Geriatric medicine and the care of older adults are about function and quality of life. It would also appear that the primary goal should be to provide the highest-quality, evidence-based care. The irony of this, based on some of the aforementioned literature, is that the common principles of geriatric medicine appear to lead to a very cost-effective, person-centered approach to care.

There is presently a renaissance in regard to person-centered care. This leads us to a chicken and egg phenomenon. Will incentives drive a person-centered geriatric approach to care? Perhaps if the existing and growing evidence can be effectively shared with clinicians, they can be both educated and incentivized. On the other hand, it is clear that consumers are pushing for person-centered care, as they ought to be. Do we just allow traditional market forces to drive an approach that will turn out to be cost-effective in regard to Medicare and the frail older adult? These questions have led to attempts to describe the "value" of a person-centered approach to care based on traditional business principles. A recent publication from the SCAN Foundation set out to describe "the business case" for person-centered care [10]. They summarized that "Person-centered care is characterized by accounting for individuals' values and preferences and using them to guide all aspects of their health care. The provision of such care for older adults with multiple chronic conditions and functional limitations is widely regarded as being in the best interests of those served—the person and their families. There is also evidence that it can enhance provider satisfaction and reduce turnover…The business case for PCC

turns on its capacity to avoid medical costs. Since the target population for PCC consists of high utilizers of the medical system, the resulting burden of medical costs presents a potentially strong basis for the business case" [ibid].

Let's go back to our assumption that physicians, nurse practitioners, and physician assistants want to do "the right thing" in regard to patient care. As professionals, their ultimate goal is providing quality care. The satisfaction of providing such care is their ultimate incentive. If we couple that with a person-centered geriatric approach to care, we have the potential for the best of all worlds. We find ourselves in the milieu of high-quality, cost-effective care. In such a setting, we can afford to provide excellent compensation and benefits to the dedicated professionals that care for many of our most complex patients. Is that not the incentive system that we really want in healthcare?

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