

Pay-for-Performance: Considerations for Implementation

Pay-for-performance (P4P) refers to a payment arrangement which offers financial incentives to health care providers for achieving pre-defined quality targets. In typical P4P initiatives, third-party purchasers align financial rewards with appropriate patient-centered care or positive clinical outcomes (a deviation from the fee-for-service model where purchasers reimburse health care providers for the quantity or intensity of services).

P4P programs may be administered by a variety of purchasers (i.e., a private health insurance plan, Medicare, Medicaid, or a provider group) and may be directed toward a variety of providers (i.e., physicians, hospitals, medical groups or other health care providers). Also referred to as value-based purchasing or quality-based purchasing, the P4P model may additionally target cost-effectiveness or may include non-financial incentives (e.g., public reporting requirements). The Centers for Medicare and Medicaid Services (CMS) defines P4P as "the use of payment methods and other incentives to encourage quality improvement and patient-focused high-value care."¹

Background

Over the past decade, the P4P movement emerged from concerns about the quality and safety of the U.S. health care system. Several prominent studies have publicized these concerns, including two Institute of Medicine (IOM) reports² and a 2003 study which found that adults receive the accepted standards of care only 55 percent of the time.³

Congress, the IOM, and other policy institutions now suggest the use of P4P as one component in promoting long-term quality improvement across the health care system. Although rewarding and improving quality is the primary goal of P4P initiatives, pressures to contain health insurance costs have led many purchasers to also focus on cost-effectiveness.⁴

Over 115 P4P programs (covering more than 50 million consumers) sponsored by private health plans, public insurance programs, and employer coalitions currently operate in the United States.⁵ Private sector health purchasers have experimented with P4P models since the 1990's, most often in primary care settings and in large practices that receive a substantial share of revenue from capitated or fixed payments.⁶ Some private health plans and employers have developed P4P programs with technical assistance from non-profit entities such as Bridges to Excellence, an employer-sponsored coalition, and Rewarding Results, a national demonstration project sponsored by the Robert Wood Johnson Foundation and the California HealthCare Foundation.

The public sector became interested in the P4P model soon after the private sector. In 2003, CMS launched the largest P4P pilot project to date, the Premier Hospital Quality Incentive Demonstration. The project offers financial bonuses to member hospitals of Premier (a nationwide organization of non-profit hospitals and health systems) for their performance on 34 evidence-based quality measures for patients with heart attacks, heart failure, pneumonia, coronary artery bypass grafts, and joint replacements. CMS has initiated several other pilot projects, including the Medicare Physician Group Practice Demonstration that rewards fee-for-service physician practices for improving the quality and efficiency of preventive care and chronic care management. Furthermore, Congress passed Medicare legislation in 2006 to pay a 1.5 percent bonus to physicians who voluntarily collect and report on a set of 74 quality measures.

Not only has the federal government experimented with P4P programs but state governments have applied the model within their Medicaid managed care, fee-for-service, and primary care case management plans. A recent survey found that over half of state Medicaid programs now operate one or more P4P programs.⁷ While efforts thus far have targeted children, adolescents, and women's health, the survey suggests a trend toward using incentives to promote chronic disease management.

Effectiveness of P4P Programs

A limited number of studies have assessed the effectiveness of the P4P model. A 2004 literature review found mixed results from nine randomized, controlled studies that measured the ability to change provider behavior or improve patient outcomes.⁸ Studies of the CMS Premier Hospital Quality Incentive Demonstration have also yielded mixed results. While initial studies suggested improvements in quality,⁹ a 2007 study comparing outcomes for heart attack patients at Premier Hospitals versus other hospitals found no evidence that financial incentives were associated with improved outcomes.¹⁰

Design Features

As a relatively new trend in the health care system, no one standard P4P model exists. Debate continues on how to measure quality and how to structure incentives and payments. The following questions and discussion illustrate the many issues to consider when designing P4P programs.

How should quality be measured? - Most P4P programs utilize a combination of process and clinical outcomes indicators to measure quality. Process measures include evidence-based clinical standards and procedures (e.g. beta-blocker therapy for heart attack patients or appropriate medication for asthma patients). Clinical outcomes measures focus on the health status of the patient after receiving treatment. Although clinical outcomes may be the most valued by the patient and provider, purchasers find them difficult to evaluate because of the multiple factors (both clinical and social) in a patient's life that influence health status. For this reason, P4P programs often utilize process measures more than clinical outcomes measures. An array of national organizations, including the National Quality Forum and the National Committee for Quality Assurance, have contributed to the development of standardized process and outcomes measures (often called performance measures). Other measures used in P4P programs include structural measures (environmental components such as the establishment of an IT system) and patient satisfaction measures (collected through patient surveys).

