Pay-for-Performance in Health Care: Trends, Impact, and Policy Issues

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

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

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, November 2, 2006.

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

- 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

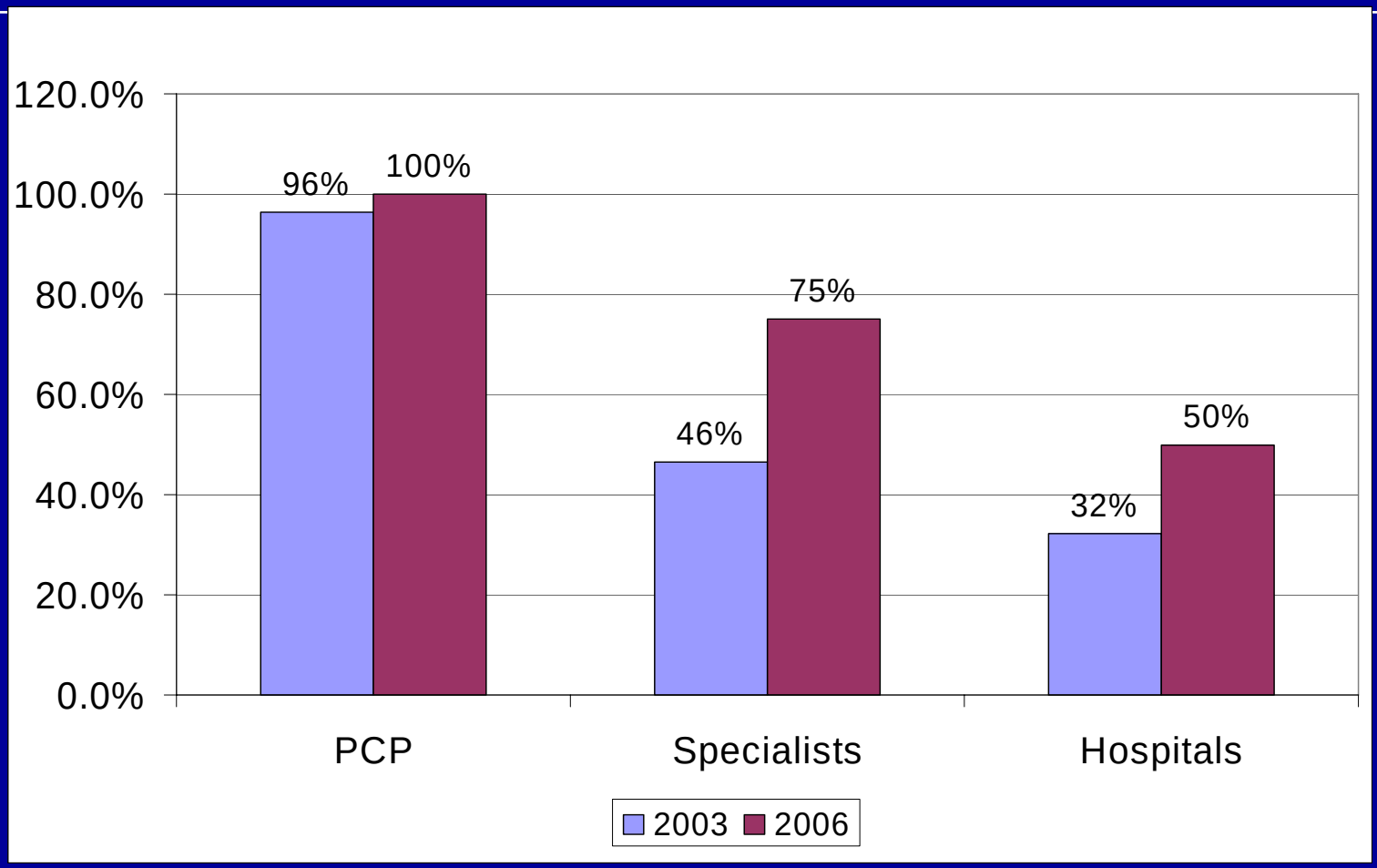
How Are Pay-for-Performance Programs Structured?

