Pay for Performance: Lessons from Experience

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Pay for Performance: A Broad Concept

Pay:

- Type: returned withhold, bonus, enhanced payment of any form
- Amount: how much at stake (% of revenue; relationship to cost to improve)
- Frequency: annual, semi-annual, continuous

Performance:

- Measure types: quality - process, quality - outcome, efficiency, satisfaction, health IT
- Compared to what: absolute level, improvement, rank against peers
- Of whom: individuals, practice site, medical group, hospitals
P4P Programs by Targeted Provider, 2007

P4P Programs by Sponsor Type, 2006

- Employer/Coalition: 5%
- Payer: 66%
- CMS: 18%
- Medicaid: 11%

Evolution of P4P

- Health plans → coalitions, purchasers as well
- Quality measures: HEDIS claims-based → HEDIS claims-based + lab
- PCP → PCP + specialty
- Including efficiency and satisfaction measures
- Incorporating incentive for use of electronic health records
- More hospital programs
- Future – more need for risk-adjustment
Marginal benefits, if any
- Rosenthal and Frank 2006 found six studies (of good quality) (most P4P is not evaluated well)
- Five involved narrowly targeted measures on individual physicians
- Two had positive results
- Rosenthal et al. 2007 noted improvements typically occurred in at least 1 measure of quality
- Felt-Lisk et al. 2006 found only one of five Medicaid plans may have seen substantial effect from their P4P on the common measure studied
- Mass: Mehrotra et al. 2007 found practices w/P4P more likely to undertake improvement actions
Massachusetts Physician P4P
(Mehrotra et al. 2007)

- Widely Implemented for Physician Groups
  - As early as 2004, 89% of Massachusetts physician groups had a P4P incentive in at least one commercial health plan contract

- In 2004, types of measures included:
  - HEDIS measures: 89%
  - Utilization measures: 66%
  - Use of information technology: 52%
  - Patient satisfaction surveys: 37%

- 56% reported incentives had moderate or significant impact on group
Massachusetts Characteristics that May Favor Impact (Physicians)

- Medium to large groups common
  - Better ability to respond
  - Incentives may be pooled across practice sites (depends on form of incentive)

- Synergy: other nonfinancial incentives exist, work in same direction
  - Public reporting
  - Tiering

- Data aggregation structure in place (groups)

- Energy around EHRs and interoperability
Physician Perspectives

- Support general concept of P4P
- Often don't understand the specifics
- Case-to-case perspective—want all cases to fit
- Patient adherence issues - implications
  - Kick out non-adherent patients?
  - Pay more for achieving goals with the underserved?
- Data trust issues
- Actionability of measures important
- Frustrated by varying incentives across purchasers/plans
Implementation Decisions

- Physician input into measure selection?
- Rollout – communication re incentives
- Feedback/communication with bonus
- Allowing providers to correct underlying data
- Any supportive knowledge-based efforts—e.g. forum featuring how big winners did it? (but don't be taken by surprise)
- Any opportunity to align incentives across settings? Purchasers?
Summary of Implementation
Lessons Learned

- Match terms of payment to desired outcomes
- Use a broad and balanced set of measures
- Anticipate physician reaction and work for trust
- Incentive size is important
- Information infrastructure will influence effectiveness
- Physician engagement is critical
Closing Thoughts

- P4P may best be used together with other means to achieve defined health goals
  - Other means may include public reporting, non-financial incentives, tiering

- Don't forget the consumer/patient:
  - Monitor for unintended consequences
  - While P4P focuses on achieving objectives, consider parallel rewards for effort (e.g. medical home concept)

- Continued improvement in use of EHRs should enhance providers' ability to respond