

## P4P: Rumors of Its Demise May Be Exaggerated

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Although pay for performance (P4P) faces numerous challenges, it may be too soon to relegate it to the list of failed healthcare reform strategies. In practice, many payers understand the limitations of performance incentives and have made efforts to avoid the worst pitfalls through targeting provider organizations rather than individual physicians and directly addressing the needs of potentially vulnerable patient populations. Thoughtful design and implementation of P4P may therefore yield improved value with minimal negative consequences. Because of the critical role payment incentives play in guiding practice patterns, it is hard to imagine substantial reform of the delivery system without coordinated changes in payment.

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Although it has become decidedly mainstream, pay for performance (P4P) still evokes strong objections from some quarters. McMahon et al<sup>1</sup> muster the well-known points of contention against what they view as the current slide towards physician-level application of P4P. Both incentive theory and empirical evidence should indeed give pause to any payer or policy maker hoping to improve the effectiveness and efficiency of care delivery with P4P alone. There are all too many ways that P4P, like quality measurement and reporting, can encounter design and implementation problems and, even in the best of circumstances, yield unintended consequences for patients and payers.<sup>2</sup>

In light of what can go wrong with P4P, it is not without cause that McMahon et al raise the alarm against the call for “market-based” incentives. Nonetheless, it may be premature to pronounce, or even hope for, the death of P4P just yet. Without disagreeing with any of the basic arguments made by McMahon et al, it is possible to arrive at a somewhat different conclusion than the authors do for several reasons. First, the practice of P4P is not as simplistic as some of the statements made by its high-level proponents.<sup>3</sup> In particular, payers have anticipated some of the adverse consequences of poorly designed incentive programs and have not, by and large, implemented the “worst case scenario” incentive schemes about which we worry most. Second, even with strong evidence of the existence of negative consequences (such as patient dumping), it is not necessarily correct to conclude that the overall effect of P4P would be to make the situation worse. Finally, it is compellingly clear that payment matters for the orientation and organization of the delivery system (witness, for example, the rise of specialty hospitals), so that a policy of delaying payment reforms until more integrated and sophisticated practices emerge as the authors suggest might further slow needed progress in the capacity for coordinated, prospectively oriented care.

### P4P IN PRACTICE IN THE UNITED STATES

Although advocacy for P4P may sound frighteningly naïve and blind to potential unintended consequences, the implementation of these programs is often much more nuanced. For example, while the Centers for Medicare & Medicaid Services is looking to profile and reward individual physicians in Medicare, many commercial health maintenance organizations (57%) have implemented P4P

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only at the medical-group level.<sup>4</sup> In addition, the designers of payment incentives in both the public and private sector have recognized the need to target improvement in care for vulnerable populations. In this vein, Blue Cross Blue Shield of Massachusetts has incorporated cultural competence training as a requirement of its P4P program, while recent Massachusetts legislation requires that the Medicaid program incorporate measures to reduce racial and ethnic disparities into a new P4P effort. This is not to suggest that P4P programs are uniformly enlightened, but that there are working examples that demonstrate the opportunity to do better, and perhaps even do good, with P4P.

### NET EFFECTS OF PERFORMANCE PROFILING AND PAYMENT

Demonstrating that incentives can and do have perverse effects has been an important part of the research and policy discussion around quality measurement, reporting, and payment. But evidence of the existence of unintended consequences alone, even sizeable ones, is not enough to prove that P4P is a bad idea. Whether P4P is good policy depends on the total net benefit, a function of the costs, including negative consequences of the incentives, and the benefits. Moreover, although negative effects such as upcoding, avoidance of high-risk patients, and excessive focus on measured processes and outcomes cannot be eliminated, they can be minimized by thoughtful design. It is important to reinforce, however, the point made strongly by McMahon et al that the effects of P4P might be very different for different populations so that net benefits need to be examined not just on average but for potentially vulnerable groups.

### THE CHICKEN AND EGG OF PAYMENT AND ORGANIZATION

As McMahon et al point out, perhaps the biggest dilemma with P4P is an assumption that incentives will somehow improve quality and efficiency of care, even if the essential systems for providing care are lacking. Nonetheless, urging policy makers to focus on addressing the lack of coordinated systems of care before introducing financial incentives ignores the need to provide an economic rationale for the development of such systems. Without performance incentives of some kind (including prospective payment in this category) there is little or no economic motivation for creating population health management tools, such as disease registries and care teams. Because it would be reasonable to conclude that

#### Take-away Points

Although unfettered enthusiasm for pay for performance (P4P) is unfounded, quality-based payment should not be dismissed.

- Innovative programs have been designed to address the major unintended consequences that critics charge will render P4P harmful.
- Evidence-based and thoughtful P4P is almost surely a necessary part of broader health system reform.

the fragmented delivery system we have is perfectly designed to take advantage of the largely volume-based reimbursement system, it might also be reasonable to suggest that changes in payment need to pave the way for a more highly evolved delivery system.

Sorting out whether and how to P4P is a complicated matter about which informed and reasonable people could easily disagree. The lackluster results from some recent, high-profile initiatives<sup>5</sup> combined with troubling reports of unintended consequences in similar programs have dampened some of what was probably excessive enthusiasm for the idea. But the need to promote a different approach to healthcare delivery, with a focus on improving outcomes and efficiency, remains critical. Financial incentives surely have a role to play; there is no better evidence for their power than our own dysfunctional healthcare system. P4P is obviously not a complete solution, and additional payment reforms supported by improvements in infrastructure, training, and quality measurement will be needed. Progress is likely to occur if these changes are coordinated within communities, designed based on evidence and with forethought to protect against potential adverse effects, and evaluated systematically to allow continuous improvement.

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■ COMMENTARY ■