Creating the Strongest Possible Incentive with Pay for Performance: Implications for Payment Strategies

R. Adams Dudley, MD, MBA

Professor of Medicine and Health Policy,

Associate Director for Research

Philip R. Lee Institute for Health Policy Studies

University of California, San Francisco

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Outline of Talk

- Very brief review of pay-for-performance research
- So, is the world different?
- What are the barriers to an effect of PFP?
- Payment strategies
- Impact of strategy on magnitude of incentive

Incentives: Question #1

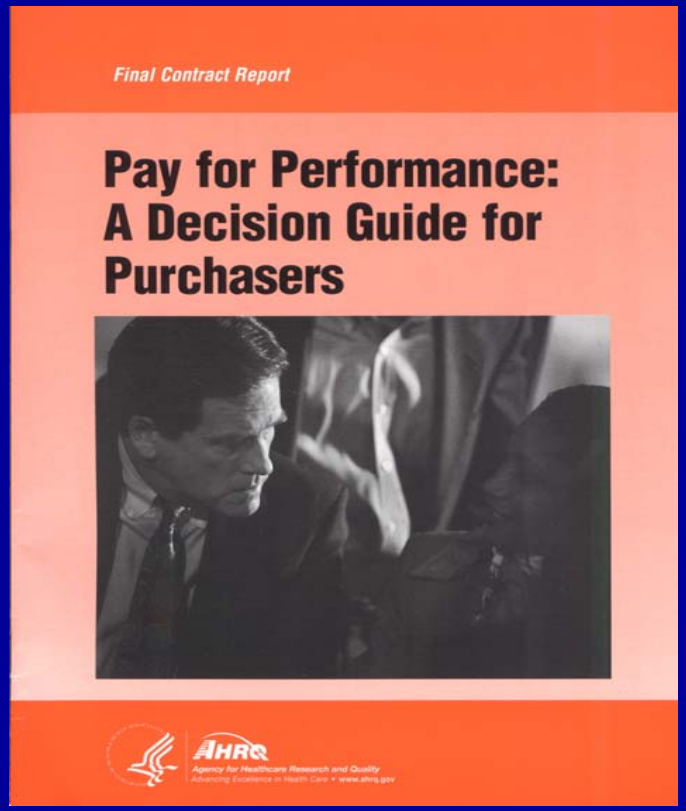
- Outcome variables:
  - Are Vanderbilt pediatrics residents present for well-child visits for their patients?
  - Do they make extra trips to clinic when their patients have acute illness
- Intervention: randomize them to receive (in addition to their usual salary) either:
  - $2/visit scheduled
  - $20/month for attending clinic

- What will happen???

Incentives: Question #1

- Answer: Hickson et al. Pediatrics 1987;80(3):344
  - $2/visit-incentivized residents did better on both measures

Pay for Performance:
A Decision Guide for Purchasers



Electronic Copy of Guide and other AHRQ P4P Resources:
http://www.ahrq.gov/qual/pay4per.htm

Pay for Performance: Will the Latest Payment Trend Improve Care?

Pay-for-Performance
Will the Latest Payment Trend Improve Care?

Meredith B. Rosenthal, PhD
R. Adams Dudley, MD, MBA

PAY-FOR-PERFORMANCE PROGRAMS ARE NOW FIRMLY ENsconced in the payment systems of US public and private insurers across the spectrum. More than half of commercial health maintenance organizations are using pay-for-performance, and recent legislation requires Centers for Medicare & Medicaid Services (CMS) to adopt this approach for Medicare.[1] As commercial programs have evolved during the last 5 years, the categories of providers (clinicians, hospitals, and other health care facilities), numbers of measures, and dollar amounts at risk have increased. In addition, acceptance of performance measurement among physicians and organized medicine has broadened, with the American Medical Association committing to the US Congress in February 2006 that it would develop more than 100 performance measures by the end

tive step from the current payment system. Nonetheless, there are many details about how pay-for-performance would actually be implemented that could mitigate or even reverse some of its good intent.

