



Robert Wood Johnson Foundation

THE SYNTHESIS PROJECT  
NEW INSIGHTS FROM RESEARCH RESULTS

# Paying for Quality: Understanding and Assessing Physician Pay-for-Performance Initiatives

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Presentation based on a Research Synthesis by Jon B. Christianson, Sheila Leatherman and Kim Sutherland

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# The Synthesis focuses on these questions

- What explains the current widespread interest in physician P4P?
- How are current incentive programs structured and how prevalent are they?
- What are the key design questions and operational issues relating to physician P4P?
- What is the evidence to date on the impact of P4P?
- What can P4P implementation experiences teach us?



# Approach

- Published, peer-reviewed literature reviewed through June 2007
- Standard search engines – MEDLINE, EMBASE, Econolit, etc.



# Why is this issue important to policy-makers?

- P4P is a way for purchasers to align physician payment and quality of care
- Experience with managed care shows that financial incentives can be powerful drivers for physician behavior
- Public program administrators are under pressure to reform physician payment methodologies



# What explains the current widespread interest in physician P4P?

- Maturing experience with quality measures
- Recognition of gap between practice and recommended care
- Lack of clear incentives, in most payment arrangements, that support quality improvement



# How are current programs structured, and how prevalent are they?

P4P programs are growing, in number and in the number of physicians they encompass

- Primary care physicians - One-third have quality incentives in plan contracts; considerable variation across communities
- Medicaid - 28 states have adopted some form of P4P
- Medicare - linking payment upgrades to quality reporting seen as step towards P4P



# The most common P4P incentives are for meeting clinical targets and for patient satisfaction

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

## Any P4P incentives



## Achieving certain clinical targets



## High ratings for patient satisfaction



## Participating in quality improvement activities



## Enhanced preventive care activities



## Managing patients with complex needs/chronic disease





# Key P4P design questions

- What should be rewarded?
  - Achievement of targets
  - Improvement
  
- What type of targets?
  - Fixed
  - Relative



# Key P4P operational issues

- Risk adjustment
- Limitations of claims data
- Relatively small numbers of patients with specific diagnoses in a single physician's practice
- Creating a "medical home" for patients
- Choosing the measures to track – number and types
- Impact of patient compliance
- Physician attitudes



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

- Results from earlier controlled experiments were not promising
  - Payment for better documentation
  - Small scale, limited measures, low-income populations, small practices
  - Irrespective of findings, relevance for policy in current environment is questionable



## What is the evidence to date on the impact of P4P? (cont.)

- Recent program evaluations of P4P efforts all find improvement in one or more quality indicators
  - Incentives almost always part of broader strategies to improve quality, making it difficult to determine the independent impact of P4P
- P4P evaluations have documented some secondary effects, both positive and negative
  - Much more research attention needs to be directed towards understanding all impacts of P4P initiatives



## What is the evidence to date on the impact of P4P? (cont.)

- P4P evaluations tell us little about:
  - The cost-effectiveness of P4P programs, to include costs and benefits of unintended outcomes
  - The “marginal” impact of financial incentives when embedded in broader quality improvement initiatives
  - The impact of incentive payments of different sizes, in the presence of different mediating factors



# What can P4P implementation experiences teach us?

- Need for carefully designed and implemented strategy for communicating with physicians about P4P programs and incentives
- Importance of risk adjustment procedures and opportunities for “gaming”
- Programs in their initial phases pay for better documentation, in addition to better quality
- Programs that pay based on benchmark achievement are likely to reward past efforts to improve quality, to a substantial degree
- When physician P4P programs are viewed as permanent, there is some evidence of investment in IT upgrades and practice staff (primarily nurses)



# Policy Implications

- Medicare and other payers should consider establishing P4P demonstrations that systematically vary design features
  - This approach will provide important, and to date lacking, evidence on which program designs and reward structures are most effective



## Policy Implications (cont.)

- Policy-makers may wish to include a mix of quality improvement and benchmark achievement strategies in their P4P programs
  - Focusing only on benchmarks might yield little improvement in the first years of implementation



## Policy Implications (cont.)

- Sufficient resources should be allocated to program design, management and surveillance
  - Communicating program features to physicians
  - Countering “gaming” behavior



# Project Information

Web site: [www.policysynthesis.org](http://www.policysynthesis.org)

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