

# Pay-for-Performance in Health Care: Trends and Impact on Quality of Care

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# Pay-for-Performance Groundswell

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- ❑ IOM's "Quality Chasm" provided impetus to address reimbursement issues
- ❑ Most payers are experimenting with pay-for-performance (even CMS); employer coalitions also engaged
- ❑ Not new, but bigger and broader than previous quality incentives (5-10 measures, 5% of revenues)

# A Snapshot of Pay-for-Performance in the U.S.

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- Inventories of programs across all types of payers document more than 100 extant pay-for-performance programs<sup>1</sup>
- In a national survey, 52% of HMOs (covering 81% of enrollees) report using pay-for-performance<sup>2</sup>

1. Baker G, Carter B. The Evolution of Pay for Performance Models for Rewarding Providers. In: Introduction to Case Studies in Health Plan Pay-For-Performance. Washington, DC: Atlantic Information Services; 2004.

2. Rosenthal MB, et al. Pay-for-Performance in Commercial HMOs. New England Journal of Medicine, in press.

# What Types of Health Plans Use Pay-for-Performance?

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- HMO programs most common, particular those with:
  - PCP gatekeeping
  - Capitation
- Anywhere but the South
- Those in markets where employers use performance-contracting with health plans

# How Are Pay-for-Performance Programs Structured?

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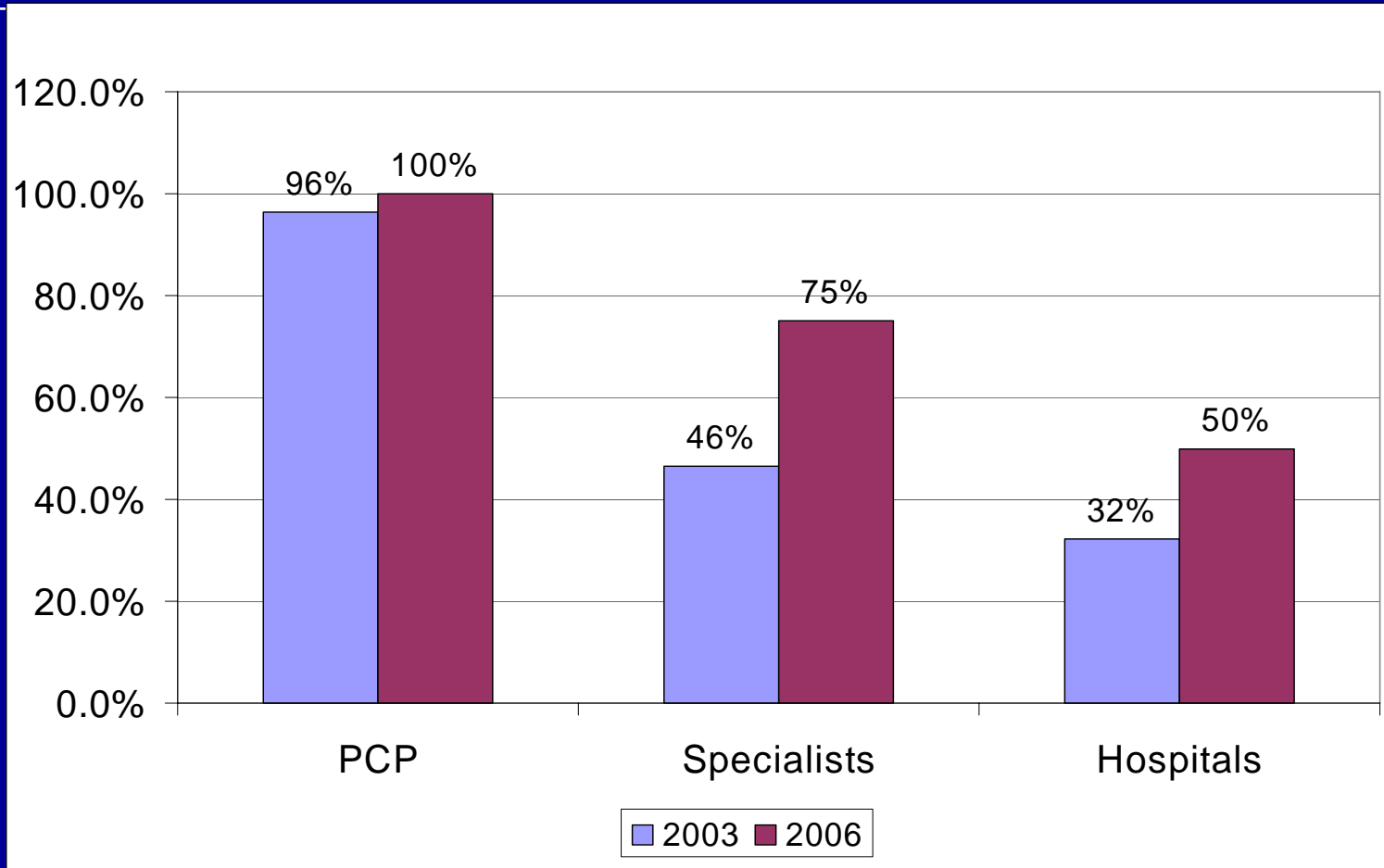
- ❑ Physicians (medical groups) about twice as likely as hospitals to be target
- ❑ Average of 5 performance measures
- ❑ Maximum bonus 5-10% of pay for physicians, 1-2% for hospitals
- ❑ Rewards for reaching fixed threshold dominate; only 23% reward improvement