Our objective is to review dimensions of pay-for-performance programs that economic theory or available data suggest would be important determinants of their influence. With CMS poised to enter the fray and many commercial payers evaluating, expanding, and updating their first-generation pay-for-performance programs, the time is right to examine critically the various approaches to pay-for-performance.

Five Key Design Elements of Pay-for-Performance

Purchasers must make many decisions when implementing pay-for-performance programs.[6] Based on our experience studying incentive programs,[4,5,7-9] 5 aspects of program design that are likely to be most consequential have been iden-

Source: Rosenthal, MB, Dudley, RA, *JAMA*, 2007; 297(7):740-744

Incentives for Physicians: My Trip to Seattle

- The American Academy of Neurology (AAN) held a special meeting in April, 2009 to consider their policy stance toward pay-for-performance and public reporting for physicians
  - I was asked to address: "Do professionals* respond to incentives?" *color added by me!

AAN Leadership Uses Bonuses:

V. Syllabus Contribution Policy

All directors and faculty must contribute to the program syllabus. Exceptions to this rule are limited and MUS
be pre-approved by Julie Grengs at the AAN office prior to the January 5, 2009, deadline. Directors and/or
faculty not contributing to the program syllabus without pre-approval will **NOT** receive an honorarium.[1]
Programs with missing faculty syllabus contributions have traditionally received lower Program Evaluation
Number (PEN) scores and negative comments and negative reviews.

All directors and faculty who meet the syllabus deadline will receive an additional $100.

NOTE: The AAN owns the copyright of all syllabus materials prepared for AAN CME-related programs. Th
AAN hereby licenses faculty to use written materials that they have authored for the AAN for noncommercial

AAN Leadership Uses Penalties:

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AAN Leadership Also Uses Public Reporting (Reputational Incentives):

Scientific

Alliance Awards: Founders
This award is designed to encourage clinical and translational research in neuroscience by physicians in clinical neurology training programs.

Alliance Awards: S. Weir Mitchell
This award is designed to encourage basic research in neuroscience by physicians in clinical neurology training programs.

Bruce S. Schoenberg International Award in Neuroepidemiology
In tribute to Dr. Schoenberg's career in training neurologists internationally in epidemiologic methods, this award salutes a young investigator selected from a developing country or Eastern Europe.

Dreifuss-Penry Epilepsy Award
The intent of this award is to recognize physicians in the early stages of their careers who have made an independent contribution to epilepsy research.

Harold Wolff-John Graham Award: An Award for Headache/Facial Pain Research
This award recognizes individuals who have submitted research results in the field of headache and facial pain.

Some selections from among the 27 reputational incentives offered by the AAN

Incentives: Question #2

- So, if incentives work, and pay-for-performance is common…why hasn't the world changed?????

- *Your thoughts??*

Using Incentives-Question #3

- Outcome variables:
  - Are cardiothoracic surgeons in Memphis present for follow-up visits for their post-op patients?
- Intervention: randomize them to receive (in addition to their usual salary) either:
  - $2/visit scheduled
  - $20/month for attending clinic
- What will happen???

