On the surface, P4P is the perfect solution to quality issues, but Rick Zall says there are several legal implications to be considered. Liz French digs a little deeper.

Raising the Bar

As more health insurance companies realize the benefits of offering additional compensation to high-performers—namely, better patient care and fewer costly complications—the perimeters defining pay-for-performance programs become hazy.

Not only do P4P standards differ from provider to provider, but also from region to region and state to state, creating a number of legal roadblocks. Rick Zall, a partner in international law firm Proskauer Rose's healthcare practice, says consistency is key to reaping the full benefits of a P4P program, but with more than 100 initiatives under way across the country, it becomes elusive.

"The challenge is to carefully define what to reward and how, as well as to develop rules of engagement for the participants that will be widely accepted as fair and legitimate," said Zall. "Few believe that P4P programs will make an important contribution to quality improvement if they consist only of a myriad of ad hoc, fragmented, individual health-plan sponsored efforts."

As Zall points out in "Implementing Pay-For-Performance Programs: Overcoming the Policy and Legal Challenges Ahead," an article published in BNA's *Health Law Reporter*, developing closely coordinated or joint P4P programs can:

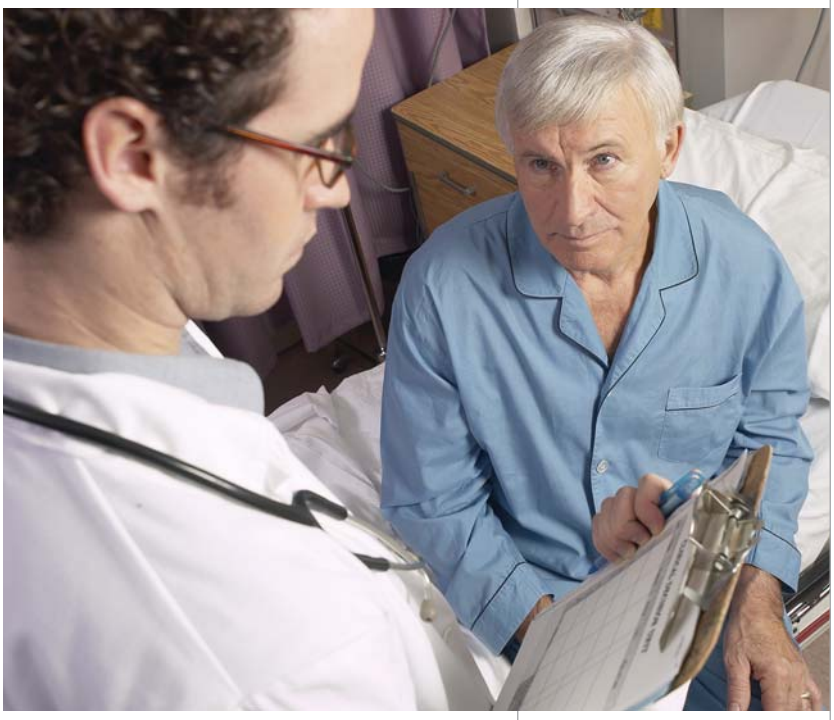
1. Give physicians consistent performance metrics and allow them to focus their attention on a few targeted areas of improvement.
2. Provide coverage to a large number of patients and give health plans the leverage they need to achieve widespread provider participation.
3. Reduce per-capita participant cost of program administration.
4. Reduce the potential "free-rider" effect whereby some purchasers and payers reap the benefits of quality improvement without paying their share of the cost.

Although in its infancy, P4P has shown promising results. A study done by CMS and Premier, Inc. several years ago found that due to financial incentives, the median performance on 34 selected processes for five common clinical conditions (heart attack, coronary artery bypass, heart failure, hip and knee replacement, and pneumonia) increased by 7.5% in the project's first year. As P4Ps will gain in popularity, there are a few questions healthcare executives should be asking.

Who sets the standards?
Health plans, many of which may not represent a significant portion of a doctor's patient base, are decided on their own standards. This forces doctors to keep track of what insurance each patient has and follow the set of standards set forth by those plans. IHA and CMS have discovered that to change behavior, you must focus on only a few goals at a time—thus, too many standards are likely to hinder progress.

To close the gaps, leaders in each medical specialty are coming together to discuss forming a cohesive set of standards and defining what should be rewarded. "For instance, it would be unfair to ask a surgeon to meet the same standards as a cardiologist because they perform different functions," Zall said. "By providers and payers working together, they can give each medical specialty a clearer direction."

Will patients be treated differently depending on their insurance? Many physicians participate in 10 or more private insurance programs in addition to Medicare. With too many guidelines floating around, there exists the potential that patients will be treated differently depending on



what insurance they have. "Some additional procedures are a lot of work. There's data collection/reporting, supplies, and time to account for. If a physician is not going to get compensated for additional work, he or she may choose not to do it," said Zall. "According to several industry reports, regional and community-based initiatives must attain at least a 30% marketshare (ideally 50%) of a clinicians' patient panel for the incentives to be effective."

Others argue that a halo effect may occur in which some physicians and hospitals give the same high-level care regardless of what insurance patients have. That sounds ideal, but it could result in one insurance provider benefiting financially from another's set of standards.

Will doctors be penalized for not reaching standards? Although P4P programs are designed to be zero sum, in reality, some physicians may be penalized for not meeting P4P standards. Payers and purchasers have argued that, with a limited amount of money circulating in the healthcare system, paying high performing physicians will mean lower reimbursement rates for average or poor-performing doctors. In addition, Zall says providers and health insurance companies need to adjust for risk in their contracts so high-performing physicians who serve sicker populations won't be penalized for circumstances outside of their control.

"Originally, the plan was to reward high performers and let mediocre or poor performers maintain status quo. The reality has been that the economics of P4P create a ripple effect that impacts everyone," Zall said. Indeed, the Medical Group Management Association has suggested all P4P programs be voluntary, with healthcare providers receiving ample notice and time to consider participating, but it may be that the economic ramifications of not participating leave them little choice.

Should P4P reward physicians for making progress? Smaller physician practices and hospitals may not be able to afford the technology and systems to hit P4P guidelines as quickly or as easily as well-funded institutions. Zall argues that as insurance providers institute P4P, they should allow a period of transition during which physicians and hospitals receive partial payments for making progress.

What if a physician wants to participate but doesn't have the resources? Zall notes that governmental, nonprofit, and community-based organizations have been developing programs to provide technical assistance, education, training, and capital for IT implementation to those who cannot make the necessary changes with their current resources. "In either rural or inner-city communities, associations are creating collective programs for performance improvement, and some governmental entities and philanthropies are offering grants," he said.