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Gail R. Wilensky

meeting the pay-for-performance imperative

Pay for performance is one of Washington's most popular healthcare buzzwords.

"Our experience has shown that linking a portion of Medicare payments to valid measures of quality . . . supports better health care. . . . Well-defined incentives can assuredly bring about appropriate system change."

—Mark McClellan, CMS administrator, noting the success of the Medicare Modernization Act's pay-for-reporting initiative

Although the term has raised the ire of some physicians, who seem to think it suggests being paid something "more" for what they are or should already be doing, most have embraced the concept as representing an important payment reform. Two other terms, *rewarding excellence* and *paying for results*, convey similar meanings but seem less offensive, and may therefore become the terms of choice in the future.

Whichever term is used, they all recognize the lack of differentiation in current methods of payment for healthcare practitioners and institutions between those who provide high-quality care in an efficient manner and those who do not. Although there is evidence that many practitioners and institutions try to deliver high-quality care, despite current incentives, a payment system that doesn't reward such behavior is not helpful. Worse yet, in some cases, exemplary healthcare providers are penalized for providing high-quality, efficient care. They often receive lower overall payments than do providers who receive extra payment for additional services that are required to "correct their mistakes" or that are of questionable value. This situation is particularly problematic under the disaggregated Medicare physician fee schedule, where physicians who practice conservatively cannot benefit from their efficiencies.

Lots of Interesting Demonstrations

The good news is that both public and private payers are well aware of the problem and are exploring various strategies that reward "desirable behavior," however it is defined. Under the terms of the 2003

Medicare Modernization Act, hospitals that report specified information on quality receive an additional 0.4 percent in their update—although that qualifies more as "pay for reporting" than for P4P, per se.

The Centers for Medicare and Medicaid Services has embarked on two demonstration P4P projects: one involving hospitals that are members of the Premier group and one involving 10 large physician groups. In the latter, the groups are allowed to keep 80 percent of the savings as long as they meet quality targets and their rate of increased spending is lower than a local comparison group.

Activity in the private sector is widespread, with more than 100 demonstrations of various kinds under way. Many of the "Blues" plans have implemented some type of a P4P activity. Other notable insurer-driven demonstrations are Aetna's Aexcel program, which the company has publicized as "a network option that encourages members to select specialists who have demonstrated effectiveness in clinical performance and cost efficiency," and the Integrated Healthcare Association in California, which involves the largest insurers in the state and uses a common set of measures, a public scorecard, and health plan payments.

Medicaid also has some demonstrations under way. In both Rhode Island and in New York, bonuses are being paid to Medicaid managed care plans that achieve certain quality targets.

The United States is not the only country exploring P4P initiatives. England has adopted a new contract for its general practitioners that uses a quality and outcomes framework. The agreement was developed

collaboratively between the government and the physicians and provides for bonuses of up to 30 percent based on their performance relative to various quality indicators, including chronic disease management, practice organization, and patient experience.

Hard Issues to Resolve

Despite all of the activity in this area, a number of difficult issues must be resolved before major changes in payment can be made to account for quality and outcomes measures. The difficulties inherent in coming up with basic measurements of quality and clinical outcomes have received a lot of attention in the various demonstrations. And attempts to define and include measures of efficiency have posed even greater difficulties.

Many are concerned that if payment for quality does not also include a measure of efficiency, expenditures might well increase rather than moderate. Of course, any attempt to measure efficiency requires agreement on how to measure performance and some assurance that the performance measures can be provided by individual practitioners as well as institutions of various sizes and complexity. And as with many of the measurements, some method of adjusting for risk will be necessary to ensure that groups that see systematically sicker patients are not penalized or that those whose patients tend to be healthier are not unduly rewarded.

In addition to measurement issues, a variety of conceptual decisions need to be made, such as whether to reward superior attainment or measurable improvement or both, whether to use only bonuses as the reward for superior performance, and whether to establish winners and losers.

All these decisions will need to consider not only how likely it is that the P4P methodology will produce the desired changes in practice behavior, but also, what other types of behavior may be produced—the so-called “unintended consequences” of a new public policy.

What's Next?

Congress has expressed substantial interest in moving forward with P4P concepts. Although it is unlikely that currently proposed P4P changes will provide the kinds of savings that many on Capitol Hill may think are readily achievable, it is important that the nation take some action on P4P now while the interest remains strong.

Health plans, hospitals, and renal dialysis centers are among the institutions that the Medicare Payment Advisory Commission has identified as early potential “targets of opportunity.” Physicians need to be included as soon thereafter as possible, especially because of all the problems associated with the current Medicare resource-based relative-value system, which not only fails to reward good performance, but also actually penalizes efficient physicians because of the SGR, or sustainable growth rate, which links changes in the fee schedule to the previous year’s growth in Medicare part B spending. Nursing homes and home care should be included along with, or shortly after, physicians.

At this time, the government is set to move forward with changing payment under Medicare and other public programs, but the private sector should drive change in this area as well. In many ways, the private sector may end up leading the way because of its increased flexibility in making changes without the need for new legislation or regulatory approval. Whichever sector becomes the standard bearer, the bottom line is clear: The United States needs to find ways to reward practitioners and institutions that “do it well, do it right the first time, and do it efficiently.” ●

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“The ultimate goal of the HQID is to determine whether pay for performance impacts the quality of care in our nation’s hospitals. Findings from the first year of this project clearly indicate that it does.”

—Richard Norling, president and CEO of Premier Inc., commenting on the Nov. 14 release of CMS-validated data from the first year of the CMS/Premier Hospital Quality Incentive Demonstration