Early Experience with Pay-for-Performance: From Concept to Practice

Growing optimism over the promise of "pay for performance" to improve the quality of health care may have been given further impetus following publication of the first study to assess the effects of quality incentives in a large health plan. With support from The Commonwealth Fund, researchers examining a pay-for-performance program implemented by PacifiCare Health Systems—one of the nation's largest health plans—found that for one of three clinical quality measures studied, a physician network that was offered bonus payments outperformed another network that was not.

As reported in "Early Experience with Pay-for-Performance: From Concept to Practice" (*Journal of the American Medical Association,* Oct. 12, 2005), physicians who were part of the incentive program performed the same or slightly better on the other two measures, though the difference between the two groups was not significant, said the study's lead author, Meredith B. Rosenthal, Ph.D., of the Harvard School of Public Health. While improvement in quality was modest, the bonuses were also modest, and improvement was assessed over a relatively short period of time (five quarters), the researchers noted.

Setting Clinical Quality Goals
In 2003, PacifiCare began offering bonuses to the approximately 172 medical groups in its California network if those groups met or exceeded 10 targets for clinical and service quality. Bonuses averaged a relatively modest 5 percent of PacifiCare's payments to medical groups. The researchers compared the California network's performance with Pacificare's Pacific Northwest network of 33 medical groups in Oregon and Washington, which did not participate in an incentive program. The study focused on three clinical care measures: cervical cancer screening, mammography, and hemoglobin testing for diabetic patients.

Improvement in Cervical Cancer Screening Rates
Although improvements in the California groups were seen on all three measures, the Pacific Northwest network also improved. Overall, the only significant difference between the two groups was in cervical cancer screening, where the California network's quality score improved by 5.3 percent, compared with 1.7 percent in the Pacific Northwest. In total, the plan awarded $3.4 million (27% of the amount set aside) in bonus payments for all three measures during the first year of the program.

Historically High Performers Earn Most Rewards
When the researchers divided the California network into three levels of performance, a clear pattern emerged. Group 3, which began the program at the lowest level of performance (more than 10 percent below the target) showed the most improvement, but received the least in bonus payouts—a total of $360,155.

In contrast, Group 1, which was already performing at or above target at the outset, received more than $1.18 million in total payouts—compared with just over $81,000 for Group 3—although it improved the least of the three groups. Thus, approximately 75 percent of incentive payments went to practices already performing at or above baseline level before the incentive program was implemented.

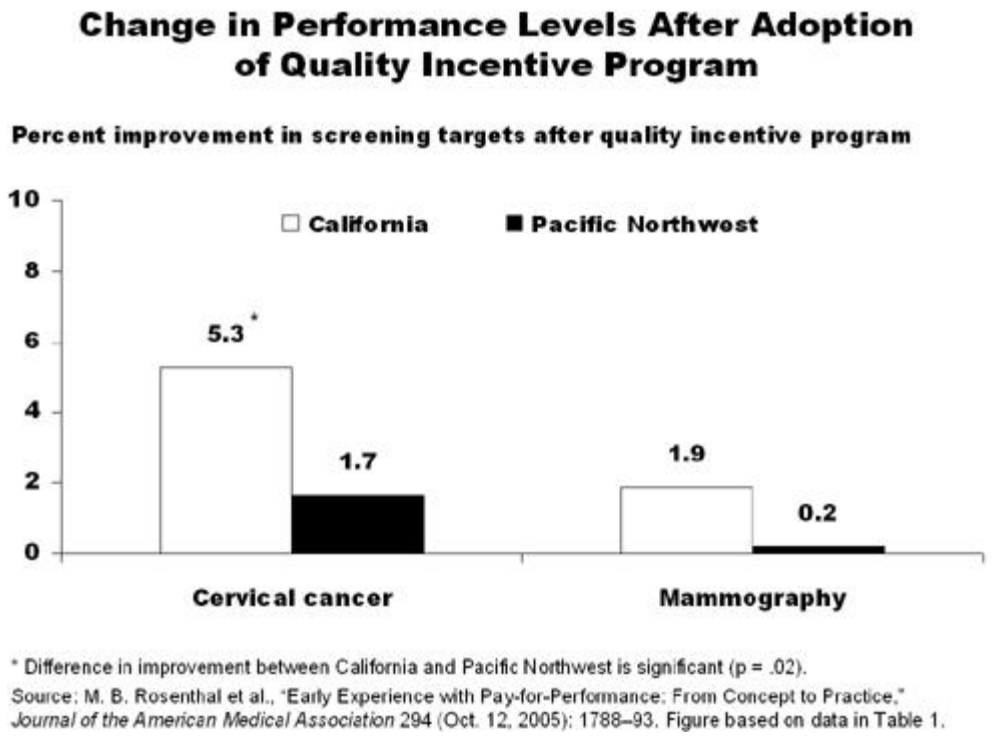
Policy Implications

In examining the physician groups' performance, Rosenthal and colleagues speculated that the groups that began the program with performance levels above the targeted threshold appeared to understand that they needed only to maintain the status quo to receive bonus payments. A more surprising finding, perhaps, is that the low-performing groups improved as much as they did, given their relatively low short-term chances of receiving a bonus. One possible reason for this, say the researchers, is that the low-performing groups may have viewed the program as a larger signal of a changing environment, one in which they would face increasing pressure to improve.

An incentive program that pays explicitly for quality improvement, rather than strictly rewarding achievement levels, would alter the incentives for high-performing and low-performing groups, distribute bonus dollars more toward the latter group, and possibly increase the overall impact of incentives. However, some health care organizations and payers may object to this idea, reasoning that it essentially condones low performance levels and fails to reward—or even penalizes—high achievers. But it is possible, say the researchers, to reward both performance and improvement through carefully designed incentive programs that draw on evidence and best practices.

Facts and Figures:

- The mean quarterly bonus payment to each medical group during the first year of the program increased from $4,986 in July 2003 to $5,437 in April 2004.
- Of the 163 eligible physician groups, 97 (60%) received bonuses related to at least one quality target in the first quarter. By the last payout, 129 groups (75%) reached at least one target.
- In total, across the three quality performance targets, 75 percent of bonuses accrued to Group 1, the physician groups with baseline performance at or above target, while only 5 percent accrued to Group 3, the physician groups more than 10 percent below the target.



* Difference in improvement between California and Pacific Northwest is significant (p = .02).

Source: M. B. Rosenthal et al., "Early Experience with Pay-for-Performance: From Concept to Practice," *Journal of the American Medical Association* 294 (Oct. 12, 2005): 1788–93. Figure based on data in Table 1.

Citation

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