

# Pay-for-Performance: A Promising Start

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ALLIANCE FOR  
HEALTH REFORM

**I**n a landmark 2001 report, “Crossing the Quality Chasm: A New Health System for the 21st Century,” the Institute of Medicine (IOM) declared the U.S. health care system to be “in need of fundamental change.” Among the many ailments cited was the failure to “align payment incentives” with quality improvement. It urged purchasers, regulators, and others to create “an environment that fosters and rewards improvement.”

In the years since the release of the IOM report, a variety of stakeholders have worked to implement changes in both the public and private sectors. A major focus of these efforts has been the development of payment incentives and rewards loosely gathered under the umbrella of “pay-for-performance” (or “P4P”). The Centers for Medicare and Medicaid Services (CMS), large employers, business coalitions, health plans and others have implemented a variety of approaches that seek to reward improvements in quality and high performance by hospitals, physicians, medical groups, and others.

More than 100 P4P programs were operating nationwide as of September 2005. The Bush Administration is pursuing a series of demonstration projects to test the value and efficacy of P4P in the vast Medicare program. Several P4P proposals have been introduced in Congress to apply the concept more broadly.

## What is Pay-For-Performance?

Pay-for-performance sets differing payment levels for providers of care based on their performance on measures of quality and efficiency.

Since the 1980s, many health plans have been reporting performance using the Health Plan Employer Data Information

Set (HEDIS), which measures how well evidence-based medicine is delivered relative to national or regional benchmarks. Research has shown that reporting such data and making the results public leads to significant improvements in performance. This approach, known as the “accountable health plans model,” forms the basis of many P4P efforts today.

Some P4P programs—often focusing on physicians—have been initiated by health plans; others have been the brainchild of large employers. In either case, P4P in the private sector has usually offered the promise of additional money if providers or provider groups achieve a certain level of performance.

## Why Pay-For-Performance?

P4P programs are becoming popular in part because of persistent deficiencies in quality in the U.S. health care system. For example, a 1999 IOM report estimated that as many as 98,000 Americans die each year as a result of avoidable patient safety errors.

“These are preventable deaths,” says David Colby, deputy director of research and evaluation at The Robert Wood Johnson Foundation. “Quality is a system problem .... We need to use all the tools in our toolbox to improve quality of care,” he adds.

P4P is also driven by purchasers’ frustration with the rapid rise in health care costs. “Employers and investors should be interested because we’re all desperate to contain health care costs,” says Suzanne Delbanco, chief executive of the Leapfrog Group, a network of more than 170 private employers and health care buyers.

Finally, P4P is motivated by a strong belief that current payment systems not only fail to reward or encourage quality,

## Fast Facts

- ▲ More than 100 health care pay-for-performance initiatives are up and running in the U.S.
- ▲ Pay-for-performance programs are gaining in popularity because of employer and government frustration with rising health care costs and because of persistent deficiencies in U.S. health care.
- ▲ About half of pay-for-performance initiatives include some measures related to the adoption of health information systems into clinical practice.
- ▲ Early results are promising in a CMS pay-for-performance demonstration project involving more than 260 hospitals. Average improvement across 33 clinical indicators was 6.6 percent in the first nine months.
- ▲ A collaboration of California health plans has already paid physician organizations more than \$60 million in performance-based bonuses.

The Alliance for Health Reform, with support from The Robert Wood Johnson Foundation, held a briefing to explore “pay-for-performance” trends. This issue brief is largely derived from the information presented at that briefing.

but sometimes penalize it. Many payment systems still pay physicians a fee for each service that is rendered. For example, under a fee-for-service payment system, a physician who follows evidence-based guidelines and performs fewer services may receive less money.

"We do not have a neutral payment system today. We have a payment system that actually rewards poor performance," says Margaret O'Kane, president of the National Committee for Quality Assurance (NCQA).

P4P aims to change that. In order to ensure that P4P programs appropriately reward better performance, however, additional work is needed to identify the best ways of making performance-based payments and develop guidelines for doing so. Inappropriately designed P4P initiatives can easily result in undesirable, adverse consequences. For example, providers who serve more challenging populations may have a hard time meeting performance goals if patients do not take medications as indicated or if patients refuse, or cannot afford, recommended treatments. (See box, "Some Advice on Designing P4P Programs.")

Not everyone supports the concept of pay-for-performance. Critics have questioned why Medicare or any other payer needs to pay more for good quality. Skeptics suggest that payment incentives may simply reward already high-performing providers.

An October 2005 JAMA article showed only modest or no performance increases in clinical quality care for three measures, for which physicians received bonus payments for improved quality. The study showed that those physicians who already performed above the performance threshold improved the least, yet received the bulk of the bonus payments. This finding may lead to modification of P4P mod-

els so that they pay for improvement rather than (or in addition to) achievement of an objective score.

