

ANNALS OF HEALTH LAW
Advance Directive

VOLUME 20

FALL 2010

PAGES 11-21

**Pay-for-Performance and the Effects on Doctors and Patients
as Currently Applied**

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I. INTRODUCTION

Pay-for-performance is another possible answer to the issues that plague access to health care and the affordability of health care. Pay-for-performance is a system that is aimed at splitting the gap between the fee-for-service system, in which physicians were rewarded for ordering more tests, and the capitated system, where physicians were incentivized to keep tests to a minimum, by providing a payment theory designed to reward physicians for delivering higher quality care as opposed quantity of services.¹ The pay-for-performance design aims to pay providers for meeting certain performance measures; however, funding is going to be tantamount to their success in getting providers to buy into the program,² and continuing to improve in the future requires a commitment to the program.³

II. THE VARIATIONS OF PAY-FOR-PERFORMANCE SYSTEMS IN THE US AND THE UK

The pay-for-performance system is a financial incentive scheme directed at rewarding those physicians that give the best overall care to their patients by following evidence based clinical guidelines and expert consensus on how to best treat single diseases.⁴ Pay-for-performance is a system that looks to put the focus back on the patient; however, in some systems, physicians still have the final say on whether or not to administer care to

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1. Matthew K. Wynia, *The Risks of Rewards in Health Care: How Pay-for-performance Could Threaten, or Bolster, Medical Professionalism*, 24 J. GEN. INTERNAL MED. 884, 884 (April 22, 2010).

2. Am. Acad. of Fam. Physicians, *Shaping the Future of Pay-for-Performance Programs*, 3 ANNALS OF FAM. MED.MEDICINE, 562, 562 (2005) [hereinafter *Shaping the Future of Pay-for-Performance*] (overview of pay-for-performance and the direction it is going).

3. See, HOSP. & HEALTH NETWORKS, INSIDE THE PREMIER/CMS PAY-FOR-PERFORMANCE PROJECT 42. (Mar. (2007) available at hhnmag.com [hereinafter INSIDE THE PREMIER] (Insights from five top hospitals).

4. Cynthia M. Boyd et al., *Clinical Practice Guidelines and Quality of Care for Older Patients with Multiple Comorbid Diseases*, 294 J. AM. MED. ASS'N 716, 722 (Aug. 10, 2005).

the patients that refuse to follow physicians' orders,⁵ and it is at these times that the ethical implications of the system can truly be seen.⁶

A. Putting the Focus Back On Patients

Pay-for-performance has become a common part of contracts between public and private insurers with physicians.⁷ In January of 2005, CMS announced its own three-year Physician Group Practice initiative, "intended to demonstrate the viability of [pay-for-performance] in 10 large, multispecialty physician practices."⁸ In Massachusetts, five major commercial insurers utilize pay-for-performance covering nearly four million enrollees.⁹ Between 2001 and 2003, the impact of multiple pay-for-performance programs introduced by those five major commercial health plans was analyzed using a statewide quality measurement and reporting system.¹⁰ In 2001, two of those five health plans utilized pay-for-performance programs encompassing only twenty six percent of the study physician groups, but by 2003, four of the five health plans installed pay-for-performance programs, involving eighty-one (fifty three percent) of the 154 physician groups in the study.¹¹

The type and size of the incentives employed by the various pay-for-performance health care plans varied significantly depending on the incentives tied to each Health Plan Employer Data and Information Set (HEDIS).¹² The HEDIS target measures typically consisted of "well-established screening measures such as mammography and chronic care issues such as hemoglobin Alc testing for patients with diabetes mellitus."¹³ The incentives paid for adhering to the HEDIS measures ranged from \$200 to \$2,500 per primary care physician.¹⁴

5. Ruth McDonald and Martin Roland, *Pay for Performance in Primary Care in England and California: Comparison of Unintended Consequences*, 7 ANNALS FAM. MED. 121, 122 (2009).

6. Wynia, *supra* note 1, at 884.

7. Steven D. Pearson et al., *The Impact of Pay-for-Performance On the Health Care Quality In Massachusetts, 2001-2003*, 27 HEALTH AFFAIRS 1167, 1168 (July/Aug. 2008)(implementing a study that examines the quality of care pay for performance measures achieved when delivered to patients from five health plans covering nearly four million enrollees, and more than ninety percent of the state of Massachusetts primary care physicians).

8. AM. ACAD. OF FAMILY PHYSICIANS, *supra* note 2, at 563.

9. Pearson et al., *supra* note 7, at 1168.

10. *Id.* at 1170.

