# Paying for Quality: Current Models and Potential Impact

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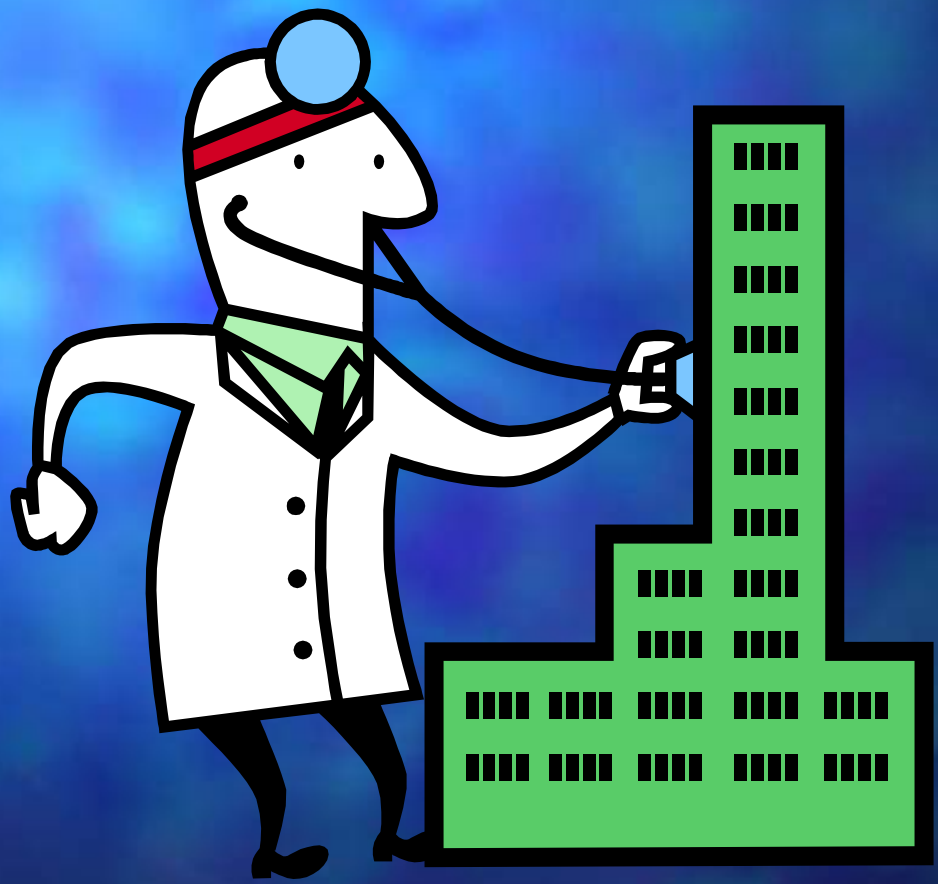
# Outline

- Evidence about health care quality
- Measuring and reporting quality to consumers
- Trends in paying for quality
- Will paying for quality do more harm than good?
- How should quality-based payment systems be designed?

# Is There a Quality Problem in Health Care?



# A Quality Chasm

- Small area practice variation: Wennberg, 1973
- Institute of Medicine 2001 Report "*Crossing the Quality Chasm*"
- Poor adherence to evidence-based standards of care is widespread and persistent in the U.S. (McGlynn, et al. 2003)

# Failure of Report Cards

- More than a decade of public health plan, hospital, and surgeon report cards
- Cardiac surgery report cards not used by prospective patients (Schneider and Epstein, 1998)
- Mixed evidence on use of health plan report cards (Scanlon, 2002; Beaulieu, 2002; Chernew, 1998)
- Maybe some promise but not the whole solution

# Paying for Quality

- In last three years more than 35 quality-contingent payment programs put in place for physicians and hospitals
- Most implemented by health plans; a minority by coalitions
- Typical program rewards physicians based on 5-10 HEDIS targets; hospitals on larger number of process, outcome measures
- Tournament-style incentives most common

# Example 1: Bridges to Excellence

- Several markets in the U.S.
- Private health plans, employers
- Small coalitions
- Rewards for primary care physicians:
  - ✓ US$100 per diabetic patient for implementing disease management, meeting targets
  - ✓ US$55 per patient for implementing office information systems, care management

# Example 2: Integrated HealthCare Association

- Coalition of purchasers, providers, health insurance plans
- Seven major health insurance plans in California; 60-65% of market
- Bonuses to physician groups for meeting or exceeding each of 10 quality targets (preventive care rates, patient-reported quality, information systems)
- Each plan pays differently, ~5% bonus overall

# Example 3: National Health Service

- General practitioners
- 76 quality indicators (clinical, organizational, patient experience, additional services)
- Subsidies for equipment and staff
- Bonuses for performance up to 1/3 of pay
- Penalties for very low performance

# Key Policy Questions

- Will this work?
  - ✓What is the economic basis for these programs?
  - ✓Do we have any evidence to date as to how hospitals and physicians respond to financial incentives related to health care quality?
- How should paying for quality programs be designed to maximize positive effects and minimize negative consequences?

# Demand-based Mechanisms

- In other areas, we rely on consumer choices to achieve optimal quality
- Assumes quality is observable to consumers/decision makers
- For service quality, consumer demand may work (maybe even too much because of moral hazard)
- To raise level of quality here:
  - ✓ Increase payments
  - ✓ Report cards

# Targeted Quality Incentives

- Most health care quality we worry about is not observable to patients and often not viewed as salient
- Patients may not be willing to choose based on measures due to trust, status quo bias
- Explicit payments make sense if we can find measures that reflect effort to achieve high quality
- Theory suggests even imperfect indicators are candidates for payment

# Empirical Evidence

- Few studies in health care setting; most small-scale and with small or null effect
- In education, paying based on aptitude scores has a significant effect
- Disability/job training literature on selection problems
- Psychology literature on negative effects of payment with intrinsic rewards

# Implications of Empirical Evidence

- Not clear past attempts are comparable to current efforts in scale and scope
- Small scale, multiple payers may generate weak incentives
- Negative unintended consequences have been found in education, job training

# How Should Payment Incentives Be Designed?

# Goals of Paying for Quality

- Reward quality improvement
- Stoke quality competition
- Weed out low-quality providers
- Reward historically good providers

# Nature of Targets

- Improvement vs. absolute levels
- Structural measures (subsidies)
- Relative vs. fixed targets
- All-or-nothing bonuses vs. proportional rewards

# Scope of Quality Indicators

- Most recent efforts entail many quality targets
- Multi-tasking models suggest concern about dimensions of quality not subject to reward
- Potential for positive spillovers
- Too many targets?

# Selection and Risk Adjustment

- Targets may be influenced by patient characteristics that are partly predictable/observable
- Physicians or hospitals may try to avoid patients that will not adhere to evidence-based guidelines or whose outcomes will be worse for any reason
- Risk adjustment may help in part

# Concluding Thoughts

- Profiling and reporting appear insufficient to drive quality improvement
- Economic theory suggests paying for quality should improve targeted measures
- Rewards need to be commensurate with cost of improving quality
- What role for consumers?