Using Incentives-Question #3

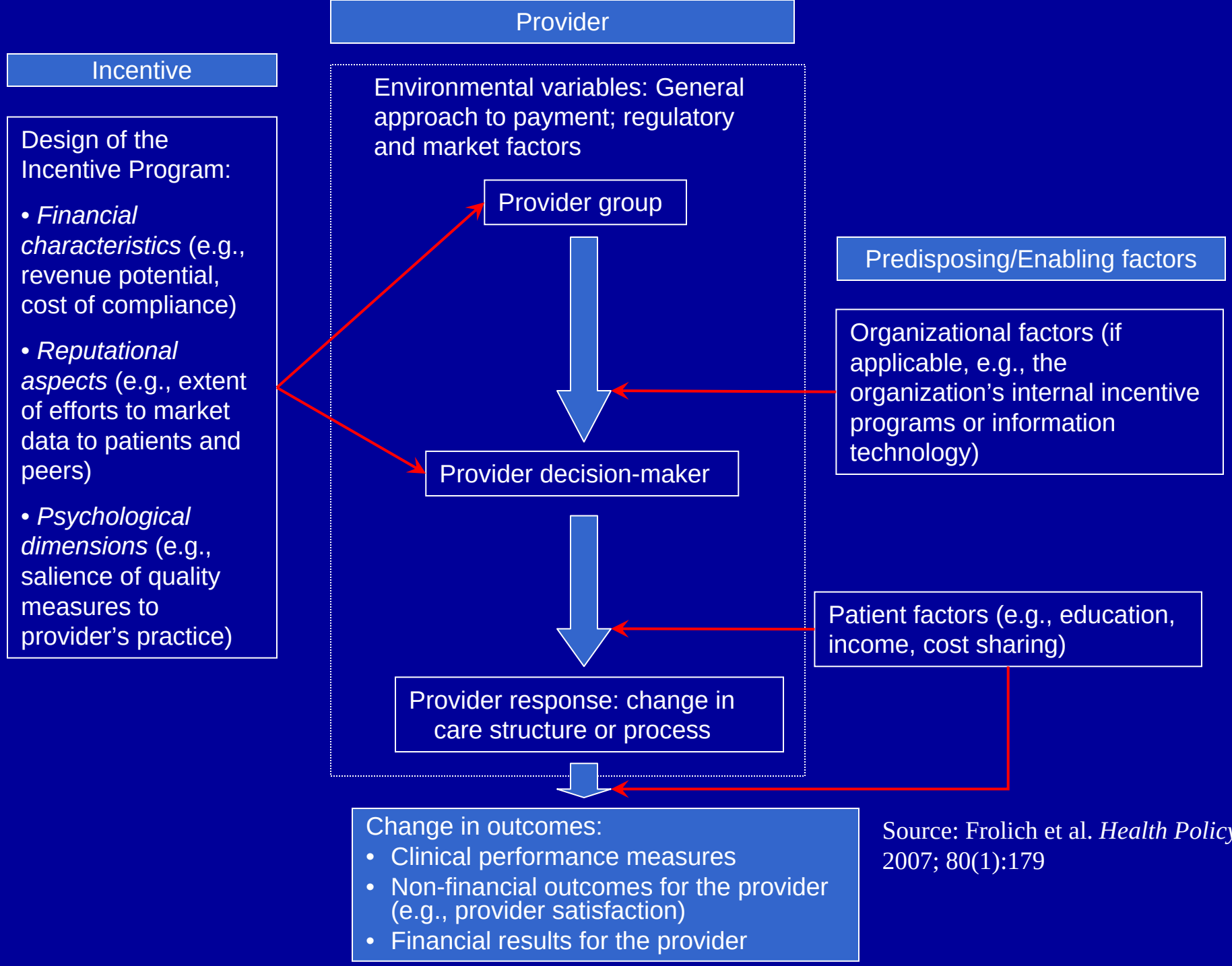
- Answer: OK, I’ve never met anyone who would dare to ask any cardiothoracic surgeons to enroll in a $2 trial

Would you clip that coupon?

Would you clip that coupon?

Enjoy your latte!

- CMS *Physician Quality Reporting Initiative* (PQRI): 1.5%
- CMS-Premier demonstration:
  - Top 10% of hospitals get extra 2% of selected covered payments, second 10% get 1%



Source: Frolich et al. *Health Policy*, 2007; 80(1):179

Using Incentives: Conclusions

- Financial incentives work!
- …except when the don’t!