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

Pay-for-Performance and IT

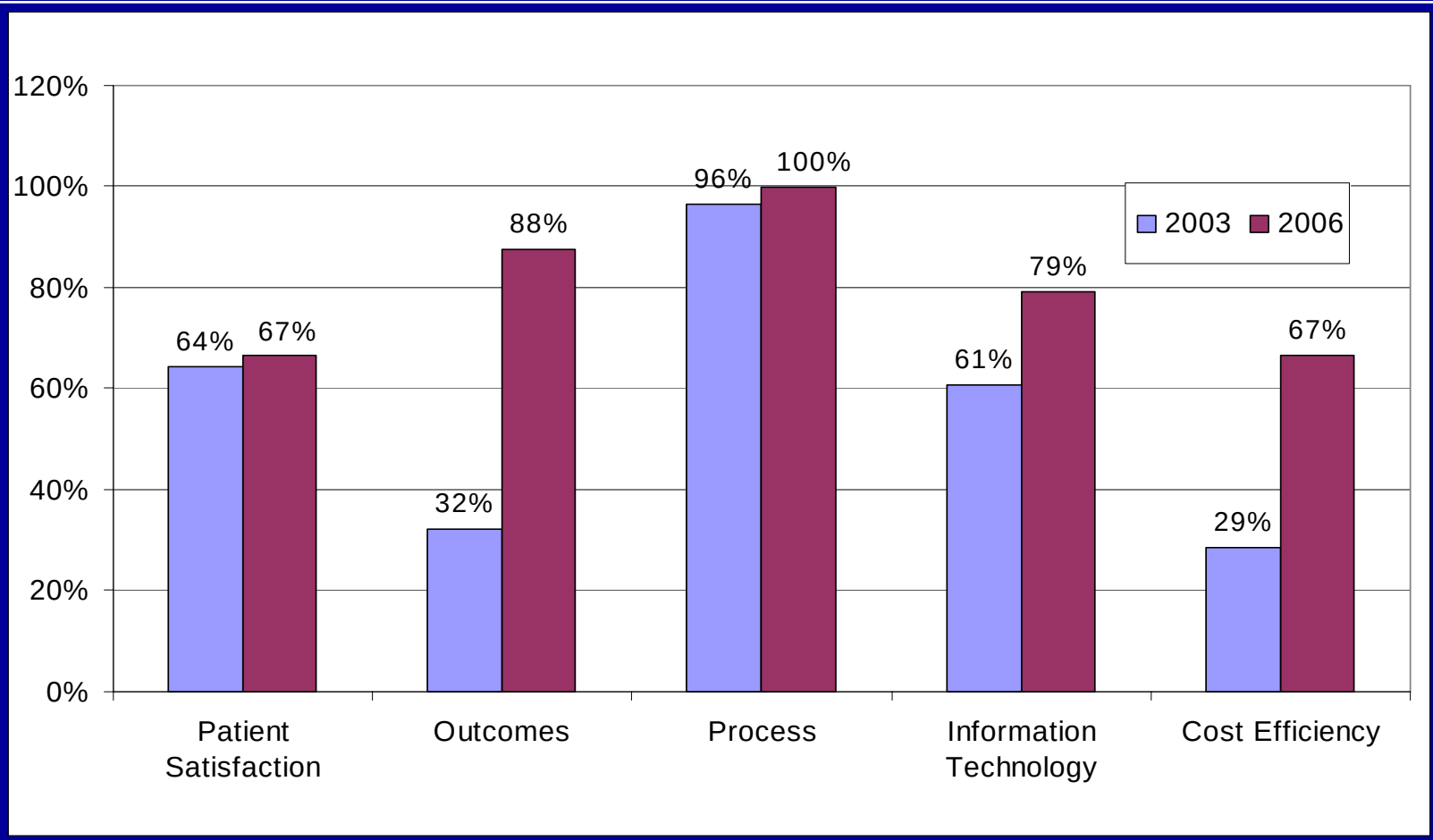
- ~60% of HMOs that have physician pay-for-performance include IT measures in their programs
- ~30% of HMOs with hospital pay-for-performance include CPOE measures
- Standardized instruments have been developed for IT process measures (to capture effective use)

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



Source: Rosenthal et al., Climbing Up the Pay-for-Performance Learning Curve, Manuscript, Harvard University 2006.

