# Pay-for-Performance: The Need to Think Strategically

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# Some Clarifications

- P4P is not new in health care (see U.S. HealthCare model of paying physicians that goes back 2 decades) and with variations is used in education (No Child Left Behind) and executive compensation.
- There is little evidence of effectiveness, and it is controversial in these other sectors as well as in health care despite inherent logic

# P4P is Not Synonymous With "Getting the Incentives Right"

- P4P uses marginal incentives and provides provider-specific rewards (penalties) based on **measurable** performance.
- The incentives embedded in basic payments applying to all providers are much more powerful than P4P marginal incentives
- Measuring health care correctly is difficult

# If It Ain’t Broke, Don’t Fix It

The converse is --

# If It's Broke, Fix It

# The Tail of P4P Should Not Wag the Dog of Basic Payment Policy

So if RBRVS/FFS payment for primary care physicians doesn't support what clinicians need to be doing for chronic care patients in Medicare, change the basic system. Don't expect P4P to solve the problem, although it might be part of the solution.

# Even Compelling Logic Does Not Guarantee Success

- Prior authorization makes good sense in theory. It only fails in reality – largely because of poor execution
- A cautionary lesson from prior auth. is that something that works well in one setting or for some conditions may work badly elsewhere
- There are reasons we have different payment systems for different providers – besides provider self-interest

# There Are Problems with Available Measures

- Outcome measures produce unstable findings, require case-mix adjustment, create perverse incentives to not treat sicker or more difficult patients, and usually do not produce actionable information
- Process measures solve some (but not all) of these problems but may not actually be associated with better outcomes

# Bradley et al., JAMA, July 5, 2006

"The publicly reported AMI process measures capture a small proportion of the variation in hospitals' risk-standardized short-term mortality rates"

In fact, explain only 6% of the variation

# Werner and Bradlow, JAMA, Dec 13 , 2006

"Hospital performance measures predict small differences in hospital mortality rates. Efforts should be made to develop performance measures that are tightly linked to patient outcomes."

The study used Medicare Hospital Compare measures for AMI, CHF and pneumonia

# The Ideal Measure Is

A process measure that is a valid and reliable surrogate for outcomes, e.g., Hemoglobin A1C in diabetes

- P4P needs to accept the fact that relying on administrative data, we do not have and **will not** have good measures for much (most) of what we would like to measure
- Legislation requiring development of new measures will not change that reality

# In short,

We need to carefully develop criteria for opportunistically and strategically using P4P, and not overload it with expectations of transforming the health care system

# Attributes of Measures for P4P

- Important
- Deficiencies in care
- Valid
- Validated
- Actionable
- Data readily available
- Not easily gameable a/o amenable to audit

# Strategic Issues in Selecting P4P Opportunities

- Are marginal rewards (penalties) enough?
- Do marginal rewards conflict with incentives in underlying payment stream?
- Are the costs of improvement manageable?
- Are there opportunity costs of focusing on P4P?
- Should the focus be attainment or improvement?
- Are there "likely," unintended consequences?
- Are there other strategic considerations?

# So Where Should We Do P4P? (on a 0-5 scale)

- Dialysis Centers 5+
- Medicare Advantage Plans 4+
- Hospitals 3+
- Primary Care Physicians 2+
- Most Specialists 1+