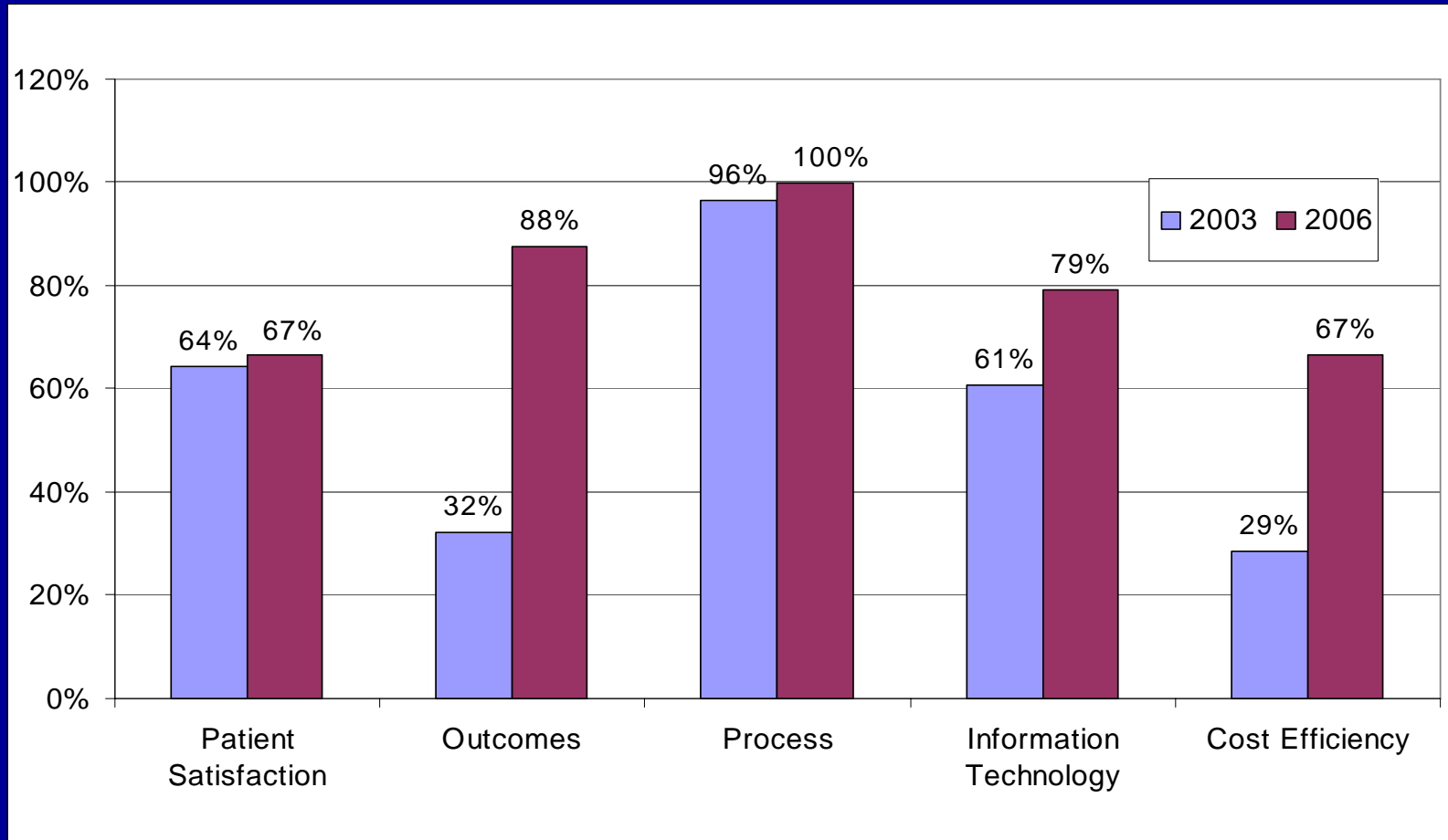
# Key Trends in Program Design

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# Increasing Inclusion of Specialists and Hospitals in Pay-for-Performance



# Increasing Emphasis on Outcomes, IT, Cost-Efficiency





# Early Results

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# Overview of Impact Estimates

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- ❑ Rigorous studies of pay-for-performance in health care are few (17 since 1980)
- ❑ Overall findings are mixed: many null results even for large dollar amounts
- ❑ But in many cases negative findings may be due to short-term nature, small incentives
- ❑ Evidence suggests pay-for-performance can work but also can fail

# Case Study #1: The Integrated Healthcare Association (CA)

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- ❑ Probably largest effort in U.S.
- ❑ Statewide in California
- ❑ Capitated, multispecialty medical groups targets
- ❑ Core measures common to 7 plans, coordinated data collection
- ❑ Public reporting of all-payer data

# 2004 IHA Measure Set

<b>Domain (Weight)</b>	<b>Measures</b>
Clinical (40%)	Mammography
	Cervical cancer screening
	Childhood immunization
