HealthAffairs

HEALTH AFFAIRS BLOG

RELATED TOPICS:
PAY FOR PERFORMANCE | PAYMENT | QUALITY OF CARE | HEALTH CARE PROVIDERS | RESEARCHERS | PATIENT EXPERIENCE | VALUE-BASED PURCHASING | AFFORDABLE CARE ACT | SYSTEMATIC REVIEWS | PATIENT CARE

The Evidence On Pay-For-Performance: Not Strong Enough On Its Own?

Suzanne F. Delbanco, Maclaine Lehan, Roslyn Murray

OCTOBER 24, 2018 **DOI:** 10.1377/hblog20181018.40069

In an attempt to shift incentives in the health care system from “volume” to “value,” private insurers, public payers, and purchasers have evaluated various models of payment reform. Of these models, pay-for-performance is the longest standing. While shared savings, shared risk, and bundled payment have garnered a lot of attention, focus on these, in their current iterations, is relatively recent. In contrast, pay-for-performance arrangements date back to the 1990s.

Before and for the short period after the passage of the Affordable Care Act (ACA) in 2010, pay-for-performance was the fastest-growing type of payment reform. However, with the recent focus from Medicare and even commercial payers on population health management, pay-for-performance has since been surpassed by shared savings as the fastest-growing and most prevalent new approach to payment. Furthermore, when pay-for-performance is used today, it is often alongside other payment methods, such as shared savings, care coordination fees, and capitation, to minimize the unintended consequences and maximize the strengths of each. While the evidence indicates that pay-for-performance may not be able to alter provider behavior dramatically on its own, it may be effective if incorporated with other incentives.

Pay-For-Performance: What Is It?

Pay-for-performance models use financial incentives and penalties to encourage hospitals, physicians, and other providers to meet performance standards. Providers are eligible to receive bonuses if their performance meets pre-determined measures related to the processes, use, and experience of care, among other metrics, including outcome measures. Some examples include 30-day readmission rates or reduction in hemoglobin A1c levels in patients with diabetes.

Pay-for-performance is typically built on top of fee-for-service payment to encourage providers to enhance the quality, efficiency, and affordability of the care they deliver. Pay-for-performance models have been used by both private and public payers, although in recent years, the ACA has encouraged further adoption of pay-for-performance models within Medicare, leading to greater uptake by public payers at the state level.

Does Pay-For-Performance Improve The Quality And Affordability Of Care?

Catalyst for Payment reviewed the literature for evidence on the effectiveness of pay-for-performance. We examined individual pay-for-performance studies and systematic reviews released by program sponsors or independent researchers of pay-for-performance program performance. The articles we reviewed suggest the evidence is mixed on whether pay-for-performance models improve the quality of care; pay-for-performance's impact on costs has not been thoroughly examined. Despite these uncertainties, pay-for-performance programs may have potential in the right conditions, particularly in combination with other payment approaches.

Medicare's Hospital Value-Based Purchasing (VBP) program is one of the Centers for Medicare and Medicaid Services' (CMS) oldest efforts to tie payments to performance, particularly to measures of patient experience with care as reported in the Hospital Consumer Assessment of Healthcare Providers and Systems survey. While CMS has been publicly reporting how these efforts have the potential to improve patient experience, independent research has found no evidence that the program accelerates improvements in patient experience.

For example, following the introduction of the Hospital VBP program, an independent study conducted by researchers from Harvard University found that VBP hospitals saw a 0.56 percent improvement in patient experience scores while non-VBP hospitals saw a near 0.47 percent improvement. Furthermore, the same researchers found no meaningful difference in

improvement between the low-performing VBP hospitals and non-VBP hospitals. Instead of seeing dramatic improvements in patient experience scores in VBP hospitals, these scores improved across all hospitals by 6.1 percentage points over six years.

According to the Integrated Healthcare Association (IHA), its value-based pay-for-performance program, another notable, longstanding pay-for-performance initiative, saw most clinical quality measures and patient experience composites remain stable year over year but more significant improvements in quality over several years. For example, the findings published by the IHA demonstrated that, from 2012 to 2016, performance on diabetes care measures improved: blood pressure control (<140/90mm Hg) increased by 9.8 percentage points and medical attention to nephropathy improved by 5.6 percentage points.

In addition to these individual program evaluations, researchers have conducted systematic reviews of pay-for-performance program evaluations to search for broader conclusions about the model. In a review published in the *Annals of Internal Medicine* in 2017, researchers examined 69 studies of pay-for-performance programs and found limited evidence of a longer-term effect from pay-for-performance. The evidence was also inconclusive about whether pay-for-performance programs led to better health outcomes. The researchers did find some evidence that pay-for-performance programs in the ambulatory setting may incrementally improve health outcomes in the short term.

Another systematic review, published in the *American Journal of Preventive Medicine*, from 1999 to 2011 focused on the performance of pay-for-performance programs by state Medicaid programs on targeted outcomes—childhood immunization rates in particular. Based on the

researchers' evaluation, the pay-for-performance program had no significant effect on the probability of a child completing the entire vaccination series. However, the introduction of pay-for-performance incentives did increase the likelihood that children received some of the individual vaccines, including measles, mumps and rubella, and chicken pox, among others.

Conclusion

The evidence of how pay-for-performance improves the quality of health care has been modest at best, and there is no evidence of the impact of pay-for-performance programs on costs. Alone, pay-for-performance incentives may encourage hospitals and physicians to give more attention to care processes that they previously neglected and to alter their clinical activities. However, the model may not succeed at improving patient care or outcomes. It could be that under pay-for-performance bonuses are paid too long after providers deliver patient care, making it difficult for them to connect rewards to their behavior. It could be that the size of the bonuses is too small to motivate change; bigger ones could spur improvements. Maybe the signals get crossed because providers are subject to multiple pay-for-performance programs, each with different quality measures and targets. Or, as some experts say, triggering a health care professional's intrinsic motivation is far more effective than peppering the professional with financial incentives.

Regardless, pay-for-performance may have a role if combined with other payment methods. As health care payers continue to test payment approaches that place providers at greater financial risk for overspending on care for a given population for a given period of time (for example, global payment, shared savings, and shared risk arrangements), pay-for-performance

can counter the incentive for providers to stint on care. If providers can balance a potential financial downside from overspending on care with, for example, a bonus for providing comprehensive care to their patients with diabetes, these patients may be more likely to receive the medical attention they need. Although pay-for-performance programs haven't shown strong evidence for improved quality and cost on their own yet, they may play an important role in combination with other payment methods.

Related

CONTENT

Payment

TOPICS

Pay For Performance

Payment

Quality Of Care

Health Care Providers

Researchers

Patient Experience

Value-Based Purchasing

Affordable Care Act

Systematic Reviews

Patient Care

Cite As

"The Evidence On Pay-For-Performance: Not Strong Enough On Its Own?, " Health Affairs Blog, October 24, 2018.
DOI: 10.1377/hblog20181018.40069