

Office Visit: Physician pay for performance

The Journal Record

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04/08/09

The value of pay for performance, like everything else, is in the eye of the beholder. Many managed care plans and employers are paying doctors for quality using a “pay for performance” program, but the approach may not be all it’s cracked up to be.

Pay for performance, or P4P as it’s often called, emerged about five years ago. The commercial-payer and employer sectors, working primarily through insurers and health plans, were the first to introduce physician P4P programs. The premise was to create financial incentives for improving performance, which in turn would result in improved quality of care and lower costs.

The rapid spread of the P4P approach promised to revolutionize managed care and create a new variable in today’s health care market. Some plans aren’t delivering what they promised. Although P4P incentives have the potential to improve the quality of care for patients, they might be used to simply control cost and improve the bottom line for insurers.

Since P4P is, in part, based on the ongoing health of a doctor’s patients, opponents argue that doctors who treat indigent populations and large numbers of terminally ill patients could be inherently penalized, and that without an appropriate electronic infrastructure, the required data gathering is difficult.

Meaningful, standardized, evidence-based measures that do not penalize physicians for treating patients with terminal illness and take into account variations in practice settings would have to be developed before P4P can be fully integrated without limiting access to health care by disadvantaged patients.

Of course, any program that adds performance pressures to physicians and alters how they are paid will raise a number of legitimate concerns among physicians, such as:

- Inadequate incentive levels – A practice’s ability to afford improvements needed to meet P4P requirements often depends on the bonus potential and number of eligible patients in the practice. For small to medium-sized practices, reimbursements may not cover the practice’s expenditures for improvements and data collection.
- Limited focus of performance measurement – Most P4P programs focus on measuring a limited number of clinical, administrative or information technology areas. As a result, physicians may tend to invest in improving only these areas, shifting resources away from non-measured areas.
- Fairness of incentive distributions – Some P4P programs require physician practices to meet specific performance levels before they can qualify for added reimbursement. Larger and better practices are more likely to start out at or above the performance

threshold than smaller ones. So P4P programs may reward already high-performing practices while limiting potential incentives for smaller practices that make large improvements but fail to reach the threshold.

- Impact on quality – The impact of P4P programs on quality of care is debatable. Some studies indicate that performance on only one of three measures was significantly better in practices participating in P4P programs than in comparable control practices.
- Impact on health disparities – Practices with sicker or socioeconomically disadvantaged populations may have a more difficult time meeting P4P requirements. Physicians may be tempted to limit access or close their practices to vulnerable patient groups. Health disparities increase when there is public performance reporting – and may be exacerbated when payment is at risk.

The American Academy of Family Physicians, along with the American Medical Association, has proposed seven principles that P4P programs should follow:

- Focus on quality of care.
- Support the physician-patient relationship.
- Use evidence-based guidelines in judging physician performance.
- Involve physicians in P4P program design.
- Use reliable, accurate and scientifically valid data.
- Reward physicians with positive incentives (rather than withholding reimbursements).
- Make participation voluntary.

Despite its challenges, P4P may be here to stay – hopefully it will evolve into a more rational mechanism for rewarding quality patient care and not result in fewer small to midsize practices (e.g., your local doctor) and limited access for those who are the sickest or most disadvantaged.

However, this may not be enough, even if successful, to affect the overall increasing costs of health insurance across the board.

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