

VIEWPOINT

Designing Smarter Pay-for-Performance Programs

Aaron McKethan, PhD
Gillings School of
Global Public Health,
University of North
Carolina at Chapel Hill.

**Ashish K. Jha, MD,
MPH**
Department of Health
Policy and
Management, Harvard
School of Public Health,
Boston, Massachusetts.

Over the past decade, public and private payers have experimented with the use of financial incentives to motivate physicians to achieve quality and efficiency. The idea behind pay for performance is simple. Because individuals and organizations respond to incentives, physicians whose patients achieve desirable outcomes should be paid more as an incentive to improve their performance. Yet the results of pay-for-performance programs have been largely disappointing.¹ One argument is that neither the right set of incentives nor the right set of metrics has been identified.² Another explanation, which has received far less attention, is that the right set of patients has not been identified for targeted efforts.

Failures of Current Pay-for-Performance Programs

Most pay-for-performance programs have used weak incentives to change clinician behavior. For example, the Premier Hospital Quality Incentive Demonstration (HQID), the model for several recent pay-for-performance programs, put only 1% to 2% of total Medicare payments at risk and resulted in little or no improvements in patient outcomes.³ Although there

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is an active and robust debate about the proper size of incentives, a different approach for structuring pay-for-performance programs that may be useful would be targeting clinicians' financial incentives on carefully selected patients who are likely to benefit from extra attention. When it comes to achieving good outcomes, some patients are likely to do well irrespective of the care they receive. No extra incentives or clinical interventions are necessary to ensure that such patients experience good outcomes. However, there is typically a smaller subgroup of patients at risk of poor outcomes. These patients frequently need greater attention, significantly more support, and a different clinical approach to improve outcomes. Pay-for-performance incentives concentrated on improved care and better outcomes for these patients can justify greater incremental investments in quality improvement for a small subset of at-risk patients and in the process, send stronger signals to clinicians about which patients need extra attention to improve population health.

Traditional vs Targeted Pay for Performance

Traditional pay-for-performance programs track success using performance measures that encompass all patients meeting certain eligibility criteria, such as diagnosis or care setting (eg, patients discharged for congestive heart failure or 30-day readmissions). Although such an approach seems reasonable, the vast majority of patients are at low risk of having poor outcomes. Many patients have mild disease, good social support systems, excellent primary care, or some combination thereof. Incentivizing busy health professionals to provide extra support to these patients is likely wasteful and distracting.

Other patients, however, are at much higher risk for poor outcomes. To the extent that higher-risk patients can be reliably identified prospectively, this information can inform the design of smarter, more targeted pay-for-performance programs. Specifically, a targeted pay-for-performance program would have, at its core, a prediction model that would identify patients who are at elevated risk of failing to meet a meaningful clinical goal or of having a bad outcome. Predictive models are not just risk-adjustment models already in use by payers to create a level playing field. Predictive models can take into account any factor that is likely to affect a patient's chance of a poor outcome. Because these models are not meant for performance reporting or comparisons of physicians, issues such as whether to adjust for socioeconomic status are not relevant.⁴ For example, if there is a factor that increases the likelihood of a patient's readmission, that factor could be used to identify the highest-risk patients.

There are several advantages to a targeted instead of a traditional pay-for-performance approach. Traditional pay-for-performance programs typically include all patients with a certain characteristic (eg, all patients with diabetes), encouraging health care professionals to give extra attention to a large number of patients. This approach can be infeasible or demotivating. By contrast, a targeted pay-for-performance approach acknowledges a basic tenet of clinical medicine—clinicians cannot and should not provide the same level of care intensity to every single patient. Indeed, care should be personalized based on each patient's needs, preferences, and the likelihood that the effort will make a difference.⁵ A targeted pay-for-performance program not only acknowledges this clinical approach, but also structures incentives to support it.

A second advantage of targeted pay for performance is the size of the bonuses from the perspective of the health care professional. In traditional

**Corresponding
Author:** Ashish K. Jha, MD, MPH, Department of Health Policy and Management, Harvard School of Public Health, Kresge 408, 677 Huntington Ave, Boston, MA 02115 (ajha@hsph.harvard.edu).

Table. Hypothetical Example of a Comparison of Traditional vs Targeted Pay-for-Performance Programs for Control of Hyperglycemia

Characteristics	Pay-for-Performance Programs	
	Traditional	Targeted
Total pay-for-performance budget, \$	1 000 000	1 000 000
No. of patients in program	20 000	4000
Effective bonus per patient outcome, \$	50	250
Total windfall payment, \$	≤800 000	0

pay-for-performance programs, the amount of money clinicians can receive for changing outcomes for any individual patient is usually small, often far less than the amount of resources required to make a difference. For example, in targeted pay for performance (see Table), instead of spreading bonus dollars over large patient populations, payers can substantially increase the amount of bonus available to clinicians based on the outcomes of their at-risk patients. Physician practices will have an easier time justifying major investments in care improvement if the amount of resources they receive for each patient in return is commensurate with the resources needed.

From a payer's perspective, there is significant waste in traditional pay-for-performance programs. These programs result in bonuses to health care professionals because of patients who were performing well before the program began. These represent windfall payments because no additional effort was needed to achieve the outcome and the bonus.⁶ By contrast, the targeted program would explicitly select patients at higher risk of poor outcomes. The bonuses would not be based not on baseline performance for the entire patient population, but on success in changing outcomes for selected patients. Therefore, it would reward high-quality health care professionals, not health care professionals whose patients are likely to do well irrespective of incentives.

For illustrative purposes, consider a hypothetical case in which a payer designs a pay-for-performance program to improve glyce-mic control for 20 000 patients with diabetes. A traditional pay-for-performance scheme might effectively reward health care professionals up to \$50 for each of the 20 000 patients who achieve the goal. However, assuming that 80% of those patients were already likely to achieve good glyce-mic control on their own, for every \$1 the plan spends on bonuses on behalf of patients who actually needed extra support to improve their outcome, it wastes an additional \$4 on bonuses on behalf of patients who most likely would have achieved good outcomes on their own (Table).

In a hypothetical targeted pay-for-performance program, predictive models would prospectively ascertain which patients are at highest risk for poor glyce-mic control. The performance bonus associated with achieving success in each of these patients would be \$250, which is 5 times as high as in the traditional pay-for-performance program. A perfect prediction model would leave no windfall payment, although in reality, no predictive models are perfect. However, any improvement in targeting over the approach typically found in traditional pay-for-performance programs would reduce the amount of windfall payments that produce little clinical benefit.

Conclusions

No effort to link financial incentives to quality is perfect, yet traditional pay-for-performance designs have been disappointing. Beyond changing the incentives or the performance measures, it might also be time to change the patients who are identified for targeted pay-for-performance programs. There is little doubt that the effectiveness of these programs will be driven, in large part, by the ability to prospectively identify at-risk patients. However, given the failure of recent efforts to meaningfully improve outcomes, testing targeted pay for performance may be worth the effort.

ARTICLE INFORMATION

Published Online: November 6, 2014.
doi:10.1001/jama.2014.15398.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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