Pay for performance: From Mesopotamian to modern

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Pay for performance (P4P) is not a new concept, but in recent years has elicited growing interest from the healthcare management world. Hospitals and other facilities are implementing forms of pay for performance in a way that was nonexistent ten or even five years ago. Such programs typically use established ratings methods and indicators to measure levels of quality (such as efficiency or patient satisfaction), then offer incentives or compensation to entities or providers who are rated highly based on these indicators. And although the pay-for-performance concept has been developing over time, it's likely that we are still in the early stages of the phenomenon and have yet to see how, and to what degree, it will take hold.

Despite pay for performance's current "fashionability" (as one healthcare blogger put it), we have good reason to think that these programs will truly become installed in U.S. healthcare's administrative landscape. Promoting the best-quality care is the right thing to do, of course. It improves customers' health and lives; we can hope that such improvements will help ease pressure on the healthcare system. But the prospect of offering compensation for quality also occurs in the context of real-world constraints. The challenge of pay for performance lies in finding a balance between the cost of the programs and the quality they elicit.

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As with many healthcare management strategies, it will take time to see how the newest generation of pay-for-performance programs will stack up in terms of generating consistent, authentic quality, and whether or not we will see satisfactory results in terms of cost savings and/or returns.

P4P: A BRIEF HISTORY

Physician incentive systems can actually be traced back to ancient Mesopotamia. There, the wisdom goes, if a doctor performed a successful surgery, he received 10 shekels, but if the operation failed, the doctor's hand was cut off. We can think of "carrot-and-stick" systems that would probably cause less physical damage, but the basic concept of reward/penalty has probably always had a place where public services are offered in the market context.

In the modern era, HMOs began utilizing capitation fees and gain-sharing in the 1980s. These forms of pay for performance promoted the sparest, fewest, or lowest-costing treatments. Physicians received compensation dollars for all patients treated in the system, no matter what doctoring services were provided. These programs essentially rewarded physicians for any healthcare dollars saved in order to promote efficiency.

In other methods, a hospital or clinic would pay physicians for developing cost-saving protocols, which were then used by the entity to lower expenses. Or the physicians and hospital would come together and agree upon common supplies or drug formularies, with the physicians receiving a percentage of the cost savings incurred. In other instances, physicians who gave routine immunizations were tracked and received a bonus dollar amount per immunized patient.

Programs from this time period reached for the easiest measurements of quality and efficiency, and stopped there. Quality indicators were simpler than those of today.

SEA CHANGE

The real groundswell of U.S. pay-for-performance programs occurred about seven years ago. This change can be traced to 2000 and 2001, when the Institute of Medicine issued two reports, *To Err is Human* and *Crossing the Quality Chasm*. The reports grabbed the industry's attention, pointing to the distressing rate of error in the U.S. healthcare system (a phenomenon that was also reported frequently in the media). At that time, general low-quality indicators were often seen. All of this spurred a significant amount of concern and discussion within the industry, followed by a drive for some type of control and reform.

Today, pay-for-performance programs use and build upon the concepts from 20 years ago, though the programs implemented within the past five years are broader and more complex. Looking beyond present-moment efficiency, they tend to focus on clinical performance and patient satisfaction in all kinds of healthcare settings: HMOs, public and private hospitals and clinics, and the like. Also, Medicare and Medicaid programs have begun to implement

pay for performance to rate quality. According to the National Pay for Performance Survey, there was a 24% increase in the number of commercial pay-for-performance programs between 2004 and 2005.

Often, programs are designed so that physician participation is completely voluntary. Through the use of scorecards, a physician might receive small bonuses per patient per preventative screening for diabetes, hepatitis, and colorectal or breast cancer, or per immunization. Another program might give physicians a basic per-member-per-month (PMPM) payment for meeting certain quality indicators. These programs can operate in conjunction with an existing reimbursement arrangement; for example, the physician is paid on a fee-for-service basis, but also gets paid an additional amount per patient member if important preventive screenings are maintained, such as the prudent two hemoglobin A1Cs per year for diabetic patients.

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Physicians might receive a standard payment for average performance and a higher PMPM payment for above-average performance. A healthcare entity might measure its levels of quality via known tools already in place, such as with standardized Health Plan Employer Data and Information Set (HEDIS) measures. Scorecard ratings may go up if the entity provides practices like community education and outreach activities. In hospitals, different types of quality indicators are being used; for example, via the waiting time for antibiotics or ACE inhibitor usage. For clinics, incentive bonus dollars might be predicated on improvements tracked from one year to the next. All in all, pay-for-performance compensation dollars amount to 1% to 2% of a physician's income, thus keeping the programs relatively inexpensive. Whether the incentives are strong enough is a question that has yet to be fully answered.

MEASURING MEASURES

If we know from a recent national survey that pay-for-performance programs are on the rise, we also know, by some accounts, that quality indicators for American healthcare are rising year by year. But proponents of pay for performance must be cautious before interpreting this data as fully optimistic. One of the slippery issues about measuring the quality of healthcare procedures is that they, like many scientific measures, can be influenced by the act of measurement itself. When one healthcare indicator is measured for quality, we know the quality tends to improve; but it is unclear whether quality is rising beyond those items being measured. Limitations in data contribute to the difficulty. Claim data is the prevalent data source because it is available and there is no additional cost to collect the data. While claim data is helpful in calculating process measurement (e.g., was a retinal exam performed on a diabetic?), it is difficult to use claim data to calculate outcomes measures (e.g., what percentage of patients have blood pressure below the target level?). The advent of electronic medical records will help in the expansion of quality measures to outcomes measures.

