Pay for Performance May Not Do Much for Quality

It is important to examine the evidence base that pay-for-performance programs improve quality.

BY JEFF EVANS
Senior Writer

WASHINGTON — The few studies that have examined the effectiveness of incentivized pay-for-performance programs have found a mix of moderate to no improvement in quality measures, which, in some instances, have led to unintended consequences, Dr. Daniel B. Mark said at the annual meeting of the Heart Failure Society of America.

More than 100 reward or incentive programs have started in the private U.S. health care sector under the control of employer groups or managed care organizations, according to Dr. Mark, but congressionally authorized programs by the Centers for Medicare and Medicaid Services have received the most attention, he said.

It is important to examine the evidence base that pay-for-performance programs actually improve quality because "people are making this association," said Dr. Mark, director of the Outcomes Research and Assessment Group at the Duke (University) Clinical Research Institute, Durham, N.C.

During the last 20 years, incentivized performance programs have shown that "what you measure generally improves and what gets measured is generally what's easiest to measure. But the ease of measurement does not necessarily define the importance of the measurement." Furthermore, very little, if anything, is known about whether these initiatives are cost effective for the health care system at large, Dr. Mark said, although he noted that that may be an oversimplification of the outcomes of such programs.

A systematic overview of 17 studies published during 1980-2005 on pay-for-performance programs found that 1 of 2 studies on system-level incentives had a positive result in which all performance measures improved. In nine studies of incentive programs aimed at the provider group level, seven had partially positive or fully positive results but had "quite small" effect sizes. Positive or partially positive results were seen in five of six programs at the physician level (Ann. Int. Med. 2006;145:265-72).

Nine of the studies were randomized and controlled, but eight of these had a sample size of fewer than 100 physicians or groups; the other study had fewer than 200 groups. "If these had been clinical trials, they would have all been considered extremely underpowered and preliminary," Dr. Mark said.

Programs in four studies appeared to have created unintended consequences, including "gaming the baseline level of illness," avoiding sicker patients, and an improvement in documentation in immunization studies without any actual change in the number of immunizations given or effect on care. The studies did not include any information on the optimal duration of these programs or whether or not their effect persisted after the program was terminated. Only one study had a preliminary examination of the cost-effectiveness of a program.

Another study compared patients with acute non–ST-elevation myocardial infarction in 57 hospitals that participated in CMS' Hospital Quality Incentive Demonstration and 113 control hospitals that did not participate in the program to determine if a pay-for-performance strategy produced better quality of care. There was "very little evidence that there was any intervention effect," according to Dr. Mark. Measures that were not incentivized by CMS also did not appear to change (JAMA 2007;297:2373-80).

In the United Kingdom, family practice physicians participated in a pay-for-performance program in 2004 that focused on 146 quality indicators for 10 chronic diseases as well as measures related to the organization of care and the patient's experience. The National Health Service substantially increased its deficit that year because the approximately $3.2 billion allocated for the project was eaten by greater than predicted success in achieving the quality indicators (83% achieved vs. an expected 75%). This led to an average increase in the physicians' pay of about $40,000 that year (N. Engl. J. Med. 2006;355:375-84).

Other investigators noted that in the 1998-2003 period prior to the NHS project all of the quality indicators had already been improving, "so it's not clear how much the program's achievements can actually be attributed to the program itself," he said (N. Engl. J. Med. 2007;357:181-90). And it is not clear what effect the program had on other conditions that were not a part of the incentive program. In any case, the U.K. government has significantly tightened up its requirements for earning extra money in the program in 2008, according to Dr. Mark. ■

UnitedHealthcare to Pay Up to $20M in Settlement

BY MARY ELLEN SCHNEIDER
New York Bureau

The insurance giant UnitedHealthcare could pay up to $20 million to state regulators to settle allegations that the company violated state laws in its claims processing.

Under the settlement, UnitedHealthcare has agreed to pay about $12.2 million up front to 36 states and the District of Columbia. Going forward, the payout could grow to $20 million if other states join the settlement.

UnitedHealthcare has also agreed to a 3-year process improvement plan that will run through the end of 2010. The company will be required to self-report data quarterly and annually on how it performs on a set of national performance standards. These benchmarks will focus on claims accuracy and timeliness, appeals review, and consumer complaint handling. A lack of compliance with the benchmarks could result in additional financial penalties, according to the National Association of Insurance Commissioners.

The settlement follows a multistate investigation that found errors in claims processing such as not applying correct fee schedules and deductibles. There were also frequent violations of prompt payment rules, according to the New York State Insurance Department, one of the lead parties in the settlement.

The settlement was praised by the National Association of Insurance Commissioners and the states involved. UnitedHealthcare also praised the settlement as evidence of how the industry can work with state regulators.

"This new, forward-thinking approach focuses the regulatory process for the states and our company on a practical set of uniform performance standards, while providing clearer and more meaningful means of assessing how well we are serving customers," UnitedHealthcare CEO Kenneth A. Burdick said in a statement.

The District of Columbia and the following states signed on to the agreement: Alabama, Alaska, Arkansas, California, Connecticut, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, West Virginia, and Wyoming. ■

Uninsured Total in U.S. Hits 47 Million

BY MARY ELLEN SCHNEIDER
New York Bureau

The number of Americans without health insurance reached 47 million last year, up from 44.8 million in 2005, according to new data released by the U.S. Census Bureau.

The percentage of individuals without health insurance also rose from 15.3% in 2005 to 15.8% in 2006.

This rise includes an increase in the number of uninsured children. The percentage and number of children under age 18 without health insurance increased from 8 million (10.9%) in 2005 to 8.7 million (11.7%) in 2006. Much of the increase in the uninsured rate for children can be attributed to a decline in private coverage, David Johnson, chief of the division of housing and household economic statistics at the Census Bureau, said during a news conference.

Overall, the percentage of individuals covered by any type of private insurance plan dropped from 68.5% in 2005 to 67.9% in 2006. And among children, the percentage with private coverage fell from 65.8% in 2005 to 64.6% in 2006, Mr. Johnson said.

At the same time, coverage by government insurance was also down from 27.3% in 2005 to 27% in 2006. The data are compiled from the 2007 Current Population Survey Annual Social and Economic Supplement.

The increase in the number of uninsured individuals between 2005 and 2006 is "pretty shocking," said Karen Davis, Ph.D., president of The Commonwealth Fund, especially in a year when states have been under less financial pressure and many have been trying to expand coverage.

The deterioration of dependent coverage among private plans is particularly disturbing and points to the importance of reauthorizing the State Children's Health Insurance Program (SCHIP) with adequate funding, she said.

The number and percentage of uninsured children had been falling consistently between 1998 and 2004 but that progress began to reverse in 2005, said Robert Greenstein, executive director of the Center on Budget and Policy Priorities. These latest data from the Census Bureau show that the country is "losing significant ground" in insuring children, he said, and he called on President Bush to rethink his position on funding for SCHIP. ■

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