11. *Id.*

12. *See generally Id.* at 1171.

13. *Id.* at 1170.

14. *Id.* at 1171.

While the HEDIS target measures set up a system for the physicians to follow, there are some physicians that see limitations on effectiveness under the pay-for-performance system.¹⁵ When answering questions about “[w]hat needs to be tweaked in the program,” Dr. David Moen, medical director for emergency medical services of Fairview Lakes Medical Center, stated that there needs to be more of an effort directed towards creating a more rapid feedback loop that can determine the best guidelines for treatment based on the most recent evidence available to physicians.¹⁶ Rapid feedback is important because new literature on a specific disease may contradict a requirement in the program.¹⁷ When there is a disconnect between the best course of action to be taken for the patients and the standards set forth by pay-for-performance programs, fewer physicians will buy into the pay-for-performance structure.¹⁸

B. Differences in the United States plans and United Kingdom plan

While physicians see the value in implementing pay-for-performance systems, there are multiple programs that can be implemented. Two examples of pay-for-performance systems that vary in execution exist in California and the United Kingdom.¹⁹ Both the U.K. and California systems involve paying physicians for meeting performance based targets; however, the U.K. system has a greater number of performance targets and allows the physicians to exclude patients from treatment or report exceptions.²⁰ The U.K. system was introduced for all primary care physicians under the program name Quality and Outcomes Framework, and the California system is a statewide initiative that covers even more physicians than the U.K. system.²¹ In the California system, the payments go to the larger medical groups and not the individual physician practices,²² whereas, the U.K. system directs payments to a much smaller group of physicians, generally less than ten.²³ In the U.K. system, these payments are also responsible for as much as thirty

15. *See generally* Boyd et al., *supra* note 4, at 716 (explaining that guidelines for one specific disease will not adequately direct doctors in their care for patients with multiple comorbid disease, an area of medicine that comprises most of the Medicare spending).

16. *Inside the Premier supra* note 3 at 40.

17. *Id.*

18. *Id.*

19. *See generally* McDonald and Roland, *supra* note 5.

20. *Id.* at 122.

21. *Id.* at 121.

22. *Id.*

23. *Id.* at 122.

percent of the individual practice incomes.²⁴ The study looked into the unintended consequences affecting both the California and U.K. systems, in particular financial incentives in the design and implementation of the two different programs in the primary care setting.²⁵

In analyzing twenty physicians in England, drawn from a northwest and a southwest region, and twenty physicians in California, drawn from four organizations ranging in size from 600 to 3,000 physicians, trends in the nature of the office visit, physician-patient relationship, and perceived impact on autonomy arose.²⁶ In England, the effect of the electronic reporting system, for the reporting of clinical targets, influenced the nature of the office visit more negatively than the office visits reported in California, where electronic reporting was not required.²⁷ Because the U.K. system relies on electronic reporting, physicians reported having to balance their time between answering the electronic questions and the patients, which caused them to have less of a connection to the patients.²⁸ In the U.S., the patient-physician relationships deteriorated because physicians that were part of the organization with the highest rewards for pay-for-performance began to resent patients that would not follow their advice.²⁹ In some extreme cases, physicians told patients to join other medical groups, bypassed consent procedures to get tests done, and lied to patients about the financial consequences of refusing to comply.³⁰

While physicians in the U.S. may have resorted to unethical or extreme behaviors, physicians in the U.K. were aware of the greater incentive to encourage patients to comply with their orders, but have not resorted to the tactics of the U.S. physicians because they maintained the option of exception reporting if a patient refused treatment.³¹ Another dichotomy between the English and Californian physicians is English physicians did not perceive the pay-for-performance system they were involved in as affecting their

24. *Id.*

25. *Id.*

26. *Id.* at 122-24.

27. *Id.* at 123.

28. *Id.*

29. *Id.*

30. *Id.*

31. *Id.* at 124.

autonomy, whereas most Californian physicians perceived the program in a negative light and as something that was externally imposed and managed.³²

Ultimately, this study revealed pay-for-performance had a negative influence on patient interaction in office visits for U.K. physicians because of electronic reporting requirements, but the ability to exempt certain difficult patients allowed for maintenance of patient-physician relationships.³³ In California, physicians did not note the same change in office visits, but did recognize the negative affect the system had on physician-patient relationships and perceived autonomy.³⁴

