Health Cost Containment and Efficiencies

NCSL Briefs for State Legislators

No. 6 May 2010

Performance-Based Health Care Provider Payments

Cost Containment Strategy and Logic

Pay-for-performance is a system of payment that rewards health care plans and providers for achieving or exceeding preestablished benchmarks for quality of care, health results and/or efficiency. Pay-for-performance is most often used to encourage providers to follow recommended guidelines or meet treatment goals for high-cost conditions (e.g., heart disease) or preventive care (e.g., immunizations). A physician might, for example, receive a year-end $25 bonus for every 2-year-old on the physician's panel if at least 80 percent have received recommended immunizations. A hospital may receive a performance payment for reducing the rate of avoidable hospital readmissions or ensuring that patients receive appropriate discharge medications. Performance awards can take many forms, including bonuses, enhanced fee schedules and directing more enrollees to high-performing providers and health plans.

Pay-for-performance is sometimes called value-based purchasing, quality-based purchasing or performance-based contracting. It usually is abbreviated "P4P."

The main goal of pay-for-performance systems is to improve health care results by ensuring that patients receive timely, cost-effective care—especially preventive and chronic care. Pay-for-performance also is intended to reduce costs. With improved quality of care, patients should remain healthier longer, the incidence of complications of care should decline, and the use of less-expensive but equally effective treatments should increase.

Target of Cost Containment

Research indicates that, for some conditions, pay-for-performance can lead to higher-quality, lower-cost care but, by itself, may not slow overall cost growth.

Pay-for-performance is designed to address health care underuse (e.g., inadequate preventive care) and overuse (e.g., unnecessary medical tests). It pays for value—efficient and effective care. Studies have shown that, in many cases, providers fail to provide care or follow guidelines that could both avoid the need for future more expensive care and save lives (Table 1). This is due in part to the fact that the current fee-for-service system does not reward quality or efficiency. With fee-for-service—where each completed test, treatment or product is billed and reimbursed as a coded line-item—providers may actually earn less by delivering cost-effective care if it means fewer services for which they can bill. Pay-for-performance is designed to address this negative incentive.

Federal Heath Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, directs the secretary of Health and Human Services to develop a "payment modifier" to allow for differential Medicare fee-for-service payments based on quality and efficiency measures (section 3007). It also establishes pay-for-performance pilot programs for psychiatric, rehabilitation, long-term care, and cancer hospitals and hospice programs that treat Medicare enrollees (section 10326).

Table 1. Performance Shortcomings in Treating Certain Medical Conditions

Condition	Shortfall in Care	Avoidable Toll if Recommended Care Guidelines Were Followed by All Providers in the U.S.
Diabetes	Average blood sugar not measured for 24% of patients	2,600 blind; 29,000 kidney failures
Hypertension	Less than 65% received indicated care	68,000 deaths
Heart Attack	39% to 55% did not receive needed medications	37,000 deaths
Pneumonia	36% of elderly didn't receive vaccine	10,000 deaths
Colorectal Cancer	62% not screened	9,600 deaths

Source: S.H. Woolf, "The Need for Perspective in Evidence-Based Medicine," Journal of the American Medical Association 282 (1999): 2358-2365.

State Examples

- In 2009, more than 250 pay-for-performance programs existed nationwide; almost half targeted hospital care. State Medicaid departments sponsored 18 percent of these, health insurers 66 percent, employers 11 percent and Medicare 5 percent.[1] Estimates are that, by 2011, 85 percent of state Medicaid programs will operate some type of pay-for-performance program.[2] Seventy percent of current Medicaid performance-based payment programs operate in managed care or primary care case management environments. Some involve nursing homes or behavioral health providers. Most focus on preventive health services and children's, adolescents' and women's health issues. Several states participate in multi-payer, pay-for-performance programs (e.g., the regional, multi-payer, pay-for-performance and quality reporting program operated by the Indiana Health Information Exchange).

