Rewarding Results Pay-for-Performance Initiative
Ten Lessons Learned

Nov. 15, 2005

1. **Financial incentives do motivate change**. But they need to be large enough to make a difference. Bridges to Excellence for example suggests that at a minimum the incentive be set at $5,000 per physician to affect quality improvement; others suggest that they need to be structured to account for at least 10 percent of a physician's annual income. The seven *Rewarding Results* sites are offering incentives at a variety of levels.

2. **Non-financial incentives also can make a difference.** Just providing support for additional staffing to make a physician's job easier or supporting infrastructure to supplement technology can motivate physicians to hit quality targets.

3. **Engaging physicians is a critical activity**. All seven projects have worked hard to engage physicians, with varying degrees of success. If physicians are not brought into the process early as collaborators to ensure that goals are clinically meaningful, they will not adopt and sustain the change.

4. **There is no clear picture yet of return on investment**. Estimating the return on investment of P4P is essential but few projects nationally are conducting rigorous research on this topic. There are still questions about who should benefit from cost savings and over what time span the return on investment should be calculated.

5. **Public reporting is a strong catalyst for providers to improve care.** However, providers need adequate tools and data to keep improving. To maximize improvement, providers also need to be rewarded for installing and using health information technology and building infrastructure to track and compare performance.

6. **Providers need feedback on their performance**. Frequent, clear and actionable feedback to providers is essential. Many of the *Rewarding Results* projects issue public report cards to help physicians compare their performance to others and make their performance more transparent to consumers. Physicians need to understand what aspect of their performance will be evaluated; how performance will be measured; and how performance and incentives are related. They also need to be given tools and guidance on how they can improve.

7. **Providers need to be better educated about P4P**. Physicians are deluged with clinical and reimbursement information. For any payer, even those with a large share of the market, it can be challenging to attract provider attention. But they need to find effective communication tools to raise awareness about P4P; if they don't, physicians will ignore quality improvement demands or as in one case, inadvertently throw bonus checks in the trash because they aren't aware of the program.

8. **Data integrity is important**. Most health care providers are deluged with quality measures from a variety of payers. They are more likely to participate and embrace P4P if they view measures as valid and scientifically based. Quality targets also need to be clinically relevant.

9. **Experience with managed care matters**. Markets where managed care has more of a foothold seem to have an easier time with P4P because physicians and the general public are more comfortable with issues related to quality improvement such as transparency, accountability, and performance comparisons.

10. **P4P is not a magic bullet**. It is one of a number of activities underway by the public and private sectors to improve quality and change incentives in the way health care is delivered and financed. If it's implemented well and aligned with other incentives including performance feedback, public reporting, and support for systems improvement, it appears to be an extremely useful tool.

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Highlights of a National Project

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► ***Blue Cross of California***. The California-based health insurer stands out for implementing P4P in the most complex and most popular health insurance model—a preferred provider (PPO) network in the San Francisco market in which a loose network of physicians are not directed by any one health plan. Their experience is significant since about 60 percent of the insured market in the United States is enrolled in a PPO and most Medicare enrollees are not in managed care. The plan worked through some operational and implementation challenges, including effectively engaging physicians and determining the optimal way to pay financial rewards. Blue Cross of California still plans to expand P4P statewide; they will have results to share about the effect of P4P on improving patient care in early 2006.

►***Bridges to Excellence (BTE)***. The largest employer-sponsored effort that rewards and recognizes physicians for meeting specific quality benchmarks, BTE doubled the number of diabetics seeing physicians. BTE has found that physicians who are recognized for providing high quality and more efficient care deliver it at 15-20 percent lower cost than physicians who don't participate. BTE says financial incentives do influence physician behavior but the award has to be big enough to have an effect. The BTE P4P program rewards and recognizes practices for implementing health care information technology. The BTE model is now in several markets around the U.S., and two states—Georgia and Minnesota.

►***Excellus/Rochester Individual Practice Association (RIPA)***. Excellus/RIPA has improved the management of patients with sinusitis, otitis, diabetes, asthma and heart disease by giving doctors measures of quality, affordability and satisfaction. The state-of-the-art program has become a national model by providing doctors with performance reports that contain actionable information to improve patient care. The actionable information is delivered to the doctor, the office and the patient in the form of status reports that encourage follow up with the physician. Excellus/RIPA is the first *Rewarding Results* project to identify a return on investment under P4P. In 2004, they invested $1 million on health information technology, which reduced health care cost trends by nearly $3 million.

►***Integrated Healthcare Association (IHA)***. A California-based coalition of health plans, physicians, health care systems, purchasers, and consumers, IHA has also issued a

public scorecard, comparing actual physician group performance. Through their efforts, they have seen an increase in improvement across the board in every quality measure they are using. Some health plans have seen a 40-percent increase in patient visits, with reduced hospitalizations, especially in patients with diabetes. Technology has proven to be a key to the success of the program. IHA has data to show a direct correlation between the use of tracking technology and improved quality care.

► ***Local Initiative Rewarding Results (LIRR)***. The largest collaborative P4P effort to improve the health of babies and teens in Medicaid, LIRR found that simple targeted incentives can improve children's health. The California-based project involved seven health plans, paid out $5 million, engaged 3,300 physicians, and touched the lives of 350,000 babies, teens, and parents. Five of seven plans improved the rate of well-baby visits, with increases from 4 to 35 percent. Visits to the doctor by teens increased from 7 to 14 percent at six of seven plans. LIRR demonstrated that P4P can help Medicaid improve care without costing more money.

► ***Massachusetts Health Quality Partners (MHQP)***. Working with five health plans and physician organizations in the state, MHQP designed and implemented a performance report that for the first time enables comparison of physician organization performance on a common set of quality measures. The performance report features information on preventive care measures such as breast cancer screening and chronic disease care, such as control of diabetes. By showing doctors how they stack up against one another and identifying areas for improvement, this statewide collaborative is affecting provider performance and in some cases, accelerating physician adoption of electronic medical records to improve patient care. MHQP is also engaged in an evaluation of the effect of financial and non-financial incentives on physician performance. Among physician groups in Massachusetts, surveys show that physicians are more likely to focus on quality improvement when health plans include P4P incentives with specific quality measures then when they don't.

► ***Michigan Blue Cross Blue Shield (BCBS)*** has been able to improve care for hospitalized patients by focusing on measures that have yielded higher than national averages for cardiac care, and decreased rates of life-threatening infections by 45 percent for patients in the intensive care unit. While the Michigan BCBS project is pleased with these results, it is in the process of expanding the use of incentive payments to transform systems of care in a wide range of areas, including cardiac procedures, general and vascular surgery, weight loss and breast cancer care.