	HbA1c Testing
	LDL Cholesterol Testing
	Asthma medication management
Patient Experience (40%)	Various patient survey composites
IT (20%)	Integration of electronic data sets
	Point of care decision support



# IHA Reported Impact

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- ❑ All targeted measures improved
- ❑ Average improvement ~ 3 percentage points (less for patient experience)
- ❑ Many measures had no valid baseline comparison
- ❑ IT measures showed strongest results
- ❑ No way to establish how much due to pay-for-performance

# IHA Part II: PacifiCare Quality Incentive Program (QIP)

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- ❑ Evaluation using one member plan's trend and comparison data suggests effects on process measure improvement minimal (only cervical cancer shows impact)
- ❑ Also gives credence to concern that rewarding all providers who can meet a fixed performance target will not stimulate uniform improvement
- ❑ Implication: pay-for-performance programs as now designed may be good screening devices but will yield little QI

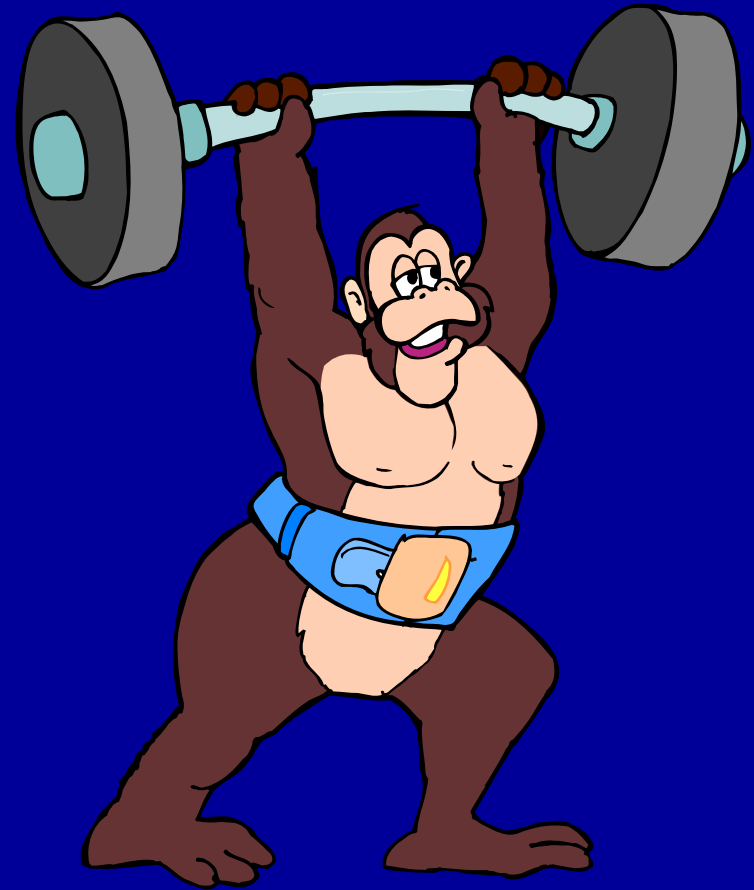
# Quality Improvement and Payments to Groups with High, Middle or Low Baseline Performance

