NEWS RELEASE

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JAMA Study: First Formal Evaluation of Pay-for-Performance Reveals Some Positive Effect on Quality; Informs Debate About P4P Design

New York City, October 12, 2005—The first study to assess the effects of a pay-for-performance program in a large health plan found significant quality improvement in a physician group with a quality incentive program (QIP) for one of the three clinical measures studied, compared with a physician group without a QIP. While quality also improved in the other two measures, the differences between the two groups for these measures were not significant. Most of the bonus money went to physician groups that performed well, rather than those that improved the most.

The findings are published in the October 12th issue of the *Journal of the American Medical Association*, in "Early Experience with Pay-for-Performance: From Concept to Practice," by Meredith B. Rosenthal of Harvard School of Public Health and colleagues. The research was supported by The Commonwealth Fund.

"There is widespread consensus that existing financial incentives in the U.S. health care system are misaligned and fail to reward high quality." said Commonwealth Fund president Karen Davis. "It is encouraging to see some initial evidence that rewarding good performance can lead to improved systems helping ensure that Americans receive regular preventive care. We need to move from just paying for services that get rendered, to rewarding delivery of the right care for helping Americans live long and healthy lives. Rewarding high quality both provides the resources for improving quality and motivates change."

"Pay-for-performance has significant potential to improve the performance of the health care system, where reimbursement has historically failed to reward, and in some case penalized, high quality," said Rosenthal. "To achieve the critical goals of improving both the affordability and quality of care we will need to look not only to well-designed payment reforms but also to such promising efforts as public reporting of quality and cost information, tiered benefit designs that give consumers incentives to choose higher quality and lower cost providers and treatments, and disease management."

The study compared quality improvements for clinical quality scores on Pap smears, mammography, and hemoglobin testing for diabetics in two groups in a large health plan, PacifiCare Health Systems. PacifiCare's California network, which implemented a quality incentive program in 2003, was compared with PacifiCare's Pacific Northwest group (in Oregon and Washington) which did not participate in a quality incentive program. The California medical groups received bonuses for meeting specific targets in clinical quality scores.

The researchers found that quality scores for cervical cancer screening improved 5.3% in the pay-for-performance group, compared with 1.7% in the group without pay-for-performance, a significant difference. For the other two measures studied, mammography and hemoglobin testing for diabetics, while both groups improved, the difference was not significant. They also found that 75% of the bonus payments went to the physician groups whose performance was above the bonus threshold before the QIP was implemented.

"This research provides important data about how incentives can best be structured to foster quality of care," said Anne-Marie Audet, M.D., vice president at the Fund. "Rosenthal's findings can really inform current debates about still unresolved issues such as what level of financial incentive is needed to produce the desired effect, or whether absolute performance targets or relative improvement levels should be rewarded. This research is still in its very early stages."

In an accompanying *JAMA* editorial, "Pay-for-Performance Research: How to Learn What Clinicians and Policy Makers Need to Know," R. Adams Dudley, M.D., of the University of California, San Francisco, notes the need for continuing research into pay-for-performance that will also study external factors such as market, regulatory, organizational, or patient variables that could "mitigate or augment the impact of pay-for-performance." Dudley suggests that it would be important to study how pay-for-performance works in organizations with varying information technology capabilities, for example.

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