Define 5 Types of P4P Strategies

1) *Relative Rank* (or Tournament): e.g., pay the top decile X%, next decile half that, everyone else nothing
2) *Relative Rank with Penalties*: e.g., same, but add a penalty if below prior year's last decile

Source: Werner, RM, Dudley, RA. Making the "Pay" Matter in Pay-for-Performance: Implications for Payment Strategies. *Health Affairs*, 2009; 28(5):1498-508

Define 5 Types of P4P Strategies

3) *Attainment*: pay for % above a threshold

4) *Attainment + Improvement*: same, plus pay for % improvement

5) *Percentage/Number Who Receive Recommended Care*: pay (or not) for each patient

Source: Werner, RM, Dudley, RA. Making the "Pay" Matter in Pay-for-Performance: Implications for Payment Strategies. *Health Affairs*, 2009; 28(5):1498-508

Define 5 Types of P4P Strategies

Which type are you offering?

OR …

Which type(s) are you facing?

Economic Theory Says…

- Has to be enough money to matter
- Best if organized so that there is always an incentive to do the right thing for the next patient that walks through the door
  - this does not necessary hold in relative rank or attainment if you know your performance already guarantees pay (or no pay)

If hold total bonus payouts at 5% of all payments, relative rank with penalties maximizes differential payments

EXHIBIT 2
Differences In Bonuses To Hospitals Received By Pay-For-Performance (P4P) Payment Strategy

	Average percentage bonus payment within decile, by strategy				
Overall hospital performance (in deciles)	Relative rank	Relative rank with penalties	Target attainment	Target attainment plus improvement	Percentage recommended
10 (highest)	30.0	35.3	8.9	7.7	5.6
9	15.0	17.6	7.5	6.5	5.4
8	0	0	6.3	5.8	5.3
7	0	0	5.5	5.4	5.1
6	0	0	4.7	4.9	5.0
5	0	0	3.8	4.3	4.9
4	0	0	3.2	4.0	4.8
3	0	0	2.7	3.6	4.6
2	0	0	2.1	3.2	4.4
1 (lowest)	0	−23.1	1.0	2.4	3.8
Total bonus ($)	$647,592,000	$647,592,000	$647,592,000	$647,592,000	$647,592,000
Total bonus (% of total payment)	5.0%	5.0%	5.0%	5.0%	5.0%

Source: Werner, RM, Dudley, RA. *Health Affairs*, 2009; 28(5):1498-508

If hold maximum difference between providers at 5% of all payments, percent recommended strategies allow percent of all pay to be based on performance

EXHIBIT 4
Differences In Bonuses Received Across All Hospitals By Pay-For-Performance (P4P) Payment Strategies

	Average percentage bonus payment within decile, by strategy				
Overall hospital performance (in deciles)	Relative rank	Relative rank with penalties	Target attainment	Target attainment plus improvement	Percent recommended
10 (highest)	5.0	3.0	5.6	7.3	11.6
9	2.5	1.5	4.7	6.2	11.0
8	0	0	4.0	5.6	10.6
7	0	0	3.5	5.1	10.3
6	0	0	3.0	4.6	10.0
5	0	0	2.4	4.1	9.7
4	0	0	2.0	3.8	9.3
3	0	0	1.7	3.4	8.9
2	0	−0.1	1.3	3.0	8.3
1 (lowest)	0	−2.0	0.6	2.3	6.7
Total bonus ($)	$106,853,000	$55,045,000	$407,983,000	$615,212,000	$1,288,317,000
Total bonus (% of total payment)	0.8%	0.4%	3.2%	4.7%	9.9%

Source: Werner, RM, Dudley, RA. *Health Affairs*, 2009; 28(5):1498-508

So, if you really want to make waves…

- …with your pay-for-performance (or any other incentive approach—the point applies to them all), make 30% of payments performance-based!
  - Avoid driving providers bankrupt by making payment base “percent recommended” or “number recommended”, rather than using a tournament or a threshold

Using Incentives: Summary

- Hard to argue incentives are “unethical” while AAN and everyone else uses them
- Financial incentives can influence provider behavior, but must be large enough and based on the right measures
- Choice of payment strategy (basis of rewards) has substantial impact on size of differential payment
  - Paying based on percent recommended minimizes differential at a fixed % bonus pool, but allows the % to be higher