### **Private Sector Leadership**

As noted, much of the momentum for P4P has come from the private sector. As of mid-September 2005, more than 100 P4P programs were operating around the country.

One of the more notable P4P efforts is the Bridges to Excellence (BTE) program sponsored by several large employers. BTE currently is operating in Cincinnati, Louisville, Massachusetts and Albany/Schenectady, and is moving into DC/Maryland/Virginia, Minnesota and Georgia.

Jeffrey Hanson is regional health care manager for Verizon Communications and president of the BTE board. Hanson notes that BTE uses three physician recognition programs devised by NCQA to recognize high-performing doctors who provide diabetes and cardiac care, and to recognize physician practices that use health information technology to improve outcomes. Physicians achieving recognition in the NCQA programs are then eligible for P4P payments. BTE studies show that physicians recognized by NCQA provide diabetes care at 15 percent to 20 percent less cost than doctors not recognized by NCQA. Nationally, only 1 percent of doctors are recognized.

In California, the Integrated Healthcare Association (IHA), a coalition of health plans, has begun a P4P program to provide medical groups with incentive payments based upon performance against quality benchmarks. Thirty-four organizations make up the IHA, including most major California health plans.

Currently 35,000 California doctors (who are responsible for 6.2 million patients per year) are involved in the IHA program, says Ron Bangasser, M.D., one of the leaders of that program. By the end of 2005, IHA had paid out an estimated \$62 million to its participating physician groups.

In the hospital realm, the Leapfrog Hospital Rewards Program offers public recognition and a variety of bonus payments to hospitals that report data on five clinical areas. Together the five areas represent 20 percent of inpatient spending for all private patients (i.e., those not covered by public programs such as Medicare or Medicaid) and 33 percent of private admissions.

### **Growing Public Sector Interest**

The initial successes of private sector P4P programs have stirred interest in the concept by

## **Some Advice on Designing P4P Programs**

"The primary issue is one of trust...(enhanced by) wherever possible, consensus decision-making..."  
—Terris King, CMS

"There has to be a trust, a feeling that it's done in the right way. You're going to get huge pushback from physicians if they don't feel that they're involved..."  
—Ron Bangasser, M.D., Integrated Healthcare Association

"Physician involvement is necessary but you can't turn (the whole P4P process) over to those being measured."  
—Margaret O'Kane, National Committee for Quality Assurance

Congress and the Bush Administration. Congress took an important step toward use of P4P in Medicare when, as part of the Medicare Modernization Act of 2003 (MMA), lawmakers included provisions encouraging hospitals to report a set of 10 quality measures. Hospitals that report such measures are given a full “marketbasket” update in their payment rates for the year. Those that do not report receive only the marketbasket rate minus 0.4 percent.

That financial incentive has led more than 98 percent of participating Medicare hospitals to report all 10 measures. Recently CMS has begun publishing the results of those measures on its website—[www.medicare.gov](http://www.medicare.gov). Early results are encouraging. CMS reported in May 2005 that quality of care “improved significantly” at hospitals participating in the program.

In the future, CMS plans to tie a part of the annual hospital update to actual performance. In FY2008, for instance, payments to hospitals will be reduced for Medicare patients who acquire an infection while in the hospital. A broader P4P Medicare program will be implemented in FY2009.

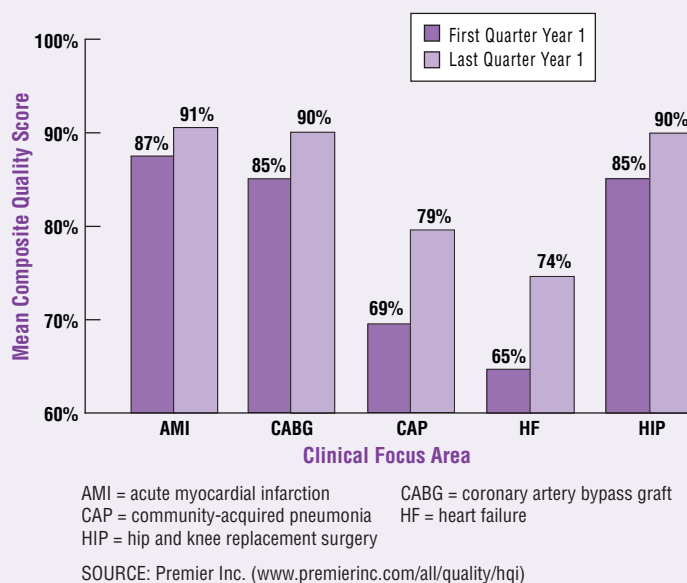
CMS Administrator Mark McClellan has been a strong P4P booster. “Medicare needs to move away from a system that pays simply for more services, regardless of their quality or impact on patient health ... to a system that instead encourages and rewards efficiency and high quality care for the Medicare program and its beneficiaries,” McClellan told the House Ways and Means Health Subcommittee in July 2005.

