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Pay-for-Performance Reimbursement in Health Care: Chasing Cost Control and Increased Quality through "New and Improved" Payment Incentives

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Abstract

Pay-for-performance (P4P) reimbursement has become a popular and growing form of health care payment built on the belief that payment incentives strongly affect medical providers' behavior. By paying more to those providers who are deemed to deliver better care, the goal is to increase quality and, hopefully, restrain cost growth. This article provides a brief explanation of: (1) how previous P4P plans in the U.S. have fared, along with their special relationship to primary care, and (2) how England's experience with P4P and newer versions of these kinds of plans being pursued in places such as Massachusetts might provide valuable case studies for how the U.S. and other countries can achieve meaningful reform of health care organization, delivery and finance.

Background, Performance of Early Plans, and Primary Care

P4P financially rewards medical providers who achieve, improve upon or exceed performance goals on specified quality benchmarks. It has developed largely in response to the cost control problems and perverse incentives associated with fee-for-service reimbursement, which is the dominant model in the U.S.[1] Instead of simply reimbursing providers more for greater volume and intensity of care, P4P pays more to providers whose care is deemed to be of higher (or sufficiently high) quality.[2] These plans are intended to lower health care costs over the long term by increasing preventative care, primary care and the improved treatment of conditions at earlier stages of development.[3] Most P4P approaches adjust payments to hospitals, individual physicians, networks of physicians or medical practice groups in one of three ways: (1) a bonus payment based on a percentage of all care delivered by a provider, (2) a bonus payment per patient member for a provider that has delivered what pre-determined measures would deem as "high quality" care, or (3) as a percentage of the total cost savings achieved relative to what costs would have been without achieving higher quality.[4]

The first generation of P4P plans that proliferated from the early to mid-2000s in the U.S. proved mostly ineffective in either increasing quality or controlling costs.[5] The bonus payments were arguably too small and the areas of clinical quality too narrow to foster significant

behavioral change on the part of providers.[6] Moreover, complex patients with multiple medical problems posed unique dilemmas for physicians when their complicated conditions did not fit neatly within individual care guidelines,[7] and their care was (often minimally) coordinated among different clinicians.[8] Concerns emerged that "the methods used to measure the quality of care unfairly penalized providers caring for patients with multiple chronic conditions."[9] Studies found that some P4P plans did actually worsen existing disparities by discouraging physicians from caring for poorer, less compliant patients.[10] In short, some providers began "cherry picking"[11] to avoid those potential patients who they perceived were likely to lower their overall quality scores.[12] One of the most prevalent changes associated with the early P4P plans was increased documentation.[13] In other words, rather than increases in quality and use of preventive services, early P4P plans generated more record-keeping. "If pay for performance was a therapy," an observer noted in 2007, "its rapid diffusion thus far would have to be considered premature."[14]

The reality in health care is that there are no fundamentally "new" methods of health care payment. Ultimately, P4P and other alternative approaches are newly blended combinations of old models – fee-for-service, salary, and capitation – each of which has its own strengths and weaknesses.

One of the areas that P4P supporters have most hoped would benefit from this new form of payment is primary care.[15] Fee-for-service reimbursement has traditionally disadvantaged primary care by overpaying for procedures and intensity of care,[16] while underpaying for evaluation and management services that require physicians to spend time diagnosing and coordinating patients' care.[17] This underpayment has led many primary care physicians to feel like "hamsters on a treadmill," seeing more and more patients to make up for reimbursements that do not keep up with their practice expenses.[18] Rather than focusing on increased volume (more office visits) to remain financially solvent, P4P advocates have suggested that primary care physicians could earn more by focusing on increased quality and the resulting bonus payments they receive.[19] Yet the problem that has emerged with this approach is that the far larger, underlying payment model that still drives the bulk of providers' behavior remains fee-for-service.[20] And P4P does nothing to address the over-supply of unnecessary medical care.[21] In short, P4P (based on quality) and fee-for-service (based on volume and intensity) do not naturally or easily complement one another in actual practice.[22]