<b>Quality Domain</b>	<b>Total PacifiCare Members</b>	<b>Pre-QIP Rate</b>	<b>Post-QIP Rate</b>	<b>Improvement (Post-Pre)</b>	<b>Bonuses Paid in Year 1</b>
<b>Cervical Cancer Screening</b>					
Group 1	597,091	53.6%	56.0%	2.5% (0.8%)	\$ 436,618
Group 2	287,610	40.8%	48.1%	7.4% (2.4%)	\$ 127,632
Group 3	305,041	23.0%	34.1%	11.1% (3.9%)	\$ 26,859

# Case Study #2: National Health Service General Practitioner Contract

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- ❑ 146 performance indicators (clinical, organizational, patient experience, additional services)
- ❑ Subsidies for equipment and staff
- ❑ Bonuses for performance up to 25% of pay
- ❑ Penalties built in for very low performance





# Scoring in the NHS GP Contract

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- ❑ Rewards under the GP contract are based on point system
- ❑ Total points vary by measure – reflecting both importance and usefulness of measure
- ❑ Within measures, there are population based thresholds: e.g., one point for screening at least 25% of patients; 2 points for screening at least 50%, etc.
- ❑ Exclusion of patients from denominator may be requested



# GP Contract Initial Results

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- ❑ Practices received on average 95.5% of available points
- ❑ Actual adherence to each of the clinical process indicators average 83.4% overall
- ❑ Median exception reporting was 6% but some practices excluded more than 15%
- ❑ Exception reporting largest factor predicting performance



# Can Pay-for-Performance Improve Quality?

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- ❑ We all believe the current payment system contributes to quality problems
- ❑ Payment reform is necessary
- ❑ Pay-for-performance is directionally correct, but...



# Limitations of Pay-for-Performance

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- ❑ Multiple payers pursuing competitive programs may lead to morass (CMS may lead)
- ❑ Current efforts have not yet worried about matching design to goals
- ❑ Balancing desire for high-powered incentives with concerns over “gaming” may be challenging



# Looking Ahead: Key Issues

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- Current pay-for-performance programs not aligned with design principles
  - Need to align incentives with the true cost of delivering the care we want (including foregone revenues)
  - Incentives should reward all increments of high-value care, not just “best” providers



# Key Issues (Cont'd)

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- Pay-for-performance is likely to focus increasingly on ROI:
  - Quality improvement with savings (e.g., reducing complications)
  - Incorporation of efficiency measures (quality-adjusted cost per episode)
  - Specialists



# What Will the CMS Do?

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- ❑ Continued sequencing of data collection, reporting, pay-for-performance for all providers
- ❑ Institutions (hospitals, home health) seem likely to be first for payment incentives— obstacles to physician pay-for-performance enormous
- ❑ Budget neutrality will influence measure selection, magnitude, structure
- ❑ Private payers likely will align with CMS



# Looking Forward

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- ❑ 1. Everyone agrees that the payment system is a problem
- ❑ 2. Payment reform is needed
- ❑ 3. 1 and 2 do not guarantee that all payment reform will lead to improvement
- ❑ Pay-for-performance needs work to succeed or it will join the stack of failed private sector reforms
- ❑ Work means: (1) thoughtful design, (2) coordination, (3) rigorous evaluation and revision