Increasing Emphasis on Outcomes, IT, Cost-Efficiency



Source: Rosenthal et al., Climbing Up the Pay-for-Performance Learning Curve, Manuscript, Harvard University 2006.

Overview of Impact Estimates

- 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)

- 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

Domain (Weight)	**Measures**
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

- 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)

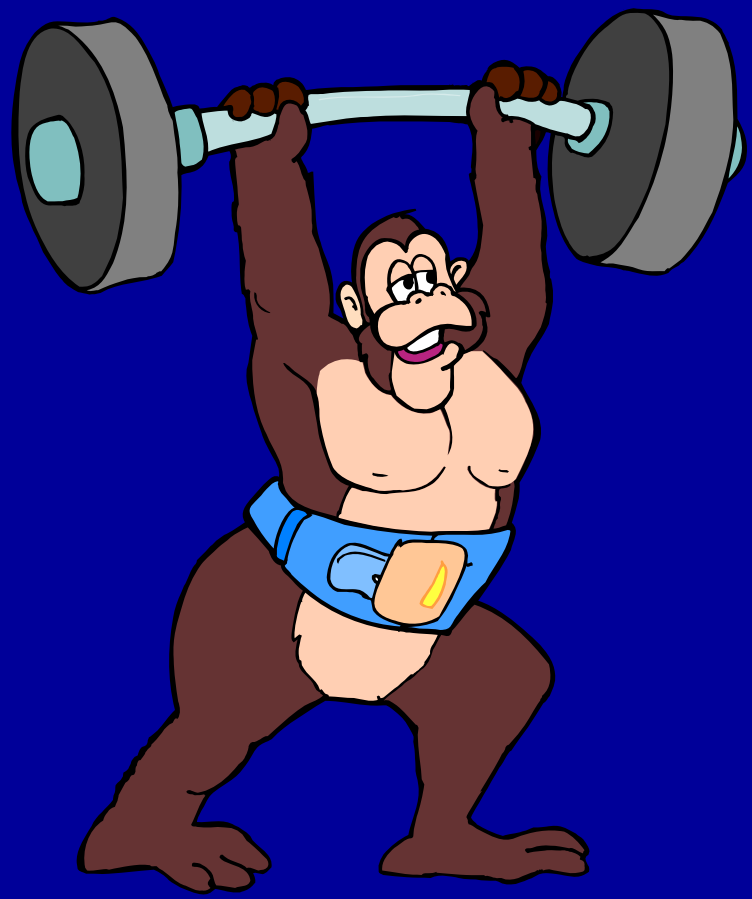
- Evaluation using one member plan's trend and comparison data suggests effects on process measure improvement minimal (only cervical cancer shows impact)
- Also gives credence to concern that rewarding all providers who can meet a fixed performance target will not stimulate uniform improvement
- Implication: 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

Quality Domain	Total PacifiCare Members	Pre-QIP Rate	Post-QIP Rate	Improvement (Post-Pre)	Bonuses Paid in Year 1
Cervical Cancer Screening					
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

- 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

- 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

- 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

Summary

- Pay-for-performance is theoretically defensible, but little is known about best practices
- Trends suggest increasing breadth, depth
- Design improvements needed to improve quality, minimize unintended consequences

Key Issues for the Future

1. Current pay-for-performance programs not consistent with incentive 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
2. 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)
3. What CMS ultimately does will clearly matter for ultimate impact