England, Massachusetts, and the Inability of Payment Reform Alone to Reform Health Care

England's experience with P4P and primary care, therefore, ought to provide an illuminating contrast.[23] If the problem of adding quality payment incentives to physicians' reimbursement in the U.S. has been that these payments have generally been too small, too narrow clinically, and overwhelmed by the incentives within the dominant fee-for-service model still in place, then P4P in England should potentially show greater results. Its primary care physicians are salaried within a national health system that rewards them with quality-based bonuses equal to as much as 25-30 per cent of their total income.[24] Introduced in England in 2004 as the Quality and Outcomes Framework (QOF), the new payment scheme included 136 quality indicators covering the management of chronic disease, practice organization, and patients' care experiences.[25] One year after the QOF's inception, the rate of improvement in quality of care for such conditions as asthma and diabetes increased.[26] While the care associated with heart disease did not initially experience this success, by 2007, "the rate for all three conditions had slowed, and the quality of those aspects of care that were not associated with an incentive had declined for patients with asthma or heart disease."[27] Continuity of care also declined after the scheme began operation. Apparently, once quality targets were reached, "the improvement in the quality of care for patients with these conditions slowed, and the quality of care declined for two conditions that had not been linked to incentives."[28]

The reality in health care is that there are no fundamentally "new" methods of health care payment.[29] Ultimately, P4P and other alternative approaches are

newly blended combinations of old models – fee-for-service, salary, and capitation – each of which has its own strengths and weaknesses.[30] And payment reform *alone* cannot correct the deeply fragmented, inefficient and costly U.S. health care system.[31] As Atul Gawande noted in his influential 2009 *New Yorker* article, "The Cost Conundrum,"[32] read by President Barack Obama and shared with his White House staff,[33] achieving high quality, affordable, integrated health care with an abundance of health promotion and prevention is invariably achieved by changing the overall culture of medicine to make it more like organizations such as the Mayo Clinic, Geisinger Health System, and Intermountain Healthcare.[34] Before this kind of cultural transformation can occur and costs can be brought under greater control, however, payment reform is a good and arguably necessary place to start.[35]

The U.S. state leading the charge in payment reform by trying to end fee-for-service medicine is Massachusetts.[36] After achieving near-universal coverage with the passage of ambitious health insurance reforms in 2006, the state embarked on the subsequent and more challenging goal of cost control.[37] It has no choice.[38] Massachusetts now spends 33 per cent more per person than the U.S. average and the state's increasingly expensive universal health plan has necessitated new taxes and fees to stabilize its finances.[39] A special commission established to find ways to control cost growth wants to replace fee-for-service reimbursement to individual providers with payments for entire episodes of patient care made to groups of clinicians ("accountable care organizations," or ACOs) who emphasize primary care and would together take responsibility for a patient's health.[40]

Moving to this capitation payment model,[41] whereby an ACO receives a fixed or "capitated" amount of money per patient member per month – adjusted for the member's health status and with built-in bonuses for achieving higher quality outcomes – would be a dramatic departure from the status quo.[42] It would encourage two behaviors that fee-for-service tends to discourage: "collaboration of physicians, hospitals, and other providers involved in a patient's care; and active efforts to reduce avoidable complications of care (and the costs associated with them)."[43] Moreover, "it accomplishes these goals by paying for all the care a patient needs over the course of a defined clinical episode or a set period of management of a chronic condition," rather than paying for individual medical services.[44]

The political stakes for this model of payment reform are high.[45] The landmark *Patient Protection and Affordable Care Act*, signed into U.S. law by President Obama in March of 2010, established a program for expanding ACOs by January 2012.[46] The hope is to begin moving the biggest U.S. federal health insurance program, Medicare, away from fee-for-service reimbursement[47] and toward a global payment model that will encourage more holistic and integrated care,[48] especially for its most expensive patients with multiple chronic conditions.[49] As its previous experiments with payment reform have demonstrated,[50] Medicare is the nation's most influential payer and, thus, directly and indirectly drives the behavior of all other stakeholders in U.S. health care system.[51] Where it leads, others inevitably follow.[52]

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