



Pay for Performance: US Experience

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P4P presentation outline --

1. What is state of P4P in the US?
2. Two US case examples
3. Top 10 P4P design tips
4. What's lurking on the US P4P horizon?



What is state of P4P in the US?

P4P has taken hold in the US:

- Over 150 programs are documented (*Dudley/Rosenthal 2008*)
- 52 percent of HMOS report use of P4P (*Dudley/Rosenthal 2008*)
- As of July 2006, 28 of 50 state Medicaid agencies operate P4P programs (*Young 2008/CHCS*)



What is state of P4P in the US?

Physicians are about twice as likely as hospitals to be focus of P4P (*Dudley/Rosenthal 2008*)

On average, programs use 5 performance measures (*Dudley/Rosenthal 2008*)

Maximum eligible bonus for physicians 5-10 percent of pay (*Dudley/Rosenthal 2008*)

Maximum eligible bonus for hospitals 1-2 percent of pay (*Dudley/Rosenthal 2008*)

Rewards for reaching a fixed threshold dominate; only 23 percent reward improvement (*Dudley/Rosenthal 2008*)



Two US case examples

Example #1 -

P4P program summary: In 2003 PacifiCare Health Systems -- one of the US's largest health plans -- began paying its California medical groups bonuses according to whether they met or exceeded 10 clinical and service quality targets.

Evaluation findings



Two US case examples

Example #2 -

P4P program summary: In 1983 Vanderbilt University began paying its pediatric residents bonuses to assess the impact on well child visits.

Evaluation findings



Top 10 P4P design tips from US experience

#1. In selecting performance measures to be incentivized, consider those that have greatest potential for gain and improvement
(Rosenthal/Dudley 2007).

#2. In selecting performance measures to be incentivized, wherever feasible, consider those that have undergone formal vetting.
(Dudley/Rosenthal 2006).

#3. In designing P4P, consider rewards for improvement as well as rewards for threshold achievement *(Rosenthal/Dudley 2007).*



Top 10 P4P design tips from US experience

- #4 In designing P4P, recognize contextual factors (e.g., underlying payment incentives) that can conflict with or undermine quality-related incentives *(Dudley 2004)*.
- #5 In designing P4P, consider phase-in strategies such as piloting the program in a smaller geographic area, begin with a voluntary incentive program, start out by privately reporting the measures and add incentives over time, begin with a modest threshold and raise standard over time *(Dudley/Rosenthal 2006)*.
- #6 In the case of physician P4P, consider practice level rewards for group-level quality improvement activities (e.g, to encourage systems improvements such as registries) as well as individual rewards (eg, to encourage smoking cessation counseling) *(Rosenthal/Dudley 2007)*.



Top 10 P4P design tips

- #7. Be transparent with providers and engage them in discussion of selection and specification of measures and incentives. Provider engagement strategies go from information sharing to advice seeking to shared decision-making *(Dudley/Rosenthal 2006, Williams 2008)*.
- #8. In determining the level of the incentive payment, consider providers' indirect and opportunity costs of making necessary changes to deliver higher quality care *(Dudley 2004)*.
- #9. Whether through formal external evaluation or informal self-evaluation plan, track change in quality over time and compare to baseline performance, and keep eye out for negative unintended consequences *(Dudley/Rosenthal 2006)*.



Top 10 P4P design tips

#1. Keep expectations in line with evidence, which indicates incentives can have a modest impact on quality -- if the design is evidence-informed -- but there is no evidence yet of US P4P implementation that has had breakthrough effect (*Luft 2008, Young 2008, Williams 2008, Dudley 2008*).

US P4P is best viewed as one strategy within larger quality framework that also considers continuous quality improvement programs, private and public report cards, consumer engagement and incentives, IT, provider training, etc. (*McNamara 2005*).



What's lurking on the US P4P horizon?

1. Incentives to encourage efficient use of resources as well as quality of care
(Williams 2008).
2. Quality incentives for specialists
(Adams/Rosenthal 2008)
3. Discussion of broader, more fundamental payment reform and underlying incentives for quality

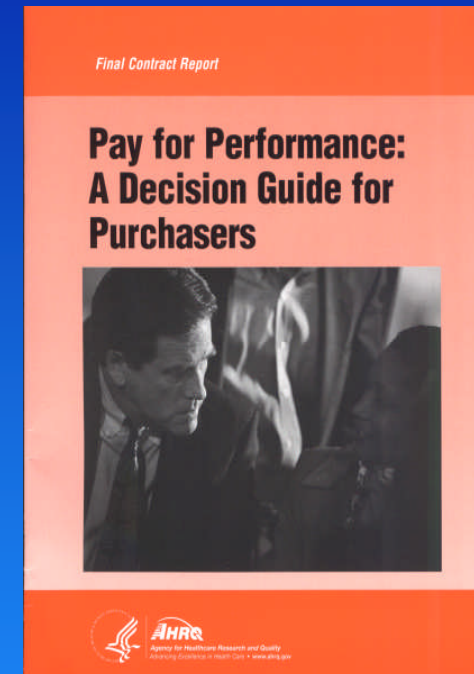


Key AHRQ resource on P4P

AHRQ commissioned:

Pay for Performance: A Decision Guide for Purchasers

A panel of 10-15 purchasers identified series of questions which became outline for the Guide





- For complete list of AHRQ resources on p4p -

<http://www.ahrq.gov/qual/pay4per.htm>

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