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## Will Pay for Performance Improve Quality of Care? The Answer Is in the Details

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In the past decade, provision of financial incentives for a higher quality of care (pay for performance) has spread across the country and beyond. In October, the federal government introduced pay for performance to all hospitals paid by Medicare nationwide. Yet most studies of pay for performance have shown modest or inconsistent effectiveness in improving quality.

An early but influential study of the Premier Hospital Quality Incentive Demonstration (HQID), involving more than 250 hospitals and serving as the model for the federal program, showed an increase of 2.6 to 4.1 percentage points in process-quality measures during the first 2 years under financial incentives.<sup>1</sup> With longer follow-up, however, these gains attenuated and almost disappeared.<sup>2</sup> Moreover, studies of risk-adjusted mortality for pneumonia, acute myocardial infarction, congestive heart failure, and cardiac bypass surgery in the HQID showed no improvement at all under financial incentives.<sup>3-5</sup> Thus, proponents of pay for performance have every right to be concerned.

A report in this issue of the *Journal* gives reason for more optimism. Sutton et al.<sup>6</sup> report improvements in 30-day in-hospital risk-adjusted mortality for pneumonia, acute myocardial infarction, and heart failure at 24 northwest England hospitals that introduced a variant of the HQID. As compared with mortality at 132 control hospitals, 30-day mortality for these three conditions decreased by 1.3 percentage points. The largest change, for pneumonia, was signifi-

cant (1.9 percentage points), with nonsignificant reductions for acute myocardial infarction and heart failure (both 0.6 percentage points). Although the improvements were modest, they stand in positive contrast to the American findings.

Beyond the obvious differences between the U.K. National Health Service and U.S. health care settings, some striking differences between the British and American versions of pay for performance might help explain the contrasting results. Although the British program was partly modeled on the HQID, the bonuses were larger and awarded to a greater proportion of participants. They covered all patients, not just those insured by Medicare. In addition, British hospital leadership agreed to invest awarded money internally toward efforts to improve clinical care. The bonus money was invested in a range of quality-improvement approaches, including specialist nurses, new data-collection systems that linked performance feedback to clinical personnel, and participation in regular shared-learning events.

Further studies will be necessary to verify generalizability and to identify the design features that foster success. Even without this information, however, the findings of Sutton et al. bring us to a point at which one can reasonably speculate about some likely developments.

First, we will surely see continued use of financial incentives, including additional efforts by hospitals to improve the quality of care and participate actively in learning collaboratives.

Pay for performance has enormous face validity and ideological support even if success to date has been modest and the optimal program configuration is unclear. Concerns about unintended consequences posited since the adoption of pay for performance, including avoidance of sicker or minority patients or those of lower socioeconomic status, have largely failed to be substantiated,<sup>7</sup> which has reduced resistance to pay for performance. Thus, reports of successful programs are likely to spur wider use.

The number of quality metrics targeted in pay-for-performance programs is likely to expand as well, although having to improve so many different areas simultaneously may overload some hospitals. During this initial year, quality indicators in the federal program are limited to clinical process measures for pneumonia, acute myocardial infarction, congestive heart failure, infections associated with health care and surgical care, and measures of patient experience. In fiscal year 2014, indicators for risk-adjusted mortality, hospital-acquired conditions, patient safety, and Medicare spending per beneficiary will be added. Private payers will probably adopt many of the Medicare quality indicators, augmenting the effect of the federal program.

The size of incentives to improve the quality of care is also likely to escalate. The Affordable Care Act requires that 1% of Medicare hospital payments be withheld this year to be dispersed under pay for performance in the Medicare Value-Based Purchasing Program. Under law, the incentive amount will rise gradually to 2% in 2017. Unless these incentives have a substantial effect, there will be strong pressure to increase them, because common sense dictates that large enough incentives will drive almost everyone to change behavior. However, higher incentives will also catalyze worry about access and quality for sicker

populations and about threats to professionalism. Because any program change is likely to be budget-neutral, resulting in both winners and losers, higher incentives will also incite push-back from low performers.

The most important lesson from the report by Sutton et al. is that the details of programmatic design and behavioral change induced by pay for performance will be critical as we refine our approach to financial incentives. Although the HQID failed to improve quality in the long term or ameliorate health outcomes, the Centers for Medicare and Medicaid Services has now changed the payment formula substantially and modified the list of quality metrics. Over time, value-based purchasing may indeed help improve the quality of care, but the speed of progress will probably depend on such details.

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