Annals of Internal Medicine

EDITORIAL

Face the Facts: We Need to Change the Way We Do Pay for Performance

Medicare and other health care payers have initiated various pay-for-performance (P4P) approaches to improve the quality and efficiency of health care delivery. The idea is simple and appealing: Providing financial incentives for quality improvement and efficiency gain should lead to both. In practice, however, the results have been disappointing. Most P4P programs attempted to date have shown little benefit.

The new article by Roberts and colleagues should be the final nail in the coffin of the current generation of P4P. The authors found that the Medicare Value-Based Payment Modifier (VM), which measures quality and cost among physician group practices and provides bonuses or levies penalties (depending on group size) accordingly, had no beneficial effect on the quality of or spending on care (1).

The article is damning to current policy, because the VM program is structurally similar to Medicare's Merit-based Incentive Payment System (MIPS), a component of the Medicare Access and CHIP [Children's Health Insurance Program] Reauthorization Act (MACRA). Like the VM, MIPS bonuses or penalties will be based on quality metrics and cost performance, as well as meaningful use of electronic health records. Thus, the VM provides important insight into how the MIPS might play out.

Using a sound analytic approach (exploiting discontinuities in VM design by practice size and time), Roberts and colleagues found that VM bonuses and penalties had no effect on the quality or efficiency of care delivered. These results are consistent with those of previous studies of physician P4P programs (2) as well as a larger body of evidence around hospital-focused P4P programs (3–5). All told, evidence that P4P improves care is scant.

Worse, the authors found that the VM likely has exacerbated existing disparities in care. Because the Medicare VM does not adjust for socioeconomic status (SES) or illness severity, practices that care for lower-income or sicker patients received greater penalties, essentially creating a reverse Robin Hood effect (6). Likewise, the MIPS is not slated to account for SES or illness severity, so it also might exacerbate disparities between organizations serving larger versus those serving smaller proportions of vulnerable patients.

Although the verdict on the current generation of P4P programs is clear, there is hope for improvements in care delivery. Aside from the MIPS, MACRA offers another pathway to encourage physicians toward higher performance: alternative payment models (APMs). These models usually require adoption of certified electronic health record technology, financial risk, and quality measures. So far, the types of models that meet these criteria have exhibited more promising performance than standard P4P programs.

Accountable Care Organizations (ACOs), for example, have reduced spending while maintaining or improving quality of care (7). Although the benefits of ACOs have been modest, at least they are a step in the right direction. In addition, some of the recent bundled payment initiatives, such as the Bundled Payments for Care Improvement program, also have reduced costs of care associated with procedures while maintaining or improving quality (8). Finally, Medicare Advantage (MA) is another alternative to traditional Medicare payment that shows promise in promoting high-value care (9). However, the current integration of MA into MACRA is indirect, and the Centers for Medicare & Medicaid Services would do well to allow MA to be more easily recognized as an APM.

What these models have in common is the expansion of the scope and duration of care tied to payment. As such, they represent meaningful departures from the fee-for-service model and its perverse incentives. By encouraging providers to innovate in care delivery within an episode (under bundled payments) or across populations (under ACOs or MA), these programs provide more of the right incentives to improve efficiency.

Although these models seem to be a step in the right direction, their effect on the quality of care patients receive remains inadequate. To make more progress, we must streamline quality measures and focus on what patients care about most: functional status, a good experience, fewer complications, and better outcomes. Part of the P4P failure is the result of an overabundance of measures, many of which have little clinical benefit. If alternative payment approaches are to thrive, we need a concomitant effort to improve quality metrics.

We should not delude ourselves into thinking that pursuit of new payment models will be easy or without serious limitations. A major drawback is the difficulty smaller practices have in managing population health and costs in ways new payment approaches require. Some provider organizations have used this impediment as an excuse to consolidate in the health care marketplace, which often raises prices without improving quality. This trend toward consolidation warrants monitoring.

Finally, under each of these models, we must carefully consider the role of SES, because it may have a large, independent effect on the health and well-being of patients. As the health care industry shifts toward measuring more outcomes, accounting for SES will become more important. Little reason exists to excessively penalize providers who disproportionately care for poorer and sicker patients. On this issue, there is broad

This article was published at Annals.org on 28 November 2017.

agreement. Although many approaches may be taken to account for SES, the spirit of the one offered by the Medicare Payment Advisory Commission (MedPAC)–basing penalty and bonus determinations on performance relative to peer institutions–is very reasonable (10).

Looking ahead, it is clear that we must seriously reconsider our approach to P4P. Little justification remains for implementing the MIPS as designed. Policymakers have several choices, including promoting alternative payment approaches. MedPAC has been clear that the MIPS portion of MACRA should be discarded, and we agree. However, as we encourage alternatives, we also must make a concerted effort to rethink our quality strategy with fewer, more patient-centered measures.

Part of making progress requires knowing what to stop doing. Although we still are learning the best ways to deliver health care to the American people, we know what does not work. The evidence on stand-alone P4P is clear and overwhelming, and it is high time to abandon this model. Plenty of alternative approaches are under way or waiting to be tried, and wasting time on strategies that do not work serves no one.

Austin B. Frakt, PhD
VA Boston Healthcare System, Boston University School of Public Health, and Harvard T.H. Chan School of Public Health
Boston, Massachusetts

Ashish K. Jha, MD, MPH
Harvard T.H. Chan School of Public Health
Boston, Massachusetts

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Disclosures: Authors have disclosed no conflicts of interest. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M17-3005.

Requests for Single Reprints: Austin B. Frakt, PhD, 150 South Huntington Avenue (152H), Boston, MA 02130; e-mail, frakt@bu.edu.

Current author addresses are available at Annals.org.

Ann Intern Med. 2018;168:291-292. doi:10.7326/M17-3005

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Current Author Addresses: Dr. Frakt: 150 South Huntington Avenue (152H), Boston, MA 02130.
Dr. Jha: Harvard School of Public Health, 42 Church Street, Cambridge, MA 02138.