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Review

What can the past of pay-for-performance tell us about the future of Value-Based Purchasing in Medicare?

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ABSTRACT

The Medicare program has implemented pay-for-performance (P4P), or Value-Based Purchasing, for inpatient care and for Medicare Advantage plans, and plans to implement a program for physicians in 2015. In this paper, we review evidence on the effectiveness of P4P and identify design criteria deemed to be best practice in P4P. We then assess the extent to which Medicare's existing and planned Value-Based Purchasing programs align with these best practices. Of the seven identified best practices in P4P program design, the Hospital Value-Based Purchasing program is strongly aligned with two of the best practices, moderately aligned with three, weakly aligned with one, and has unclear alignment with one best practice. The Physician Value-Based Purchasing Modifier is strongly aligned with two of the best practices, moderately aligned with one, weakly aligned with three, and has unclear alignment with one of the best practices. The Medicare Advantage Quality Bonus Program is strongly aligned with four of the best practices, moderately aligned with two, and weakly aligned with one of the best practices. We identify enduring gaps in P4P literature as it relates to Medicare's plans for Value-Based Purchasing and discuss important issues in the future of these implementations in Medicare.

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1. Background

The concept of pay-for-performance (P4P) – that payers should explicitly link provider reimbursement with performance on quality measures – is compelling. Because patients have a limited ability to observe the quality of care that they receive,[1] providers have lacked the incentive to provide sufficiently high quality care, resulting in suboptimal quality across the health care system.[2] In response, both public and private payers have attempted to incentivize the delivery of high quality care through the payment system by initiating P4P programs. P4P has now been implemented nationally by Medicare for inpatient care[3] and for Medicare Advantage (MA) plans, and starting in 2015 will be implemented for physicians as part of the Physician Value-Based Payment Modifier.[4]

However, despite the best efforts of researchers, the question “Does pay-for-performance improve quality in health care?” remains frustratingly elusive. Even after widespread implementation of P4P in the

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United States, international P4P efforts,[5] and accumulating research, much is still unknown about the conditions under which P4P is most effective and whether P4P has the potential to be a cost-effective means of improving quality.[6] Further, research has little to say about extensions of P4P "version 1.0," such as how P4P can improve the value of care,[7] not just quality. While policymakers would like to know how a specific incentive targeted towards a specific provider can be expected to impact a specific quality measure, research to date can, at best, guide policymakers towards general principals of implementation. Nonetheless, the existing literature on P4P can provide some guidance to policymakers about how we should form expectations as to the likely effectiveness of future programs, the key design features that will influence the success of these programs, and how we can understand the risk and reward trade-off between more highly powered incentives and the potential for unintended consequences.

In this article, we draw on the recent literature in P4P to identify key insights that are relevant to national P4P implementation efforts. We focus on how the literature may inform P4P, now referred to as Value-Based Purchasing, implementations in Medicare: the Hospital Value-Based Purchasing (HVBP) program, the Physician Value-Based Payment Modifier (PVBPM), and the Medicare Advantage Quality Bonus Program (QBP). We then discuss additional considerations for the design of these programs and how research can support these efforts.

2. Summary of research on hospital and physician P4P

By 2004, 37 separate P4P programs had been implemented in the United States, almost exclusively by private payers in the outpatient setting,[8] and by 2006 more than half of the HMOs used pay-for-performance[9] and most state Medicaid programs were using some form of P4P.[10] National estimates indicate that, by 2007, approximately half of physician practices had been exposed to P4P from private payers or Medicaid.[11,12]