Looking further into the U.K. and U.S. pay-for-performance systems, apart from exemption reporting the compensation also differs between the United Kingdom and the U.S. system found in Massachusetts.³⁵ The new family practitioner contract in the UK allows each physician to obtain approximately \$139,000 as a quality bonus or incentive, which, when compared to their average yearly income between \$122,000 and \$131,000, can have the effect of more than doubling their yearly income.³⁶ In general, the financial incentives in Massachusetts for diseases such as diabetes were usually between \$1,000 and \$2,000 per physician, and total pay-for-performance incentives consisting of 2.2 percent of the physicians' income.³⁷ The amount of incentives in Massachusetts and the result of improved patient care suggest that in the United States, not enough money is at stake to truly drive up the level of care.³⁸

C. Complications in treating multiple diseases

One of the disadvantages presented to the overall structure of pay-for-performance systems is the structuring of guidelines around only one chronic condition leaving doctors to determine the way to provide care to patients, specifically older patients with more than one chronic condition, while still adhering to the guidelines on how to treat one disease.³⁹ In the United States, 89 percent of Medicare's budget is spent on individuals with three chronic conditions; however, most guidelines, which pay-for-performance

32. *Id.*

33. *Id.* at 122-24.

34. *Id.*

35. PEARSON, *supra* note 7, at 1174.

36. *Id.*

37. *Id.* at 1175.

38. *Id.*

39. Boyd et al., *supra* note 4, at 716-17.

incentives base their incentives on, are designed for the care of one chronic disease, and not three occurring simultaneously.⁴⁰ By designing specific elements of care around guidelines for treatment of one chronic disease, there is a possibility the incentives will cause doctors to ignore the complexity of care necessary for multiple comorbid diseases and dissuade physicians from treating patients with multiple comorbid diseases.⁴¹ In the system in place in California, doctors might choose not to accept patients, whereas in the UK, doctors may exempt the patients and continue to provide care for them without the fear of not meeting performance standards, since their standard is benevolent to both doctors and patients.⁴²

The complexity created by multiple comorbid diseases does not only affect the doctors and the way they treat the patient, but also has the potential to adversely affect the patient and the patient's quality of life.⁴³ One study looked at a hypothetical patient, a seventy-nine year old woman with osteoporosis, osteoarthritis, type two diabetes mellitus, hypertension, and chronic obstructive pulmonary disease, all of moderate variety.⁴⁴ Based on compilations of clinical practical guidelines and following those recommendations, the hypothetical patient would take twelve separate medications, requiring nineteen doses per day, taken at five times during a typical day.⁴⁵ The patient's medications would also cost her \$406.45 per month or \$4,877 annually.⁴⁶ The recommended regimens can present the patient with unsustainable treatment burdens that make independent self-management and adherence difficult.⁴⁷ In order to avoid over medicating or producing non-optimal care, pay-for-performance standards should begin trials that focus on older patients with several chronic diseases as opposed to forcing adherence to protocols designed to deal with only one chronic disease.⁴⁸ The difficulty of combining treatment plans is an inconsistency that directly conflicts with the calculated rate of adherence standards that determine the payment to physicians in pay-for-

40. *Id.* at 716.

41. *Id.* at 716-17.

42. McDonald and Roland, *supra* note 5, at 123.

43. Boyd et al., *supra* note 4, at 716.

44. *Id.* at 717.

45. *Id.* at 719.

46. *Id.* at 720.

47. *Id.*

48. *Id.* at 723.

performance programs and can negatively affect the overall quality of care for older patients.⁴⁹

Pay-for-performance initiatives focus on the adherence to standards designed for treatment of one disease, “rather than the more difficult task of weighing burdens, risks, and benefits” presented by multiple chronic diseases.⁵⁰ This could create an atmosphere where more difficult patients are shifted around, neglected, or treated in a manner that is inconsistent with their needs, but consistent with incentives outline in a pay-for-performance system, thereby undermining the ultimate goal of better quality of care that program strives to achieve.⁵¹ Because of the high percentages of Medicare costs being derived directly from patients with multiple comorbid diseases, Medicare should design a pay-for-performance incentive system for doctors that incorporate clinical guidelines designed to take into account multiple diseases, thereby optimizing care for the situations in which multiple diseases arise and that meets the stream line goals of the pay-for-performance system.⁵² The American College of Physicians (“ACP”) expresses concern that the pay-for-performance systems will lead to worse care, especially in elderly patients with multiple chronic conditions because physicians could improve their performance scores by refusing to treat the more difficult patients.⁵³ The worry is that the pay-for-performance systems, creating incentives on a few specific elements of a singular disease, will cause doctors to neglect other portions of a patient’s treatment that do not involve incentives or may conflict with the incentives.⁵⁴

D. Positive Results

While there are issues within the pay-for-performance structure, doctors recognize the importance and benefits of adhering to a structured treatment plan.⁵⁵ The structured plans reduce the variability of care and increase accountability through the reporting required by the programs that can result in benefits to the patient such as reduced infection rates

49. *Id.* at 720-21.