But all is not perfectly muddied; we can still take reports of improvement at face value, at least to some degree. A 2006 report in the *Annals of Internal Medicine* reported positive results in quality indicators from pay-for-performance incentives. Another report, conducted by Medicare in the second year of its quality improvement organization program, reported improvements in 34 of 41 measures studied.

PITFALLS?

Measuring quality takes time and costs money. That is just one potential roadblock that administrators may face in deciding whether or not to implement pay for performance. Programs should be designed intelligently so as to minimize or avoid any excess costs. Administrators must decide: Should existing quality measures be used, or should some be added and at what cost? Some programs measure only a few indicators, but if it is decided at some point to switch to other indicators, what will be the cost of trying to collect that data?

In addition, administrators must create plans that will deal deftly with other types of problems. In the context of offering "carrots" to physicians to help them perform, what steps will administrators take in regard to the underachievers, those physicians in the system who may simply not be interested in improving performance, or who consistently score low on indicators? We would have the option of allowing these doctors to continue in this way or to find ways of motivating them to improve; would there be other options? In a related way, we might ask if pay for performance ultimately creates a two-class system, ranking certain physicians into higher tiers, and if this higher ranking will make it difficult for patients to see those physicians. How might we redesign programs to eliminate any unfair advantages? Administrators also might need to be alert to physicians who are "gaming" the system by excluding sicker patients in order to make their indicators look good. These are but a few of the challenges that pay-for-performance designers must consider.

A LURKING PROBLEM?

In a system that is somewhat different from the one that bound the unfortunate Mesopotamian physicians, contemporary programs tend to emphasize rewards for providers, and at times, rely on the fact that team members can thrive inside the spirit of incentive, participation, and scoring-motivated group effort. It's also fair to say that current programs seek healthier lives and a more careful administration of healthcare as their goals, placing performance and satisfaction in the foreground. Ideally, future pay-for-performance programs will balance clinical quality, efficiency, and patient satisfaction. So far, patient satisfaction in particular has been a nebulous goal that has been difficult to measure.

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Still, the costs of implementing quality measurement and physician and clinic incentives remain high, despite efforts to be economical. Pay-for-performance advocates say the costs of incentives are nominal; for example, at 1% to 2% of a physician's total compensation. Given the already high cost of healthcare, these added percentage points beg an important question: Will pay-for-performance programs cause premiums to rise, with the unintended effect of excluding some of the very individuals we wish to cover? At present, the answer is unknown.

FURTHER FRONTIERS

Administrators are finding that when pay-for-performance programs are put in place, participants may actually help shape them. At one institution in the Pacific Northwest, various physician groups and clinics received private scorecards for tallying their quality measures. When results were measured and shared among the groups, one group of physicians in a clinic saw that another clinic was performing at a much higher level and receiving higher ratings. The lower-rated clinic sent observers to the higher-rated clinic, which helped the lower-rated clinic to develop better protocols, thereby improving its scores.

Proponents of pay for performance state that quality measurements help keep healthcare entities alert to quality in a more global way, more so than if there were no programs in place in that entity. Proponents also suggest that the costs of pay for performance represent an investment in the future. Improved quality today, they say, will function in the long term as a ballast for each entity and for the system as a whole, creating stability and preventing future problems. Although we do not yet know if these programs save money in the long run, the consensus is that they improve quality where measured. In a perfect world, today's current pay-for-performance trend may contribute to a wholesale change in healthcare administration and a more quality-driven U.S. healthcare system overall.

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Medicare P4P Programs

Medicare has begun to offer various pay-for-performance programs for hospitals and physicians. These include:

Hospital Quality Initiative This is Medicare's first foray into pay for performance. The goal was simply to get hospitals to report based on 10 quality measures, with the reward coming in the form of the full update to the diagnosis-related group (DRG) payment. Most hospitals were already reporting on these measures elsewhere, so this proved a simple enough hurdle, with more than 98% of eligible hospitals in compliance.

Premier Hospital Quality Initiative This program includes 34 quality measures that are based around five clinical conditions and reported publicly. Hospitals finishing in the top 10% receive a 2% bonus payment, while those in the next 10% receive a 1% bonus payment. While this has to date been a "carrot" program, the "stick" looms: In the third year, hospitals that do not measure up will see a reduction in their DRG payments.

Physician Group Practice Demonstration This Medicare fee-for-service program targets 10 large (200+ physicians) physician groups across the country. It rewards improvements in quality and efficiency and encourages coordination between Medicare Part A and Medicare Part B (without this encouragement, Part A and Part B would act in their own respective best interests, possibly adverse to one another). Rewards are doled out when the physician group has achieved savings relative to a baseline established by a control group.

Care Management Performance Demonstration This new program is modeled on the "Bridges to Excellence" concept and focuses on small and medium-sized physician practices. It promotes the adoption and use of IT as a way of improving the quality of care for the chronically ill. Doctors that exceed performance expectations receive a bonus.

Medicare Health Quality Demonstration This brand-new program is a five-year demonstration. It aims to enhance quality by improving patient safety and to reduce utilization by using evidence-based guidelines, encouraging shared decision making, and using culturally and ethnically appropriate care.

While each of these programs is different, the mere fact of so many being launched demonstrates the growing commitment to the pay-for-performance concept.

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