- Several states link pay-for-performance to hospital reimbursement rates. The Maryland Health Services Cost Review Commission, which sets hospital reimbursement rates for all payers, rewards hospitals that score well on specified quality-of-care measures (e.g., surgical infection prevention, following evidence-based heart attack treatment guidelines) as part of its Quality-Based Reimbursement Initiative. The authority for this program comes from state law that allows the commission, in determining if rates are reasonable, to consider objective standards of efficiency and effectiveness.[3] A 2006 Massachusetts law provides that Medicaid hospital rate increases be contingent upon quality measures.[4]

- In 2008**,** Minnesota passed comprehensive health reform legislation that, among other provisions, requires the commissioner of human services to implement quality incentive payments for enrollees in state health care programs.[5] The law requires development of a payment system that rewards high-quality, low-cost providers. Minnesota's Medicaid and state employee health benefits programs also are partnering with nine private sector employers in a statewide pay-for-performance program.

- Maine's Medicaid program includes a Physician Incentive Program that ties 30 percent of a performance bonus to appropriate reductions in emergency department use.[6]

- A 2007 Texas law directed the Health and Human Services Commission to investigate outcome-based performance measures and incentives in all Medicaid contracts with health maintenance organizations (HMOs). If the commission determines that performance incentives are feasible and cost-effective, it is authorized to develop and implement a pilot project in at least one health care service region. Legislation is intended to improve access to care and strengthen the link between reimbursement and hospital-based programs that can reduce the cost of care for Medicaid enrollees.

Several states have either passed a series of bills to streamline various administrative processes or have enacted comprehensive administrative simplification bills.

- Several states have estimated likely savings from implementing pay-for-performance programs. The Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program, estimated the cost of and projected savings from implementing a physician incentive program to provide optimal care to patients and ensure full immunization of all 2-year-olds. It estimated that, over three years, the program would cost $4.6 million but would save the state $10.1 million.[7] Despite these projections, the Arizona Legislature did not approve a 2008 request to fund the program, due to budget shortfalls and the need to make a significant up-front investment before any savings would be realized. In 2009, Massachusetts estimated that implementation of pay-for-performance standards called for in the state's FY 2010 budget would save the state $62 million.[8]

Non-State Examples

- Under Medicare's Physician Group Practice Demonstration Project, physician groups are eligible for performance payments if the growth in Medicare spending for the population assigned to the physician group is less than the growth rate of Medicare spending in their local market by more than two percentage points. Performance payments are based on meeting efficiency and quality targets.

- A number of large employers and health plans use pay-for-performance systems.

  — More than half of commercial HMOs include performance-based incentives in their provider contracts. Collectively, these HMOs manage 81.3 percent of the nation's commercial HMO enrollees.[9]

  — Bridges to Excellence is an employer-led, national initiative to improve health care quality and hold down costs. Participants include large employers (e.g., General Electric, Proctor and Gamble, and UPS), health plans (e.g., Aetna, Humana and several Blue Cross Blue Shield plans) and physician groups. Bridges to Excellence focuses on improving diabetes and cardiovascular disease care and patient care management systems.

  — The California Integrated Healthcare Association launched a pay-for-performance initiative in 2003. It includes seven major health plans and 225 physician groups that care for 46.2 million people.

Evidence of Effectiveness

Little research exists on the effect of performance-based pay on health care costs. Most research focuses on improvements in quality of care rather than on cost savings. Research for this

brief did not uncover any assessments of cost savings from state pay-for-performance programs. Existing evidence, mainly from the private sector, has produced mixed results. Some have found that, for certain conditions, pay-for-performance can lead to higher-quality, lower-cost care. Others have found that, for the most part, performance-based pay does not yield net savings but can improve care quality.

- Bridges to Excellence reports that physicians who are recognized by the program for providing high-quality and more efficient care deliver it at 10 percent to 15 percent lower cost than nonparticipating physicians. The average annual cost of care for diabetes patients, for example, is $1,400 with recognized physicians versus $1,600 with others.

