The rampant use of P4P by public and private insurers over the last 15 years is the natural outcome of the demonization of the fee-for-service payment method that began circa 1970. Once you get it into your head that the desire for money is the reason doctors went to medical school and it's what gets them out of bed in the morning, then it seems logical to treat doctors like rats in a Skinner box -- to subject them to financial incentives that reward less use of medical care and penalize more use of medical care.

Professionalism, love of patients, fear of criminal and malpractice suits, umpteen years of education, licensure, the opinion of peers -- all of it be damned. The illuminati just know financial incentives are what motivates doctors and hospital executives.

If the campaign to demonize FFS had been based on evidence when the campaign began 50 years ago, we might have had reason to think P4P would work when MedPAC and other "thought leaders" jumped on the P4P bandwagon in the early 2000s. But there was no evidence that FFS was causing even a portion of the overuse when the demonization campaign began, much less all of it. Not surprisingly, therefore, there was no evidence P4P would work when it became all the rage in the early 2000s. Not surprisingly, we still have no evidence P4P works and much evidence it doesn't.

You might think the people advising Bernie Sanders would know that P4P doesn't work and would have objected strenuously to Section 611(b) in Bernie's "single payer" bill, S 1804. That section authorizes the Secretary of HHS to inflict upon the entire population numerous P4P programs currently inflicted on the elderly, including the Merit-based Incentive Payment System (MIPS), ACOs, and the Hospital Readmissions Reduction Program.

For a recent example of the large body of evidence indicting P4P schemes for their inability to impact quality and cost positively, see an article in the Feb 20, 2018 *Annals of Internal Medicine* by Eric Roberts et al. which reviewed Medicare's first giant P4P scheme, called the Value-based Payment Modifier. This was the P4P program that preceded the awful MIPS program, which began in 2017. The title of Roberts et al.'s paper was, "The value-based payment modifier: ... implications for disparities."
https://annals.org/aim/article-abstract/2664654/value-based-payment-modifier-program-outcomes-implications-disparities

Then read the first few paragraphs of an accompanying editorial about that article by Austin Frakt and Ashish Jha
https://annals.org/aim/article-abstract/2664379/face-facts-we-need-change-way-we-do-pay-performance

Then, if you're up for another short indictment of P4P, read this statement from a recent article in JAMA entitled, “How value-based Medicare payments exacerbate disparities”: “In this [value-based payment] game, the losers are more likely to be physicians who care for poorer or sicker patients, and, in turn, their patients. ‘We are literally taking money from providers that serve the poor and giving it to providers that serve the rich,’ said Karen Joynt Maddox, MD, MPH, a cardiologist and health services researcher at the Washington University School of Medicine in St. Louis.”
http://www.pnhp.org/news/2018/february/exposing-the-value-based-paymentmeme