Evaluating pay-for-performance initiatives

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Goals of P4P evaluation

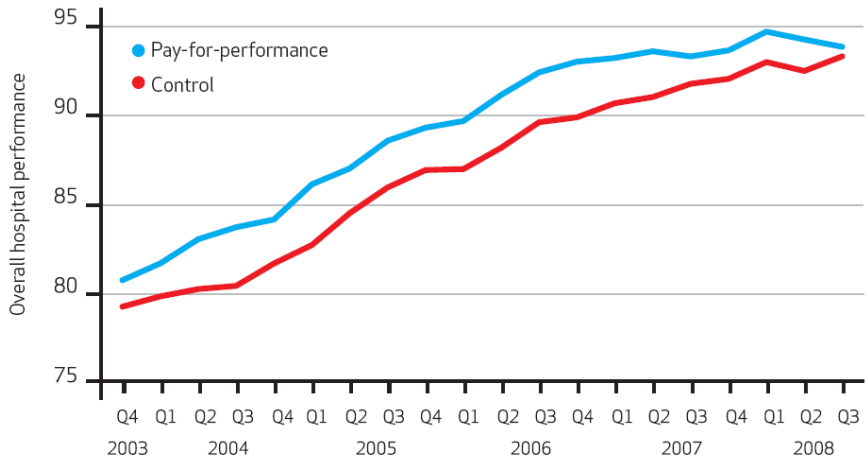
- Does P4P improve care?
- Does the design of P4P matter?
- Does P4P decrease quality in some cases?

Medicare's P4P demonstration

- Partnership between Medicare and Premier Inc.
  - 260 hospitals
  - October 2003 to present
- Rewards hospitals based on process-based performance in 5 clinical areas
- Payment is a per-patient add on to DRG payments
  - Total: $48 million in first 5 years
  - Average: $60,000 per hospital/year

EXHIBIT 1

Average Overall Performance In Pay-For-Performance And Control Hospitals, Fiscal Years 2004–08



Werner et al. (2011) *Health Affairs*

Factors affecting improvement

Werner et al. (2011) *Health Affairs*

- Size of incentive
  - Hospitals eligible for larger incentives improved more
- Hospital resources
  - Hospitals with stronger finances improved more
- Market competition
  - Hospitals in non-competitive markets improved more

Patient Protection and Affordable Care Act (2010)

- Establishes of P4P for all U.S. hospitals
  - October 2012
- Per-discharge payment based on:
  - Process-based performance (70%)
  - Patient experience of care (30%)
- Funded through 1% reduction in DRG payments
  - Average payment reduction $250,000
  - Total bonus pool $850 million

Redistribution of payments

- Which hospitals will benefit?
- Which hospitals will lose money?
- What does this mean for patients?

Key Issues

- How can P4P be used in combination with other incentives?
  - Can P4P be targeted?
- Is the goal of P4P to improve low-performing providers or reward high-performing providers?
- How can we design P4P to avoid harming care?
  - Are additional resources needed for poorly resourced providers?