Incentive Design Principles

To develop an effective P4P program, several important decisions regarding the incentive design must be considered. The table below provides a framework to discuss several different program design elements. It includes an overview of each design element, the tradeoffs for different approaches, as well as recommended best practices for plans to consider when designing their P4P programs. The table is intended to provide the best thinking and facilitate discussion about the different incentive design elements. It is not intended to drive greater standardization of incentive design structures or universal adoption. Unlike the current need for greater collaboration around a core measure set, Medi-Cal plans all have very different provider populations and must develop an incentive design structure that meets their local needs.

Overview	Key Questions	Tradeoffs	Best Practices
FUNDING A variety of approaches are used to fund P4P programs. Two common funding methods are: ▪ Budgeting a specific pool of dollars for incentive payments ▪ Withholding a percentage of monthly capitation payments and redistributing funds later as financial incentives, contingent on provider performance	What funding approach is most appropriate?	**Budgeting** PROS: Budgeting with a fixed pool of dollars is easier to implement since provider contracts do not require renegotiation or rewriting. Participation in bonus programs can also be made voluntary. Payout amount is known for health plan budgeting purposes. CONS: If the program is budget neutral, poor performers might be penalized since funds would be allocated to high performers. *Sources: 1, 7* **Withholds** PROS: Withhold payments are perceived as a loss in income and theoretically a loss of income leads to a greater behavioral response than a gain in income. CONS: A perceived loss of income generally causes a significant negative psychological reaction; tends to be perceived as unfair and providers may choose not to participate especially if they can choose to contract with multiple plans. Generally, providers are not receptive to withholds since they prefer arrangements where there is upside risk only. Unlike bonuses, withhold incentives have to be written into assigned contracts and are not voluntary. *Sources: 1, 4, 5*	**Fixed Budget** Up-side risk only; participation can be voluntary and does not require renegotiation or rewriting provider contracts

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INCENTIVIZING PROVIDER BEHAVIOR Incentive methodologies for P4P programs can be structured in several ways based on the goals of the program and contracted provider entities.	What approach should plans use to tailor their incentive programs? ▪ Attainment ▪ Improvement ▪ Per-Activity	**Attainment** PROS: Attaining a target/threshold is a transparent approach, involves less uncertainty, and sends an explicit message to providers indicating where they should target their improvement efforts. CONS: Low achievers with no realistic prospects for achieving a single absolute threshold score will have no incentive to seek even modest improvements, while high achievers will have no motivation to improve once the threshold has been attained. *Sources: 3, 4, 5, 7* **Improvement** PROS: All providers will be motivated to seek continued improvement. Motivates low performers to improve rather than simply rewarding high performers. *Sources: 7* **Combination of Attainment and Improvement** PROS: Combines advantages of both attainment and improvement; leads to a more equal distribution of payouts across providers caring for patients with socioeconomic disadvantage **Per-Activity** PROS: Least complex approach; creates most certainty for providers; providers can more easily accomplish task. CONS: Paying for activities that would have happened anyways; not outcomes based *Sources: 5,6*	**Score each measure on both attainment and improvement, take the higher of the two for payment purposes** Based on CMS' Hospital Value Based Purchasing model and used by IHA's Value Based P4P program

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TARGETS/THRESHOLDS A provider's response to incentives may be based on their ability to make improvements and the thresholds/benchmarks against which their performance is assessed.	How should providers' performance be assessed? ▪ Absolute thresholds? ▪ Relative thresholds? ▪ Single or multiple thresholds?	**Absolute Thresholds** A tiered series of absolute thresholds/targets (e.g. 25 percent, 50 percent, 75 percent, and 90 percent of measure distribution) is preferable to relative thresholds (e.g., top 25 percent of physicians receive bonus). Setting multiple absolute thresholds along a continuum will motivate improvement at all levels of performance. **Relative Thresholds** Relative thresholds (e.g., top 25 percent of physicians receive bonus) create greater uncertainty for providers; not knowing if their efforts will be sufficient to earn incentive. Relative thresholds encourage negative competition and may reduce collaboration and dissemination of best practices and may sustain performance gaps across providers. **Single Thresholds** In a single-threshold program, providers, who at baseline have low performance or high performance, have little reason to use more resources to improve quality. *Sources: 3, 4, 5,7*	**Create a series of absolute quality performance thresholds to meet; increasing amounts of money for achieving 50%, 60%, 70%, 80%, and 90% thresholds rather than using one threshold (e.g.75%)** Good balance, rewarding higher than average performance but rewards improvement; inclusive enough to motivate low performers, not just rewarding elite performers
AMOUNT There is no conclusive evidence that a financial incentive must equal a specific amount to be effective in motivating behavior change among providers. However, it is generally thought that P4P programs are more effective at engaging providers when the incentive payments affect a significant portion of a provider's business.	What is the right level of payment to be effective?	Incentives need to be large enough to motivate a behavioral response and to compensate providers for the effort required to improve performance on a measure; otherwise, providers will simply not make the effort. However, the size of the incentives should not exceed the value obtained from improved provider behavior or the program will not be cost effective. Increasing incentives substantially could lead to large redistributions of resources between providers and have the undesired effect of taking away resources from providers who scored on the lower end the spectrum and who may be most in need of resources to be able to improve quality. *Sources: 3, 6, 7*	**10% of total physician payments** Many researchers/insurers point to this proportion as representative of a significant amount of a provider's business and effective at motivating provider behavior change

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PAYMENT FREQUENCY Depending on the measure, incentive payments can be made more frequently than once a year. More frequent payments could reinforce positive provider behavior.	At what frequency should incentive payments be made? ▪ Annually? ▪ More frequently?	**Annually** PROS: Annual incentive payments are the easiest to administer. Annual payments can also be timed better with annual patient satisfaction survey scores and HEDIS results. Annual payments allow for manual reconciliation of complex calculations used for incentives. CONS: A large, annual lump-sum payment will likely be less effective than a series of smaller, more frequent payments. In practice, data collection and validation may considerably delay payments, and long performance periods may be necessary to yield sufficient reliability. **More Frequently** PROS: More-frequent payments may motivate more persistent gains in performance. A shorter time between care and receipt of incentive is preferable. CONS: Time lag between care delivery and data reporting can be problematic *Sources: 1, 4, 5, 7*	**Annually** Not ideal but realistic; more frequent payments require sophisticated data collection and reporting capabilities and more automated analysis which can be time consuming and costly

Sources:

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