



Paying for quality: Understanding and assessing physician pay- for-performance initiatives

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based on a Research Synthesis
by Jon B. Christianson, Sheila Leatherman
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SUMMARY OF KEY FINDINGS

- > **Number growing.** The number and variety of physician P4P programs appears to be growing, but there is no systematic tracking effort.
- > **Limited focus.** Current P4P initiatives reward physicians based on treatment of a small number of chronic diseases and the provision of a limited number of preventive services.
- > **Tempered support from physicians.** Physicians support P4P programs in concept, but have several concerns.
- > **Positive findings, but unclear if due to P4P.** Recent program evaluations of large-scale P4P efforts consistently find quality improvements following P4P interventions, although results often cannot be disentangled from other simultaneous quality improvement interventions. The findings of controlled studies of smaller scale efforts are less positive.

Why is this issue important to policy-makers?

- **Pay-for-performance (P4P) initiatives are being pursued by state Medicaid programs and private health plans and are of great interest to Medicare.** P4P has gained traction as a way for purchasers to better align physician payment and quality of care delivered.
- **Experience with managed care shows that financial incentives can be a powerful driver for physician behavior.** Policy-makers are interested in knowing to what extent and under what circumstances P4P and other incentives will improve the quality of care delivered by physicians.

What explains the recent interest in P4P?

- **The present interest in P4P is the result of several factors:**
 - Maturing experience with quality measurement
 - Evidence of a substantial gap between actual practice and recommended evidence-based care
 - The support of large purchasers and national bodies
- **New P4P programs are layered on top of existing payment arrangements and seek to counter the lack of quality incentives in those systems.** Physician incentive programs are likely to have different effects on physician behavior depending on the existing payment approach.
- **P4P efforts build on decades of experience developing and implementing quality improvement measures,** including the Healthcare Effectiveness Data and Information Set (HEDIS) initiative.

How are P4P programs structured?

- **Payers typically use a mix of performance measures in incentive programs,** addressing clinical care, efficiency, patient satisfaction and use of information technology (Figure 1). Clinical measures for the most part draw from claims data and typically focus on a small number of chronic diseases and provision of a limited number of preventive services.

Recent program evaluations consistently show quality improvements following P4P interventions,

CURRENT P4P EFFORTS

A recent survey of HMOs with physician P4P programs highlights key decisions regarding program structure and size (Reference 1):

What should be rewarded?

- > 20 percent of plans said they paid for improvements in physician performance, while 80 percent paid for meeting benchmarks.

What type of target?

- > 62 percent paid for achievement of fixed performance thresholds, while 38 percent paid for relative targets.

What is the size of potential incentives?

- > 40 percent indicated the *average* payment was less than five percent of their total payment to physicians.
- > 28 percent said that the *maximum* payment was less than five percent.

Figure 1. Examples of P4P measures used by a large HMO

Clinical

- Diabetes management (control of HbA1c)
- Cancer screening rates (mammogram and colorectal)

Patient experience

- Does doctor show respect for patient?
- Can patients get an appointment when they want one?

Information technology

- Use of computerized patient registries; updated twice a year
- Use of e-prescribing

Information on Pacificare from Rosenthal, et al. 2005 (Reference 4)

■ **Two key design decisions for P4P initiatives—“What should be rewarded? What types of targets should be used?”** (Figure 2). Both have important implications for how physicians will respond to incentives. For example, measures to reward improvement are more likely to motivate low- than high-performing physicians.

