The New Pay-for-Performance Plans

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The concept of receiving additional resources or privileges, on the basis of better-than-expected results, is the bedrock of the American business model. Whether it’s bonuses, promotions, or congratulations from the boss, rewards are meant to motivate individuals and teams to strive for excellence. And these rewards do work! However, the design of an incentive program can get tricky, because the goals must be meaningful and clearly understood, not vulnerable to negative unplanned consequences.

For example, increasing output, while decreasing quality, is not a good thing; therefore, incentive goals should capture both aspects of production. Similarly, if both output and quality increase but customer service and delivery decrease, organizations can suffer strategic damage. Humans are extremely creative in “getting the cheese.”

Now let us return to the topic of health care. Payers, after exhausting numerous other approaches to control rising expenditures while simultaneously preserving quality of care (e.g., by instituting capitation, gatekeepers, the need for second opinions, limited networks, and issuing an increasing number of denials of coverage) are now trying a “carrot first, stick later” approach to addressing quality. Individual physicians and hospitals throughout the U.S. have been selected for a “pay-for-performance” (PFP) experiment. (You’re welcome for my unveiling of yet another acronym in health care writings!)

The version of the plan produced by the Centers for Medicare and Medicaid Services includes hospitals from one hospital alliance that voluntarily submit to scrutiny of their electronic clinical data against “evidence-based quality measures” in hospitalized patients who are being treated for acute myocardial infarction, heart failure, community-acquired pneumonia, coronary artery bypass, or hip or knee replacements.1 These measures will be electronically quantifiable as being (or not being) met.

After one year, hospitals will receive an extra 2% for each condition for which they score in the top 10% and an extra 1% for being in the 11% to 20% range. All hospitals in the top 50% get a pat on the back.

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As you can imagine, the competition should be intense by year three. My only concerns are these: (1) Is the extra 2% for a diagnosis that pays $10,000 (i.e., $200) enough for me to give vaccinations, tests, screens, and counseling to all patients in that category? (2) How do I split the institutional bonus if I get it? and (3) Does this performance surrogate marker indicate that I’m “top-notch” in everything else?

On the West Coast, physicians are being offered the California Pay-for-Performance program.2 The size of year-end bonuses is estimated to be 5% to 10% of total revenue. Although the metrics are still somewhat fuzzy, this plan does represent an improvement over the older models, which often required income to be withheld according to how much was spent on patient care.

As these models gain traction and experience, I offer the following questions for health service researchers to ponder:

• Do health care professionals really need an extra monetary motivation to do the right thing every time and all the time?
• What does one do with underachievers over the long haul (after their payments have been reduced)?
• Can electronic systems be consistently relied upon to capture the nuances of contraindications and those of unnecessary or undesired services?
• Can this model be rolled out to include all, or at least most, clinical practices?
• How can treatment advances be incorporated into optimal practice models in real time?

I presume that the readers of P&T might have more concerns, but for now, PFP is the new plan, which certainly sounds better on paper than the old ones. Please feel free to share your ideas with me. You can reach me at my email address, matuszewski@uhc.edu.

REFERENCES