The Medicare Payment Advisory Commission (MedPAC), an independent federal body that advises Congress on issues affecting the Medicare program, has also recommended that Medicare adopt a robust P4P strategy.

But moving from a system that pays largely based on volume to one that pays based on performance will be difficult, says Terris King, the CMS standards and quality deputy. Keys to success include working with stakeholders (including beneficiaries, providers, measurement experts, and others), selecting or developing quality measures, collecting and analyzing the data using these measures and then identifying needed improvements.

CMS is already using its demonstration project authority to test some of the concepts of P4P. The MMA included authority for a three-year pay-for-performance demonstration program with physicians to focus on “the adoption and use of health information technology and evidence-based outcomes measures for continuity of care.”

**FIGURE 1**  
*Early Results for CMS/Premier P4P Demonstration Project By Clinical Focus Area*



Early results from one of these projects, the Premier Hospital Quality Incentive Demonstration, show that a pay-for-performance program produced measurable improvement. The average improvement across 33 indicators in five clinical areas was 6.6 percent, Premier reported, for the more than 260 hospitals participating. (See graph—“Early Results for CMS/Premier P4P Demonstration Project.”)

Hospitals scoring in the top 20 percent for a given set of quality measures will receive bonus payments. In the third year of the demonstration, those hospitals that do not meet a prescribed score on quality measures will be subject to reductions in payment.

Congress is also considering proposals to expand this approach nationwide.

### Challenges Ahead

Speakers at the Alliance/Robert Wood Johnson Foundation briefing agreed that multiple challenges must be overcome to make P4P programs a sustainable success. All agreed physician acceptance of the concept and the measures is critical.

But already some physician groups have raised objections to a voluntary CMS reporting program, under which some physicians began reporting on 16 quality measures in January 2006. The American Medical Association and the Medical Group Management Association have voiced concerns that the program imposes onerous administrative burdens without providing extra reimbursement for collection of the new data.

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The Alliance is a nonpartisan, not-for-profit group committed to the education of journalists, elected officials and other shapers of public opinion, helping them understand the roots of the nation's health care problems and the trade-offs posed by various proposals for change.

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*Alliance for Health Reform*  
1444 I Street, NW, Ste 910  
Washington, D.C. 20005  
Phone 202/789-2300  
Fax 202/789-2233  
[www.allhealth.org](http://www.allhealth.org)

Such concerns pertain not only to physicians but also to health plans, hospitals, home care agencies, nursing homes, community clinics and other providers. Across all settings where patients are cared for, proponents of P4P must come up with good answers to questions such as:

- ▲ How big does the bonus or penalty need to be to make a difference in quality?
- ▲ Will provider incentives be sufficiently high to promote appropriate utilization without creating incentives to over or underutilize specific services?
- ▲ What information technology systems should providers adopt in order to best comply with P4P guidelines, and who should pay for this technology?
- ▲ What adjustments should be made to P4P systems designed for medical specialists vs. non-specialists, home care vs. hospital care or nursing home care, providers in low-income communities vs. providers in wealthier communities?

- ▲ To what extent should P4P programs reward improvement as well as achievement, so that high performing providers continue to have an incentive to improve and low performers are not penalized for a willingness to service more challenging populations?

In a relatively short time, pay-for-performance has become a serious part of the ongoing debate over how to rein in costs while improving the quality of care—whether purchased by the government or private industry. The bottom line question: As P4P is enlisted in pursuing the often-contradictory goals of higher quality and lower cost, will the rewards of P4P ultimately justify the costs of implementation?

(For the sources used in this publication, click on the title of this issue brief at [www.allhealth.org](http://www.allhealth.org) under “Publications.”)

(Note: If you would like the meaning of “evidence-based medicine,” “marketbasket” and other terms used in discussing pay-for-performance, please go to [www.allhealth.org/sourcebook2004/pdfs/glossary.pdf](http://www.allhealth.org/sourcebook2004/pdfs/glossary.pdf)).

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- ▲ **Phillip Dunn**, *National Quality Forum* 202/783-0206
- ▲ **Alan M. Garber**, *Stanford University, School of Medicine* 650/723-0920
- ▲ **Jeffrey Hanson**, *Verizon, Bridges to Excellence* 207/878-5912
- ▲ **Karen Ignagni**, *American Association of Health Plans* 202/778-3207
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- ▲ **Terris King**, *Office of Clinical Standards and Quality (CMS)* 410/786-6841
- ▲ **Barbara Kurtzig**, *National Committee for Quality Health Care* 202/331-7535
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