50. *Id.* at 722

51. *Id.* at 722.

52. *Id.* at 723.

53. Lois Snyder, and Richard L. Neubauer, *Pay-for-Performance Principles that Promote Patient-Centered Care: An Ethics Manifesto*, 147 *Annals of Internal Med.* 792, 792 (2007).

54. *Id.*

55. Inside the Premier, *supra* note 3, at 38.37.

and fewer readmissions.⁵⁶ By having a target goal outline by these guidelines, it can give doctors and administrators the additional incentive to go the extra step as well as increase transparency, allowing both patients and doctors to see the actual results and benefits, generating more buy-in to the system.⁵⁷

Doctors buying into the system can have dramatic results, especially in areas dealing with screening and preventative care.⁵⁸ One program orchestrated by Integrated Healthcare Association, a nonprofit association based in California working to bring together all healthcare parties for the collaboration of health care topics, oversees a pay-for-performance program paying out a total of \$88 million to 235 California medical groups.⁵⁹ Evidence of the quality of care in California shows that nearly 150,000 more women received cervical cancer screening, 35,000 more women received breast cancer screening, 10,000 children got two needed immunizations, and 18,000 more people received a diabetes test.⁶⁰ By having family physicians and primary care physicians involved in pay-for-performance programs, there is an ability to increase preventative screenings, hopefully reducing the amount of emergency care needed.⁶¹

III. PAY-FOR-PERFORMANCE SYSTEMS' INFLUENCE ON ETHICS

A core tenant of professionalism is that physicians need to work to improve and ensure the quality of the health care they deliver and that the patients' interests and well-being should come before their own monetary or personal interests.⁶² These core tenants of professionalism conflict with the current fee-for-service programs, which encourage providing more services than necessary, including some services that might be useless or harmful.⁶³ Capitated payment models, which created a system that incentivized doctors for providing less care and thereby violate these core tenants, emerged in the 1990s in response to fee-for-service becoming too expensive.⁶⁴ Pay-for-performance focuses more on the quality of care that is delivered to patients by providing incentives to encourage

56. *Id.*

57. *Id.*

58. *See generally* Am. Acad. of Family Physicians, *supra* note 2, at 562.

59. *Id.*

60. *Id.*

61. *Id.*

62. Wynia, *supra* note 1, at 884.

63. *Id.*

64. *Id.*

physicians to give better quality care to patients, and utilizing a reporting system to ensure that doctors are following the guidelines set forth for providing that higher quality of care.⁶⁵

One worry may be that the ethics and professionalism of doctors operating under this system may be challenged.⁶⁶ Incentives can be good for motivating people; however, the most damaging thing for the pay-for-performance system would be creating a system in which the doctor only treated patients because they were being incentivized to do so.⁶⁷ Unlike the system in the U.K., where a physician may choose to treat a patient but exempt them from the pay-for-performance reporting, some systems in the U.S. require either the patient be treated and reported or turned away.⁶⁸ In adhering to their duty to be professional, physicians should work to ensure and improve quality, and patients' interests should always come before financial interests.⁶⁹ Many physicians are drawn to their jobs because they find the work challenging and interesting; however, some studies have shown that tangible rewards, such as money, can have negative effects on the motivation to do interesting tasks.⁷⁰ "In general, the more cognitive sophistication and open-ended thinking that is required for a task, the worse people tend to do when they have been led to perform that task for a reward."⁷¹ This notion may be the reason that Martin Roland, director of the National Primary Care Research and Development Center in England, "believes that the 'most damaging' long-term consequence of pay-for-performance would be 'if you ended up with a system where, essentially, doctors only did anything because they were paid for it and has lost their professional ethos.'"⁷²

Controlling rewards can also undermine the intended goals of pay-for-performance systems; however, one way of preventing this undermining effect is to allow the recipient

65. See generally *INSIDE THE PREMIER*, *supra* note 3, at

66. See generally Wynia, *supra* note 1, at 884. (Demonstrating the conflict between incentives and the highly motivated professional and explaining that small incentives often have a negative result with the highly motivated individual, such as doctors).

