Our health care system is in the midst of a difficult period. Expenditure as a portion of gross domestic product continues to increase, surpassing the portion spent by any other developed country. At the same time recent reports, especially the Institute of Medicine reports *To Err is Human* and *Crossing the Quality Chasm*, have drawn attention to the fact that there are massive variations in the quality of care delivered by our current system. This has caused a great deal of activity as stakeholders in the system struggle to find ways to control costs and improve quality and consistency. One of the new approaches that is beginning to gain widespread support is pay for performance. Pay for performance is a reaction against the toxic payment systems described in *Crossing the Quality Chasm*, and seeks to realign providers’ incentives to reward the quality rather than the quantity of care provided. Though there is a groundswell of support for these programs, many questions remain.

This thesis will attempt to address these questions. Research was conducted using a combination of literature review and interviews with experts at the University of Virginia and at other institutions across the country. The thesis begins by examining our health care system and describing briefly some of the problems that have sparked the recent interest in reform, focusing on the large quality gaps between top performing providers and the national average and the failure of many providers to implement the latest standards of evidence based care. Following that is a discussion of the theoretical arguments underpinning pay for performance. Though the notion of linking rewards to quality has an intuitive appeal, some concerns must be addressed. These are centered around the question of whether or not health care providers respond predictably to financial incentives. Though physicians are bound by an ethical code and dedicated to improving the welfare of their patients, studies show that their behavior is also shaped by the structure of their financial incentives.

With this knowledge in hand the thesis moves on to examine current payment systems. Capitation, fee for service and per case payments dominate the health care industry. Analysis will show that each of these, while having some redeeming qualities, ultimately stands in the way of quality improvement and creates conflicts of interest, forcing providers to choose between financial gain and the welfare of their patients. To illustrate this point there are two examples of quality improvement projects undertaken by hospitals that resulted in improved quality of care and a loss of physician income.

The thesis then moves on to analyze in depth three current pay for performance programs. The first is a joint effort between the Center for Medicare and Medicaid Services and two hundred and sixty two hospitals from Premier, Inc., a chain of over 1,500 not for profit hospitals. This program uses a competitive incentive structure to reward top performers in each of five clinical categories: coronary artery bypass and graft, hip and knee replacement surgery, acute myocardial infarction, heart failure and pneumonia. Top
performers in each category will receive a bonus of up to two percent of Medicare payments for the measurement year. As of now, the program has reported data for eighteen months, and the results look very encouraging. All participating hospitals have seen improvement, with average composite score gains of 6.6% in the first year. There is also evidence to suggest that improved quality carries with it reduced cost through fewer complications and shorter length of stay.

The next program is the Anthem Quality-In-Sights: Hospital Incentive Program. This initiative rewards Virginia hospitals for high performance in a number of clinical areas. Rewards are also based on investment in systems associated with the provision of high quality care, such as computerized physician order entry. The final measure used to determine reward eligibility is patient satisfaction. After explaining the design of this program the discussion will shift to analyze the experience of the University of Virginia’s hospital in the program. The results for the first year are mixed. Some improvement is evident, but it is not as marked or as uniform as that in the CMS/Premier program. However, discussions with faculty involved with the program reveal that it has lead to increased institutional awareness of quality and that the next measurement period will likely show further gains.

The final program is Bridges to Excellence. This program was started by a group of large employers to provide bonus payments to physicians that are recognized as high quality providers by the National Committee for Quality Assurance. It recognizes physicians for achieving high standards of care for diabetics and cardiac patients, as well as for investing in systems that allow for the tracking of patients with chronic conditions. Studies of this program indicate that patients who attend recognized physicians have fewer acute episodes and thus have both improved levels of health and lower health care costs.

The final discussion section looks at the lessons learned from these three programs. The thesis concludes that pay for performance is a valuable idea that should be implemented quickly but carefully throughout the health care system. There are two main reasons for this. The first is that, by linking rewards to adherence to best practices guidelines, pay for performance can increase the spread of evidence based medicine and thereby reduce unnecessary variation. This should then lead to both higher overall quality of care and in many cases a reduction in cost. The second main reason to implement pay for performance is that by increasing the reporting burden on physicians these programs encourage the adoption of information technology such as electronic health records and computerized physician order entry. These systems not only facilitate reporting and measurement but also have the ability to prevent certain kinds of errors. Finally, the thesis discusses some factors that must be considered when designing new pay for performance programs. These include the incentive structure and size, payer leverage, metrics and measures used, and physician buy-in.