Pay-for-performance: What can you expect?

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Pay-for-performance programs (P4P) are spreading. Medicare has committed to a national P4P demonstration project, a large employer group has initiated its own program, and the American Medical Association (AMA) has published principles it will use to assess such programs. The American Academy of Family Physicians (AAFP) published its own criteria last year. What are the characteristics of P4P programs, private and public examples, and benefits and risks of their use?

How does it work?

Pay-for-performance refers to financial-incentive programs that pay bonuses to participants (physicians, physician groups, health plans, or hospitals) that make progress, or attain specific benchmarks, in quality and efficiency. Alternatively, P4P programs may create different tiers of providers based on quality standards, and then give patients financial incentives (such as lower co-payments) to use one tier instead of another. This latter mechanism is currently the subject of a nasty argument between the Barnes Jewish health system in St. Louis and United Healthcare.

Goals may be clinical or nonclinical. Clinical goals usually measure processes of care (eg, measurement of hemoglobin A_{1C} and lipids in persons with diabetes, use of beta-blockers and aspirin after myocardial infarction, anti-inflammatory medications for chronic asthma, or appropriate cancer screening). However, of late there has been movement toward using intermediate outcome measures, such as control of hypertension and blood sugar, and long-term outcomes such as mortality, morbidity, and quality of life. Nonclinical goals include implementing such information technology as electronic health records, or improving access to care and patient satisfaction.

How prevalent is P4P? A national survey conducted by Med-Vantage, a health informatics company, in November 2004, identified 84 programs—covering 39 million beneficiaries—that had some P4P characteristics.

They found P4P programs expanding from primary care providers to specialist involvement, from HMOs to PPOs, and from annual bonuses to tiered fee schedules. They also reported an emphasis on using the National Commission for Quality Assurance (NCQA) measures as performance goals, rewarding information technology adoption, and increasing involvement of the Center for Medicare and Medicaid Services (CMS).

P4P programs surveyed reported quality improvement as the #1 reason for their programs, validity of the data as their #1 concern, and early provider involvement and use of standardized measures as the main recommendations for new programs.[1]

National programs and how they might affect you

MedPAC and providers stress information technology. The Medicare Payment Advisory Commission (MedPAC), which makes recommendations on provider

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TABLE 1

Bridges to Excellence key principles
• Reengineering care processes to reduce mistakes will require investments, for which purchasers should create incentives.
• Significant reductions in defects (misuse, underuse, overuse) will reduce the waste and inefficiencies in the health care system.
• Increased accountability and quality improvements will be encouraged by the release of comparative provider performance data, delivered to consumers in a compelling way.

payments to CMS, announced in its 2005 annual report that Medicare should begin paying all physicians differently based on how they perform. MedPAC envisions rewarding the use of information technology such as electronic health records first, and later adding measures for quality outcome.[2]

Almost simultaneously with this recommendation, CMS announced that 10 large physician group practices would participate in a new P4P Medicare demonstration project. These practices hope to improve quality and lower Medicare costs (by focusing on disease management strategies and information technology), and in return, CMS will return a portion of the savings to them. Initially, CMS will base the majority of bonus payments on financial savings rather than quality improvement; this has led to concern that costs are the primary driver of the program.[3]

FAST TRACK

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Premier Hospital Quality Incentive focusing on 5 clinical areas. CMS also sponsors the Premier Hospital Quality Incentive Demonstration, a P4P program that tracks performance for 5 common clinical conditions at 270 participating hospitals. The program rewards high performers from a bonus pool of $7 million per year over a 3-year period. In May 2005, Mark McClellan, MD, PhD, the director of CMS, announced improvement in all 5 areas (acute myocardial infarction care, coronary artery bypass graft surgery, care for congestive heart failure, hip and knee replacement surgery, and pneumonia care) in the first year of the project.[4]

Bridge to Excellence encourages more patient involvement. A national private sector response to the P4P movement has been Bridge to Excellence (BTE), a nonprofit organization whose board represents employers, providers, and health plans (emphasis on the employers) with major funding from large companies. It was created in response to the Institute of Medicine's 2001 report, *Crossing the Quality Chasm*, which included a recommendation to redesign the way providers are paid to encourage quality improvement (**TABLE 1**).

BTE has developed several P4P programs in cooperation with the NCQA. *Physician Office Link* pays physician's offices up to $50 per year for each patient covered by a participating employer or plan. NCQA criteria include the use of clinical information systems, education to promote patient self-management, a quality improvement system, and programs to care for patients with chronic disease.

Diabetes Care Link rewards physicians who meet NCQA standards for its Diabetes Physician Recognition program with up to $80 for each patient with diabetes covered by the employer or health plan sponsor.

Cardiac Care Link rewards physicians who qualify for NCQA's Heart/Stroke Recognition Program with up to $160 for each covered patient with cardiac disease. Physicians must submit data on blood pressure, lipid testing, antithrombotic use, and smoking cessation. Physicians qualify for the bonus based on a combination of process measures (performing tests/screenings) and outcome measures (eg, appropriate LDL level, aspirin use).[5] The program started with about a dozen employers in just a few areas (Cincinnati, Massachusetts, and upstate New York). In March 2005, BTE announced that coalitions in 3 additional states (Illinois, Colorado, and Arkansas) are working with employers to license and launch BTE-related incentive projects later this year.[6]

NCQA. As the leader in accrediting managed care organizations, the nonprofit

NCQA is often thought of as the expert in developing reliable performance measures. For almost 15 years, the NCQA has been refining its Health Plan Employer Data and Information Set (HEDIS) as a means for evaluating health plans. Many physicians have had their care reviewed as part of having contracts with managed care companies that apply for NCQA accreditation. The NCQA's longstanding commitment to the development of reliable performance measures and the involvement of multiple health system stakeholders in its work has given them a great deal of national credibility.