Figure 2. Key P4P decisions: Implications and examples

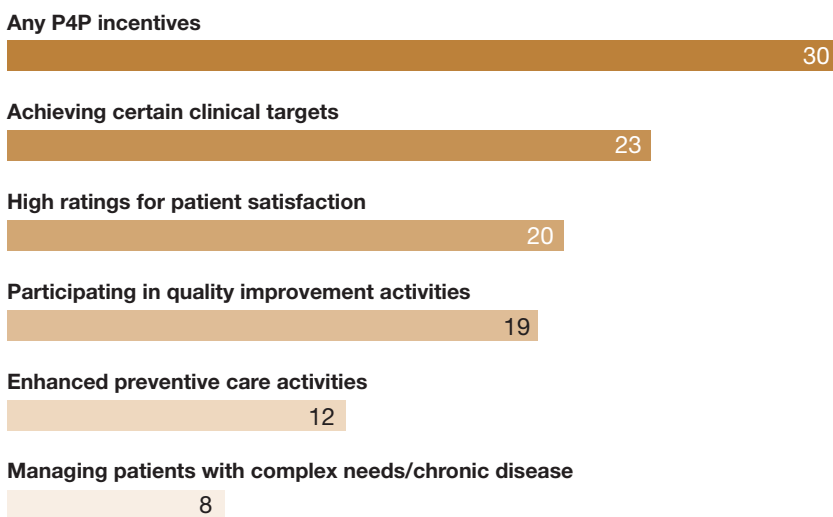
		What type of targets?	
		Fixed	Relative
What is rewarded?	Improvement <ul style="list-style-type: none"> • Low achievers have stronger incentives to improve quality, but high achievers are “punished” • Rewards may go to physicians whose performance does not meet quality standards 	Example: Rewards physicians with X percent improvement on mammogram rate	Example: Rewards physicians with mammogram rate improvement in top X percent
	Achieving Benchmarks <ul style="list-style-type: none"> • Rewards superior physicians, but without motivating improvement • Incentives may be out of reach for low performers 	Example: Rewards physicians with X mammogram rate	Example: Rewards physicians with mammogram rate in top X percent

but these results are hard to interpret.

How prevalent is physician P4P?

- **Almost one-third (30 percent) of U.S. primary care physicians have P4P quality incentives in their plan contracts** (Reference 2, Figure 3). The most common are incentives to achieve clinical or patient satisfaction targets.
- **And just over one-quarter of primary care physicians are actually paid based on quality incentives.** A recent study found that 28 percent of primary care physicians in group practice have quality incentives in their compensation arrangements (Reference 3).

Figure 3. Percent of U.S. primary care physicians facing specific P4P measures, 2006



What is the evidence to date on the impact of P4P programs?

- **Recent program evaluations of P4P efforts all find improvement in one or more quality indicator** (References 4, 5, 6). Because they assess the “real world” application of interventions, these studies are more relevant to policy-makers than those from older and smaller controlled experiments, which generally did not show positive results (References 7, 8, 9).
- Because P4P incentives often were accompanied by other changes to improve quality, the precise impact of the incentives cannot be determined.
- Although not yet the focus of research, some authors have speculated that P4P may have unintended consequences, both positive and negative.

KEY OPERATIONAL ISSUES

Risk adjustment. Unless measures are accurately risk-adjusted, physicians who attract more than their share of clinically complicated patients may find it difficult to score well on quality indicators that are based on patient outcomes.

Claims data. The use of claims data to construct P4P measures is attractive because the data are readily available. There are a limited number of measures that can be constructed from these data, however.

Linking patients to physicians. Not all patients have an easily identifiable “medical home.” This raises the issue of how to connect patients, particularly those with chronic conditions who are more likely to see multiple providers, to physicians for the purpose of performance measurement.

Patients have a role in outcomes. Measures of patient outcomes are affected by the decisions of patients as well as the actions of physicians.

Physician attitudes. Efforts to improve clinical care processes seldom succeed without physician support and engagement. Physicians are supportive of P4P in concept, but do not have confidence that payers will develop metrics or rewards that are fair and effective.

Ability to respond. Larger practices and those with health information technology capabilities are better able to respond to P4P initiatives.

Policy Implications

- > **Medicare and other payers should consider establishing P4P demonstrations that systematically vary design features** including the nature and size of rewards, the types of measures used and proportion of physician revenues affected. This approach will provide important evidence, to date lacking, on which program designs and reward structures are most effective.
- > **To raise the overall level of quality, policy-makers may wish to include a mix of quality improvement and benchmark achievement reward strategies in their P4P programs.** Focusing only on benchmark achievement is appealing because it reinforces the concept of a clear quality “bar”, but could yield relatively little actual quality improvement in the initial years of a program.
- > **Sufficient resources should be allocated to program design, management and surveillance.** There is evidence from existing programs that, with respect to raising the level of quality, “the devil is in the details”. Care must be taken to structure incentives to achieve desired results, communicate effectively with physicians and establish oversight to limit “gaming” of P4P rules.

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