67. *Id.*

68. McDonald and Roland, *supra* note 5, at 123

69. *Id.*

70. See generally Wynia, *supra* note 1, at 885 (Showing a counterintuitive result that when volunteers were offered a small amount of money for the tasks they performed, they spent an average of four hours less volunteering, undermining motivation).

71. *Id.* at 886.

72. *Id.*

of the award to have more input in how the award is distributed.⁷³ This method is controversial, but it is similar to the method being employed in the pay-for-performance system in the U.K.⁷⁴ By allowing physicians to determine whether or not the particular measures are appropriate for the patient in their care, also known as exception reporting, gives the doctor more control of the pay-for-performance system and also correlates with higher pay-for-performance scores.⁷⁵ Exception reporting may also allow doctors to feel more comfortable treating patients with multiple comorbid diseases how they think best as opposed to relying on piecing together multiple protocols set forth by their pay-for-performance providers.⁷⁶

While exception reporting may work better for the doctor, the cynics will push back against doctors deciding whether or not to include patients in their reports for fear that the doctor will game the system and only include patients that improve performance scores.⁷⁷ There is also a fear that pay-for-performance will crowd out care that is not tied to incentives.⁷⁸ In systems such as those in Massachusetts or California, where the doctor cannot exempt a patient from the pay-for-performance system, a doctor choosing not to treat the patient would leave the patient with fewer health care options.⁷⁹ The fear of losing more funds are a concern held by hospitals that disproportionately serve the poor because they routinely struggle to deliver high-quality care for lack of capital to invest in quality improvement activities.⁸⁰ Since pay-for-performance is designed to reward those for providing higher quality care, poorer hospitals that cannot invest the capital to improve their quality will lose out on the additional incentives that would help underfinanced hospitals.⁸¹ The hospitals that need the money in order to better serve their community will then lose out on the financial incentives provided for by the pay-for-performance systems, and those incentives will go to the wealthier hospitals that can

73. *Id.*

74. *Id.*

75. *Id.*

76. *See* Boyd et al., *supra* note 4, at 716 (determining that multiple chronic diseases do not fit within the regular guidelines designed to treat one disease and that elderly patients presenting with multiple diseases may become “medical hot potatoes”).

77. Wynia, *supra* Note 1, at 886., at 886.

78. Rachel M. Werner, *Does Pay-for-Performance Steal from the Poor and Give to the Rich?*, 153 *Annals of Internal Med.* 340, 340 (Sept. 7, 2010).

79. *Id.*

80. *Id.*

81. *Id.*

afford the investments to insure high quality on the first place, creating a system in which the rich get richer.⁸²

While there are fears of the pay-for-performance system creating an ethics conflict for doctors and will take money away from the safety net hospitals, there have been suggestions already on how to tweak the system to make it better.⁸³ The ACP suggests that the health care systems should incorporate incentives that reward doctors for caring for the sickest and most vulnerable patients, and not incentives that lead doctors to discriminate against more difficult patients.⁸⁴ Furthermore, to promote trust between patients and doctors, there must be a level of transparency that doctors maintain so that patients know of incentives that are adverse to their interests.⁸⁵ While this may seem to create an opening for distrust, secrecy on the part of a doctor would be a far worse option because the transparency allows the patient to know how their doctor performs on quality measures.⁸⁶ Since developing complicated procedures for every variation of multiple chronic diseases would be difficult, it may be possible to develop objective measures of continuity, communication, and access.⁸⁷

IV. CONCLUSION

Pay-for-performance is a step in the right direction by focusing on quality of care; however, the system still needs to evolve so as to provide complete care for all.⁸⁸ Incentive programs must keep the ethics implications in mind when developing a system that rewards doctors for better care.⁸⁹ Ultimately, pay-for-performance is a system that achieves good through better screenings⁹⁰ and has some flaws dealing with multiple diseases.⁹¹

82. *Id.*

83. *See*, Snyder and Neubauer, *supra* Note 53, at 793.

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.*

88. *See*, INSIDE THE PREMIER *supra* Note 3 (commenting on the progress pay-for-performance has made, while recommending changes that could be made to improve the functionality of the system).

89. *See*, Wynia *supra* Note 1, (analyzing the ethical dilemmas posed by pay-for-performance systems).

90. *See*, Am. Acad. Of Family Physicians *supra* Note 2 (discussing the achievements and future of pay-for-performance systems).

91. *See*, Boyd *supra* Note 4, (examining how systems designed to treat one disease may negatively affect those patients that present with more than one disease as is common in elderly adults).