TABLE 2

AMA principles to evaluate P4P programs

1. Ensures quality of care: focus on improving health, not reducing utilization.
2. Fosters the patient-physicians relationship: don't restrict patient access to needed care.
3. Allows voluntary participation: doctors can opt out without financial penalties.
4. Uses accurate data and fair reporting: scientifically sound measures, allow physician input, and not use results unfairly in physician credentialing.
5. Provides fair and equitable incentives: offer new funds for positive incentives for physicians, not penalties.

Concerns

While embracing the quality improvement movement, major physician organizations have been cautious in their support of current P4P programs. Both the AAFP and AMA guidelines emphasize the need to focus on quality rather than cost reduction, involve physicians in program design, use evidence-based and statistically valid performance measures, reward both performance improvement and attainment of predetermined targets, and use new money for incentive payments rather than reducing existing payments to physicians (**TABLE 2**).[7,8]

Benefits and risks

The hope is that P4P will change physician and systems behavior to improve quality and patient safety. It may be that such changes will also reduce costs, although it is certainly true that additional resources will be needed initially to help implement the technology expected to make such improvement more likely. Proponents hope that incentive payments and improved information systems will also lead to improved population management: caring for an entire practice, not just the patient who comes to the office. Disease registries and electronic health records are envisioned as 2 of the keys to making this happen.[9]

Why success will not be easy. One hurdle will be the difficulty of providing sufficient incentives to individual physicians or small group practices that deal with numerous insurers. One company's P4P program may not matter much to a physician who cares for only a small number of that company's patients. Groups of health plans and purchasers will need to cooperate in developing a common set of measures and incentives to use in a P4P program. Such cooperation will not be easy to accomplish.

Another challenge will be to identify the right number and type of measures to engage providers and actually improve care.

Then there are the financing issues—will additional money be made available for positive incentives, or will there be a revenue-neutral system in which some providers get more money while others less? This is an issue that greatly concerns the AAFP and AMA.

Finally, how will P4P affect physicians who care for the underserved and socioeconomically disadvantaged. These patients are often more difficult to care for than those with adequate healthcare coverage, and often require more intensive use of resources—all of which may limit the ability of their providers to qualify for incentive payments through P4P programs. This could lead to the unintended consequence of physicians reducing the number of underserved patients they care for.

One way to address this problem would be to improve risk-adjustment

FAST TRACK

The AAFP and AMA want the focus on quality, not cost reduction ... and use new money for incentives rather than reduce existing payments

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Evidence-based medicine ratings

THE JOURNAL OF FAMILY PRACTICE uses a simplified rating system system called the Strength of Recommendation Taxonomy (SORT). More detailed information can be found in the February 2003 issue, "Simplifying the language of patient care," pages 111–120.

Strength of Recommendation (SOR) ratings are given for key recommendations for readers. SORs should be based on the highest-quality evidence available.

- **A** Recommendation based on consistent and good-quality patient–oriented evidence.
- **B** Recommendation based on inconsistent or limited-quality patient-oriented evidence.
- **C** Recommendation based on consensus, usual practice, opinion, disease-oriented evidence, or case series for studies of diagnosis, treatment, prevention, or screening

Levels of evidence determine whether a study measuring patient-oriented outcomes is of good or limited quality, and whether the results are consistent or inconsistent between studies.

STUDY QUALITY

1—Good-quality, patient-oriented evidence (eg, validated clinical decision rules, systematic reviews and meta-analyses of randomized controlled trials [RCTs] with consistent results, high-quality RCTs, or diagnostic cohort studies)

2—Lower-quality patient-oriented evidence (eg, unvalidated clinical decision rules, lower-quality clinical trials, retrospective cohort studies, case control studies, case series)

3—Other evidence (eg, consensus guidelines, usual practice, opinion, case series for studies of diagnosis, treatment, prevention, or screening)

Consistency across studies

Consistent—Most studies found similar or at least coherent conclusions (coherence means that differences are explainable); *or* If high-quality and up-to-date systematic reviews or meta-analyses exist, they support the recommendation

Inconsistent—Considerable variation among study findings and lack of coherence; *or* If high-quality and up-to-date systematic reviews or meta-analyses exist, they do not find consistent evidence in favor of the recommendation

methods to compensate for the increased difficulty in providing high-quality care to certain kinds of patients. Development of such methods will likely be difficult to implement. Another way would be to evaluate providers based on their quality improvement over time rather than establishing minimum targets that have to be met to qualify for any incentive payments.

P4P is likely to expand

The recent entrance of CMS into P4P programs as well as the interest coming from large employers makes it likely that P4P will continue to expand. While paying more for higher-quality care makes sense and should save money in the long run, the constraint on resources currently available from the government and private insurers to reward higher performers as well as fund improvements necessary to ensure better care make it probable that there will be increased tension between P4P as a quality-improvement vs a cost-savings effort. ■

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