

Pay-for-Performance: Groping Forward

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Pay-for-Performance Groundswell

- IOM's call to align payment with quality goals generated widespread pay-for-performance activity
- Most major health plans at least piloting pay-for-performance in one or more markets
- Programs reward hospitals, medical groups, physicians

Characteristics of Initial Efforts

- First generation pay-for-performance programs look like Phase I trials – small doses, targets of convenience (e.g., widely accepted screening measures, administrative data)
- Payers will learn incrementally and ramp up efforts
- True potential of pay-for-performance probably can't be judged from these early efforts

The Early Effects

- Pay-for-performance has stimulated substantial activity around measure generation, the need for common measure sets (NQF etc.) and coordination
- Payers and providers engaged in dialogue about critical areas for quality improvement
- Focus on need for better information, investment in information technology (IHA reports suggest increase IT adoption)
- Internal (uncontrolled) studies by Premier and IHA suggest quality improvement has occurred, but evaluations suggest that untapped opportunities exist

Now What?

- Pressing need to improve quality of care AND affordability
- How can pay-for-performance be designed to contribute most effectively towards these goals?

Phase II Questions

- Will pay-for-performance be cost-increasing as currently formulated?
- If pay-for-performance comes from a redistribution of existing funds will there be casualties in the provider market?
- Will bonuses for measurable aspects of care distract providers from other critical tasks?
- How much do we need to pay to get providers to really make big changes in care delivery?
- Are there important mitigating factors that will affect the response to pay-for-performance – patient factors, or infrastructure – that need to be addressed to enable QI (e.g. giving patients incentives too, or providing loans for IT)?