



Michigan's Fee-for-Value Physician Incentive Program Reduces Spending and Improves Quality in Primary Care

Synopsis

An evaluation of one of the nation's largest "fee-for-value" initiatives demonstrates that physicians can control costs while improving their performance under a traditional fee-for-service arrangement. Primary care doctors who were offered financial incentives to form patient-centered medical homes and engage in quality improvement activities reduced spending by 1.1 percent on a per-member per-month basis compared with a control group. Performance on measures of preventive care and chronic disease management also improved. Spending increased initially, but declined by the program's second year of participation.

The Issue

Policymakers, health care providers, and payers are seeking ways to reduce growth in health care costs while improving the quality of care. One strategy, known as fee-for-value, involves adding incentive payments to fee-for-service reimbursement. Commonwealth Fund-supported researchers examined Blue Cross Blue Shield of Michigan's Physician Group Incentive Program, which uses this approach for more than two-thirds of the state's primary care doctors. Physicians in the program can earn higher office visit fees, among other incentives, if they employ core tools of the patient-centered medical home—such as registries to track patients and manage their care—and if they achieve certain cost and quality targets. The evaluation analyzed the program's impact on quality and spending from 2008 to 2011 for more than 3 million beneficiaries in 11,000 physician practices.

Key Findings

- Total spending by practices participating in the incentive program decreased by \$4 per member per month, or 1.1 percent more than in practices not taking part. These savings did not begin to accrue until a practice's second year, however; spending increased by \$5.95 in the first year.
- Changes in spending were greater for children than adults. Participating practices decreased total spending on children by \$5.44 per member per month, 5.1 percent more than nonparticipating practices. Spending on adults decreased by \$3.53 per member per month, or 1.1 percent more.
- For adult patients, savings of \$1.85 per member per month were achieved through greater reductions in outpatient facility costs. Spending for professional services, meanwhile, declined \$3 per member per month. Inpatient facility costs, however, were higher, by \$5.42 per member per month, or 0.5 percent.
- Participating practices achieved the same or better performance than nonparticipants over time on 11 of 14 quality measures. The researchers saw significant improvement on three of seven indicators related to preventive care: adolescent well care, adolescent immunization, and well-child visits at ages 3 to 6.

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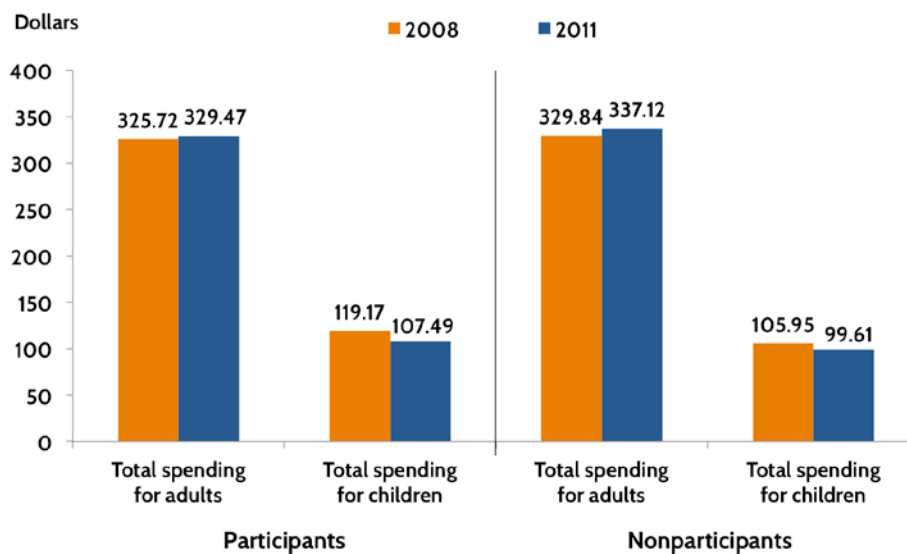
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They also observed significant improvement on four of the seven quality measures for diabetes care: screenings for HbA1c, low-density lipoprotein cholesterol, nephropathy, and the delivery of ACE inhibitors to patients with hypertension.

How Performance Differed Between Participants and Nonparticipants in Michigan's Fee-for-Value Physician Incentive Program, 2008 to 2011



Source: Adapted from C. Harris Lemak, T. A. Nahra, G. R. Cohen et al., "Michigan's Fee-for-Value Physician Incentive Program Reduces Spending and Improves Quality in Primary Care," *Health Affairs*, April 2015 34(4):645-52.

The Big Picture

Rewarding primary care physicians for improved performance on quality and cost metrics can lead to higher spending initially because of increased billing for preventive care and chronic disease management. While these additional services can produce downstream benefits by reducing the need for outpatient care, achieving similar reductions in hospital spending may take longer to achieve, at least with commercially insured populations that have younger, healthier members. Payers designing similar reward programs should consider this when setting expectations for reduced hospital use.

About the Study

The study used Blue Cross Blue Shield of Michigan's utilization and spending data collected between 2008 and 2011. To study the impact of the program over time, the authors compared the pre- and post-intervention performance of practices that participated in the Physician Group Incentive Program and those that did not. The program's impact on quality was assessed between 2008 and 2010 and relied on Healthcare Effectiveness Data and Information Set (HEDIS) process measures for preventive and evidence-based care. The study population included more than 3.2 million people under age 65 and more than 11,000 physician practices.

"It is possible to transform reimbursement within a fee-for-service framework to encourage and incentivize physicians to provide high-quality care, while also reducing costs."

The Bottom Line

Payers can contain costs and improve quality of care without disrupting the fee-for-service reimbursement model but should anticipate that spending may increase before it declines.

C. Harris Lemak, T. A. Nahra, G. R. Cohen et al., "Michigan's Fee-for-Value Physician Incentive Program Reduces Spending and Improves Quality in Primary Care," *Health Affairs*, April 2015 34(4):645-52.

This summary was prepared by Sarah Klein.