A number of influential articles have assessed the extent of P4P implementation and evidence of payment for quality programs implemented in the previous two decades.[6,13–15] While equivocal, reviews of the early published studies suggested that financial incentives for quality could generate improvement under some circumstances.[13] More recent reviews of the literature have painted a more mixed picture of the overall effectiveness of P4P, and have also begun to identify conditions under which P4P could be more effective. A review by Flodgren et al.[16] found that financial incentives were generally effective in improving processes of care (improving 41/57 measures from 19 studies) but generally ineffective in improving compliance with a pre-specified population quality target (improvement observed for 5/17 measures from five studies). Other systematic reviews of the evidence found insufficient evidence to support (or not support) the use of financial incentives for quality of care in primary care and for individual physicians.[17,18] This work also suggested that more methodologically rigorous studies were less likely to find positive effects of P4P.[18] In addition, a review by Van Herck et al.[19] found that P4P programs tended to show greater improvement on process measures compared to outcomes, that the positive effect of incentives was generally greater for initially low performers compared to higher performers, that it was unclear how the magnitude of incentives impacted the effectiveness of P4P programs, and that programs aimed at the individual-provider level and/or team level generally reported positive results.

However, most of the programs evaluated in these reviews were small scale P4P experiments, initiated either by a single payer within a health care market or for a select group of providers. The extent to which results from these programs would generalize to national, mandatory implementations of P4P is unclear.

3. Precursors to nationwide implementation of Value-Based Purchasing in Medicare

For hospitals, the research that is most relevant to Medicare's implementation of HVBP comes from the Premier Hospital Quality Incentive Demonstration (HQID). Under this demonstration, 266 hospitals, all subscribers to Premier's "Perspective" hospital performance benchmarking service, agreed to collect and report data on a set of quality measures and make their performance subject to financial incentives. Implementation of the HQID occurred in two phases. Results from initial studies of the phase 1 HQID implementation appeared promising: two studies reported that participating hospitals experienced modestly greater rates of quality improvement for process of care measures compared with comparison hospitals for each of the incentivized diagnoses examined in the first three years of the program.[20,21] However, subsequent studies on the HQID raised doubts that the program improved quality performance.[22–24] Even more discouraging were results from phase 2 of the HQID which found that changes in program design did not generate additional quality improvement.[25,26] Detailed re-analyses of the initial data suggested that the early program success may have been due to selection of stronger hospitals into the demonstration and the later slowdown in improvement may have resulted from many of the incentivized performance measures becoming "topped out".[26] Other research found that the HQID did not appear to improve mortality outcomes across both phases of implementation.[27]

On the physician side, while numerous P4P programs have been implemented by private payers and state Medicaid programs, there are few large-scale programs to predict what might occur under a Medicare-implemented physician Value-Based Purchasing program. The most substantial private payer implementations of P4P have been for physician group practices in California including the PacifiCare Quality Incentive Program (QIP) and the California Integrated Healthcare Association's (IHA) P4P program. Evaluation of the QIP found very modest results[28] while the IHA initiative was found to have changed the behavior of the physician organizations, leading to an increased organizational focus on quality and IT adoption.[29] Less optimistically, evidence from a major P4P initiative implemented by five large commercial payers in Massachusetts found that the program did not improve performance on a series of incentivized HEDIS quality measures.[30]

In a few cases, P4P programs have been implemented among physician practices that focus on improving both cost and quality performance, using a shared savings incentive model. The Medicare Physician Group Practice (PGP) demonstration in 10 physician practices shared savings contingent on physician groups demonstrating improvement in quality on clinical measures and reductions in beneficiary costs. Another program, the Blue Cross Alternative Quality Contract (AQC), uses quality bonuses along with a shared savings model based on global budgets that includes both upside and downside risk for 11 participating provider organizations in Massachusetts. Compared to a comparison group of non-participating practices, quality improved more for AQC practices for chronic care management, adult preventive care, and pediatric care in the second year of the program, and has resulted in modest reductions in spending trends.[31]

4. Medicare's Value-Based Purchasing programs

Following the experience of the HQID, the Affordable Care Act (ACA) enacted Hospital Value-Based Purchasing (HVBP) for all acute care hospitals in the United States, making HVBP the first national implementation of P4P in the United States. Under

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