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

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Pay-for-Performance Groundswell

- 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.

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

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

- HMO programs most common, particularly 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
- 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
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.
Early Results
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

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

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Total PacifiCare Members</th>
<th>Pre-QIP Rate</th>
<th>Post-QIP Rate</th>
<th>Improvement (Post-Pre)</th>
<th>Bonuses Paid in Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cancer Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Group 1</td>
<td>597,091</td>
<td>53.6%</td>
<td>56.0%</td>
<td>2.5% (0.8%)</td>
<td>$ 436,618</td>
</tr>
<tr>
<td>Group 2</td>
<td>287,610</td>
<td>40.8%</td>
<td>48.1%</td>
<td>7.4% (2.4%)</td>
<td>$ 127,632</td>
</tr>
<tr>
<td>Group 3</td>
<td>305,041</td>
<td>23.0%</td>
<td>34.1%</td>
<td>11.1% (3.9%)</td>
<td>$ 26,859</td>
</tr>
</tbody>
</table>
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
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
Can Pay-for-Performance Improve Quality?

- 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

- 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

- 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)

- 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?

- 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

- 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