Pay for Performance Not Yet Showing Efficacy

BY TIMOTHY F. KIRN
Sacramento Bureau

SEATTLE — When the physicians of Rochester, N.Y., first had a pay-for-performance program imposed on them, they ignored it.

That denial ended when the first performance-based checks were disbursed, and after 3 years, pay-for-performance (P4P) measures have paid off in reduced health plan costs of almost $5 million, said Dr. Howard B. Beckman, the medical director of the Rochester Individual Physician Association (IPA), speaking at the annual research meeting of AcademyHealth.

Dr. Beckman was one of three physicians who presented research on whether pay for performance improves quality of care and efficiency in medicine enough to make worthwhile all the effort being put into it. He was the only one of the three to have a positive conclusion.

The other two investigations of pay for performance, in California and Massachusetts, looked more specifically at individual aspects of clinical care. Those investigators found they could not document an impact from the programs.

But those investigators also pointed out that, as in Rochester, it takes time for physicians to get accustomed to the idea of greater accountability, and to develop the capabilities to record and report for the programs, so their findings might reflect the fact that the programs have not been going long enough.

On the other hand, the findings may show that financial incentives do not work for professionals, something research in other fields has suggested, they noted.

The Rochester physicians went through stages of acceptance of pay for performance, Dr. Beckman said.

After the first performance bonus checks were sent out and denial ended, there was anger. The physicians complained that strict performance measures impinge on their autonomy, and they were even offended by the implication that money could influence their behavior, he said.

Then, after about 2 years, the general resistance abated, and the angry phone calls stopped, Dr. Beckman said. Now when he gets phone calls about the program, it is an individual physician trying to negotiate something.

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Ignoring pay for performance won't make it go away, said Dr. Howard B. Beckman, medical director of the Rochester IPA.

The Rochester IPA represents all 3,200 physicians in the Rochester area and has insurance contracts that cover about 50% of the community market. Its individual physician profiling program began in 2002.

The program's individual physician payments vary, but overall the program pays out about $15 million a year, and the average internist can earn from $4,000 to $12,000 from the quality reports. The physicians get three reports a year, and payments are made at the end of the year.

Dr. Beckman looked at the provider profile data for patients with diabetes and coronary artery disease. He found that when expected costs were compared with actual costs in the diabetes patients in 2003 and 2004, there was a savings of about $1 million in the first year and $2 million in the second year. Most of that savings, about $1.3 million, came from reduced inpatient hospitalization costs.

The savings for the coronary artery disease patients was about $2 million over the 2 years, for a total savings for just those two groups of patients of about $5 million, Dr. Beckman said. Given what the group had put into the program (about $1.1 million, mostly for computer capability), the return on investment for the program was about four times what was spent.

Dr. Beckman pointed out that many people have expressed concern that pay-for-performance programs could be unfair to physicians with the most difficult, least compliant patients, so he looked at different practices. It appeared that differences were greater between individual doctors than they were between practices and practice locations.

Pay for performance began in California at about the same time as the Rochester program, and it has yet to show any meaningful overall improvement in clinical care, said Cheryl L. Damberg, Ph.D., a researcher for the RAND Corp., who has been analyzing data from the California collaborative managed by the Integrated Healthcare Association, which includes seven HMOs and point-of-service plans contracting with 225 physician groups.

In Massachusetts, doctors with pay-for-performance contracts have improved their quality since programs were introduced into the state, but so have doctors without contracts, said Dr. Steven D. Pearson, the director of the Center for Ethics in Managed Care at Harvard Medical School, Boston.

He looked at data collected from the state's pay-for-performance programs put together by the Massachusetts Health Quality Partnership, a collaboration of five nonprofit health plans covering 4 million people, and physician groups representing about 5,000 primary care physicians.

In 2001, there were four pay-for-performance contracts in the state. That rose to 8 in 2002, and 18 in 2003.

Comparing Health Plan Employer Data and Information Set measures from the groups with those contracts to measures from control groups without contracts, Dr. Pearson found that, for 4 of 30 measures, the contract groups had more improvement for those years than the control groups. For 21 measures, the groups had similar improvement.

But, for five measures—chlamydia testing, hemoglobin A_{1c} testing in diabetics, LDL cholesterol testing in diabetics, urine testing in diabetics, and well-child visits by adolescents—the control groups had more improvement. And, two of the four measures for which the contract groups outperformed the control groups were dominated by a special contract and a single 38-physician practice, Dr. Pearson said.

Moreover, when he restricted his analysis to just groups termed "high-incentive" groups, there was still no more improvement than in controls. High-incentive groups were defined as ones that could receive performance bonuses of $100,000 or more, or for whom individual primary care physicians could receive bonuses of more than $1,000.

There are two plausible explanations for the findings, Dr. Pearson said. "Either P4P has worked in Massachusetts because it is part of this atmosphere of driving quality improvement or P4P has failed because it is either too weak—not enough money on the table—or it was poorly designed."

Money indeed may turn out to be the pressing issue as pay for performance becomes more common.

Slowly but surely, many physicians seem to be coming around to pay for performance because they see it as an effort in medicine to make quality a priority, these investigators said.

But Dr. Damberg said California groups have told her they want help recouping their investments. If it doesn't come, she is afraid they will lose patience. "It is really still too early to declare victory or defeat for pay for performance," Dr. Damberg concluded. ■

Fragmented Care Undermines P4P

Pay-for-performance schemes may be thwarted by patients seeing too many doctors, making it difficult to assign any one patient's care to a particular physician, according to a study presented at the annual research meeting of AcademyHealth.

The average Medicare patient sees seven physicians (two primary care, five specialists) over a 2-year period, Dr. Hoangmai Pham, a senior researcher with the Center for Studying Health System Change, Washington, said at the meeting.

Dr. Pham analyzed data from a number of Medicare sources to come to her conclusion. These sources included claims data and nationwide physician surveys for 2000-2003.

Not only do patients see a number of physicians, but their main physician may not even see them the majority of the time; they also switch their primary provider often.

Only 53% of Medicare beneficiaries' evaluation and management visits, and 35% of their total visits, are with the physician identified as their primary, or usual-source-of-care, physician.

During a 2-year period, 30% of beneficiaries switch their usual-source-of-care physician, and in 59% of the cases where beneficiaries switch, they never even see one of the designated physicians in a year, Dr. Pham said.

According to the physician survey data, a primary care physician's regular, usual-source-of-care patients make up an average of only 39% of his or her total patient population.

What is really needed is an overhaul of the way the medical system is organized to allow single physicians or groups to be responsible for individual patients.

Alternatively, there needs to be more financial incentive in pay for performance to make it worthwhile for physicians to invest in the infrastructure needed to participate, because they are going to be able to show good performance for only a small proportion of their patients, she added.

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