Pay-for-performance fails to improve quality of health care payer programs

November 25 2015, by Laurel Thomas Gnagey

Double bonuses paid to some Medicare Advantage plans under a pay-for-performance program did not result in higher quality ratings, according to research conducted by the University of Michigan.

In fact, the only measurable change from the extra investment in quality was nearly a 6 percent increase in the number of plans offered, said lead author Andrew Ryan, associate professor in the Department of Health, Management and Policy at the U-M School of Public Health.

"What we found is that those double payments cost over $1 billion annually. That's a lot of money paid for extra quality that we just didn't see," Ryan said of the study that appears in the December issue of *Health Services Research*.

Under the Patient Protection and Affordable Care Act, the Centers for Medicare and Medicaid Services has been conducting demonstrations in recent years to encourage various participants in the health care system to improve quality by paying them for better performance. Most of those programs have involved providers: physicians, hospitals, nursing homes, home health care companies and other outpatient services.

The Medicare Advantage Quality Bonus Payment Demonstration in the current study is different in that it targeted those who administer private health care plans. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans and Medicare Medical

Savings Account Plans.

Initiated in 2012, the bonus program paid based on plan-level quality scores, using a star rating system. Plans received 1 to 5 stars on more than 30 measures across five domains: preventive care and staying healthy, management of chronic conditions, health plan responsiveness and care, customer satisfaction and telephone customer service.

In counties that comprised the demonstration, double bonuses were paid at rates of 3 to 10 percent of plan payments, compared with the usual 1 to 2 percent. Ryan offered three scenarios that could explain the inability to move the needle on quality.

It may be that the payers wanted to use the extra incentives to make positive changes but the short-term constraints of a three-year demonstration did not allow them enough time to contract with new physicians and institutions that could provide better quality plans or improve existing plans, he said.

Another possibility is that they did make some changes, like hiring more care managers, but those just didn't work, he said. Finally, some may just have taken the double bonuses without making changes.

Previous research has shown mixed success on pay-for-performance when it comes to quality improvement among health care providers, Ryan said. And little research has been conducted to determine if the amount of improvement compared with the costs of the incentives makes the program worthwhile.

Ryan said it's too early, however, to say if pay-for-performance is a failure.

"These programs are not transforming care in a way people hoped they

would," he said. "We are trying to accumulate as much information as possible about them one study at a time to determine how they can optimally be designed to improve health care, or if there are other alternatives we should be considering."

More information: Timothy J. Layton et al. Higher Incentive Payments in Medicare Advantage's Pay-for-Performance Program Did Not Improve Quality But Did Increase Plan Offerings, *Health Services Research* (2015). DOI: 10.1111/1475-6773.12409

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