How Should Incentives and Payments be Structured? - The design of provider incentives and payments involves a lengthy list of considerations:

- Who should be targeted? (e.g., Hospitals or clinicians? Individual physicians or groups?)
- What types of conditions should be targeted? (e.g., preventive or chronic care?)
- Should incentives be financial or non-financial? (e.g., should public reporting of quality indicators be required as a non-financial incentive?)
- How much of a payment is necessary to motivate providers?
- Should provider participation be voluntary or mandatory?
- Should high quality be rewarded or low quality penalized? (or a combination of both?)
- Should efficient use of resources be rewarded?
- Should IT capabilities and data reporting functions be rewarded?
- How should bonuses be structured?
 - Should P4P reward high performance or improvement in performance? (Rewarding for improvement may encourage the lower performers to improve, but would fail to reward those already performing well.)

- Should bonuses be tiered? (e.g., a bonus payment if the provider achieves a benchmark 80 percent of the time and a larger bonus payment if the provider achieves it 90 percent of the time.)
- Should bonuses be based on comparative rankings? (e.g., a bonus payment if the provider ranks in the top 50 percent and a larger bonus payment if the provider ranks in the top 25 percent.)
- How should payments be distributed? (by reallocating an existing pool or by adding compensation on top of a standard reimbursement?)

Implementation Challenges

P4P purchasers face the obstacle of designing programs without much evidence regarding which structures work best in which situations. Several implementation barriers, common to all P4P approaches, complicate the process.

Adequacy of Quality Indicators - Providers, patients, and health plans often disagree over the definition of quality as well as the appropriate tools used to measure quality of care. Achieving consensus on which indicators to use becomes especially difficult when working with a large and diverse population. In a given situation, a provider may deviate from clinical guidelines to appropriately address the complexity of the illness and social factors. If payment incentives are not flexible, P4P requirements may encourage the provision of poor quality care in certain instances. Additionally, providers sometimes disagree on the reliability of the latest research findings. This further complicates the ability to achieve consensus on performance measures and suggests that P4P is best suited for preventive care settings, where performance indicators (e.g., vaccines, mammograms, or colonoscopies) are less disputed. As the model now expands into the area of chronic and complex conditions (e.g., diabetes and heart disease), the risk of inadequate process measures presents a challenge.

Limited Availability of Data - P4P initiatives face barriers to collecting performance measures because clinical data often remain inaccessible to third-party purchasers. Even when electronic systems provide clinical data, the lack of data exchange capabilities may hinder the collection and comparison of performance measures across the health system. Health plans often resort to claims data to assess provider performance, which further limits the breadth and depth of indicators used in P4P programs.

Assigning Provider Responsibility - Another barrier to implementation arises when patients utilize a variety of providers. According to a 2007 study, Medicare fee-for-service beneficiaries saw a median of two primary care physicians and five specialists working in four different practices.¹¹ Assigning certain responsibilities to certain providers or assigning shared responsibilities complicates the coordination of care, especially with chronic or co-morbid conditions. If P4P incentives overlap across providers working with the same patient, the incentives could encourage inefficiencies or harmful practices such as over-prescribing or unnecessary ordering of procedures.¹²

Considerations for Policymakers

Whether implementing a P4P program within Medicare, Medicaid, or a private insurance plan, policy makers should consider its impact on both providers and consumers.

Provider Reception - The current perception of P4P programs among health care opinion leaders remains mixed, with 44 percent supporting or strongly supporting the expansion of current programs.¹³ Concerns of providers include the possible loss of income as incentives are realigned, the extra time and effort needed to report data, and the possibility of being penalized for something out of the provider's control (e.g., the patient does not follow through on a recommended therapy). For long-term success of the P4P model, providers must view its processes and metrics as meaningful.

Involving providers early on in the design process is necessary to gain their trust and to inform the development of appropriate indicators.

Health Disparities - Policymakers should consider the possible unintended consequence of creating health disparities among consumers of P4P programs. Providers in low-income and minority communities may face difficulty in reaching quality benchmarks due to patients with fewer resources and more severe illnesses. P4P incentives should therefore adjust for risk so that providers do not feel discouraged from treating patients who are sicker or poorer.

Conclusion

Given the early stages of P4P demonstration projects and the lack of randomized evaluation studies, the question still remains: Will investing in P4P approaches lead to long-term improvements in quality across the health system? To succeed, both public and private sector health purchasers must encourage the development of standardized performance measures as well as the development of data reporting capabilities. Policymakers should consider P4P within the context of overall health system reform and should therefore coordinate P4P efforts with cost containment strategies as well as other quality and safety initiatives.

Endnotes

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October 2007
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