- A 2007 study examined the results of a pay-for-performance program in Rochester, N.Y.—the Excellus/Rochester Individual Practice Association Rewarding Results Initiative. It reported a 5-to-1 return on investment for the initiative's diabetes and coronary artery disease programs.[10]

- A 2008 report to the Texas Legislature found that, "Despite the broad application of P4P programs across commercial insurance, Medicaid and Medicare in programs across the country, there is limited evidence of clinical effectiveness and no evidence of cost effectiveness."[11]

- A 2008 study of health care quality and value published by The Bipartisan Policy Center reported, "Most pay-for-performance experiments to date have shown some evidence of small improvements in measured quality of care, but little evidence of cost savings."[12]

- A study published in 2009 concluded that pay-for-performance is good for rewarding improved use of underused services (e.g., colonoscopy screenings and mammograms) but does not reduce overused services.[13]

- With respect to quality, several studies have found that pay-for performance programs can improve health care quality, as measured by such things as cervical cancer screening and mammogram rates, frequency of well-baby visits, percent of women receiving appropriate postpartum care and childhood immunization rates.[14] Others have found little evidence to support the effectiveness of paying for quality.[15]

Researchers have suggested several reasons for the apparently limited effect of performance payments on overall costs.

- The cost of, and administrative expenses associated with, incentive payments may offset any savings from reductions in preventable complications and unnecessary services.

- The various ways different payers structure and target their performance incentives may dampen the effect as providers attempt to respond to incentives.

- Incentive payments may account for only a fraction of a provider's patients.

- Programs have not been implemented on a large enough scale or for long enough to demonstrate net savings.

- Performance pay programs tend to focus on rewarding improvements in quality-of-care measures but not on improved efficiency or cost of care.

Challenges

Several challenges exist to implementing a performance-based payment system that can both control costs and improve quality. One is determining how large a performance incentive is necessary to affect physician behavior. Another is deciding how savings will be measured—will they be based on costs under the program compared to a control group, trend or a baseline measure of cost? Also, will the effect on overall costs be measured (e.g., annual expenditures for children on Medicaid) or only the effect on costs associated with the targeted, performance-based incentive (e.g., reduction in emergency room use by asthmatic children)? Other challenges include 1) consolidating enough payers that use the same pay-for-performance incentives to ensure program impact and 2) securing sufficient front-end funding to implement a pay-for-performance program (e.g., establishing a system for reporting, collecting and analyzing performance data and appropriating funds to pay performance bonuses).

Complementary Strategies

Performance-based pay often is used in conjunction with other payment methods and health care programs. Examples include global payments (i.e., risk-adjusted capitation programs), disease management programs, medical homes and care coordination programs. Combining pay-for-performance with these strategies, which are the subject of other briefs in this series, may result in a greater level of cost containment than could be achieved by implementing any one by itself.

For more information

Bailit Purchasing LLC. *The Feasibility and Cost-Effectiveness of Making Pay-for-Performance Opportunities Available to Texas Medicaid Providers.* Needham, Mass.: Bailit, December 2008, http://www.hhsc.state.tx.us/reports/Pay-for-Performance_0209.pdf.

Hasselman, Diane. *Provider Incentive Programs: An Opportunity for Medicaid to Improve Quality at the Point of Care.* Hamilton, N.J.: Center for Health Care Strategies Inc., March 2009, http://www.chcs.org/usr_doc/P4P_Resource_Paper.pdf.

See list of pay-for-performance papers published by The Commonwealth Fund, http://www.commonwealthfund.org/Search.aspx?search=pay+for+performance.

Notes

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2. Kathryn Kuhmerker, *Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs* (publication no. 1018) (New York, N.Y.: The Commonwealth Fund, April 2007); http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=472891.
3. Md. Health-General Code Ann. §219.
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14. Gary Young et al., *Pay-for-Performance in Safety Net Settings: New Evidence from the Agency for Healthcare Research and Quality,* PowerPoint presentation to the AHRQ 2008 Annual Conference, Sept. 9, 2008, www.ahrq.gov/about/annualmtg08/090908slides/Young.htm.
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About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple alternative state policy approaches, with an emphasis on documented and fiscally calculated results. The project is housed at the NCSL Health Program in Denver, Colorado. It is led by Richard Cauchi, program director, and Martha King, group director, with Barbara Yondorf as lead researcher.

NCSL gratefully acknowledges the financial support for this publication series from The Colorado Health Foundation and Rose Community Foundation of Denver, Colorado.

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National Conference of State Legislatures
William T. Pound, Executive Director

7700 East First Place
Denver, Colorado 80230
(303) 364-7700

444 North Capitol Street, N.W., #515
Washington, D.C. 20001
(202) 624-5400

www.ncsl.org