

Pay for Performance: Is this the Cure for Medicare's Ills?

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I was having dinner the other night with a number of doctors and lawyers, and the doctors were complaining about reimbursement issues. One physician (who happens to be my husband) pointed out that in the law, there is great disparity between the fees collected by senior partners at high-power law firms and young solo practitioners. In contrast, he noted that all physicians, regardless of skills or experience, are reimbursed the same amount for a given procedure or visit. We all agreed that this was a major problem with our medical system. Apparently, we are not the only people to come to this conclusion. The idea of tying provider compensation to some measure of quality is getting a great deal of attention these days. Congress has held hearings on just this issue.¹ The clear focus of the testimony was to find a way to reward, and therefore encourage, efficient and high-quality care.

This article will provide an overview of some of the pay-for-performance initiatives currently being undertaken, and the steps involved in implementing such a system on a larger scale. We will also address some of the policy issues surrounding this type of financial incentive.

Healthcare reimbursement policy is almost like a pendulum that swings back and forth in this country. Until relatively recently, we had a mostly fee-for-service system. As costs skyrocketed, policy analysts declared that we were rewarding doctors who provided too much care. In the era of managed care, providers often received incentives to reign in costs. However, this led to some cases of patients not receiving adequate care. And it did not manage to stem the rising costs. As one physician leader put it in his testimony, "We have all witnessed the past and present attempts to contain costs in U.S. healthcare delivery: the

poorly designed control of access and resource utilization by HMOs and other payers; the application of the principle of “picking the low hanging fruit” by streamlining purchasing, eliminating easily identifiable excesses, and discharging patients earlier without appropriate safety nets...” Now the industry is turning to another promising approach-- rewarding care that achieves better patient outcomes while controlling costs. It seems too good to be true. Can we really improve the quality of the care delivered to patients while lowering expenses? Research suggests that it can be done. One study found that up to 17 percent could be saved just by better provider selection—this is without any incentives for improvement. The secret lies in minimizing costly medical errors and complications. Preventive and early treatment is also a key factor in reducing overall costs.

DISPARITY IN QUALITY OF CARE

Most people would not doubt there is a disparity in the quality of care available in the United States. However, most would assume that the distinction is based on identifiable factors such as urban versus rural, academic versus community hospitals, or on the economic status of the patient. This is not necessarily the case. One study found that the quality of care provided by similarly well-regarded, major academic institutions could range from below average to superior.² A RAND study found that overall, adults received only about 55 percent of recommended care with substantial differences depending on diagnosis. For example, people with cataracts received about 79 percent of recommended care; those with hip fractures received about 23 percent.³

There is also enormous variability in cost-efficiency. One study found that patients today are as likely to be seen by physicians who are both lower quality and less cost-efficient

as they are by high quality, more cost-efficient doctors.⁴ Moreover, the vast majority of providers do not even know where they stand in terms of the quality and cost-efficiency of their care. Therefore, their patients do not have the necessary information to make better choices.

Some specialties do gather that level of information. The Cystic Fibrosis Foundation gathers data and ranks program. It found that patient expected life span was significantly different between the best centers and average centers (in 1997 it was 46 years versus 30 years). A recent article in the New Yorker related the story of how this data collection began when the foundation could not believe the amazing results one specialist was claiming—their research proved that his patients had an average life expectancy seven times longer than the national average. As a result, his methods became the standard of care.

Our country claims to have the greatest health care available in the world. While clearly the highest level of care can be found in the U.S., we pay a staggering cost for our highly inconsistent quality of care. The United States spends much more than other modern industrial nations on health care costs, but we consistently rank towards the bottom in a wide variety of health indicators.⁵

These costs are bankrupting the Medicare system. Therefore, CMS is showing increasing interest in pay-for-performance models which link quality and cost-containment. In recent years, a number of initiatives have emerged that seek to measure provider performance, make that information available to providers for improvement, and reward better performers with bonus payments or by public recognition. The Leapfrog Group

recently published a listing of 90 pay-for-performance programs sponsored by health plans, private purchasers, CMS and others.

GETTING THE DATA

The basic premise behind pay-for-performance is that savings can be achieved by reducing medical errors, lowering complications and using quality-guided resource utilization management to provide cost-efficient, appropriate treatment. In order to do this, there must be clinically relevant data that is used to develop reliable, valid and trusted measures of care that are scientifically credible. Therefore, the first step in measuring performance is collecting extensive data, preferably nationwide. Information technology, especially the use of an electronic health record, is critical in this process.

In his testimony before Congress, one physician expert, outlined his specialty's success in this area through development of the Society of Thoracic Surgery National Cardiac Database (STS NCD).⁶ Because cardiac surgeons have been collecting uniform clinical data for fifteen years, there are over 2.7 million patient records in the STS NCD. The detailed nature of the data is also important—the database contains nearly 200 elements on each patient, ranging from demographic factors to clinical risk factors, encompassing the whole spectrum of the complexities of cardiac surgery. We can draw meaningful lessons from both their process and findings regarding quality and the link between quality and cost-containment.

Through scores of peer reviewed studies on this data, this specialty has been able to reduce racial and gender disparities and prove the efficacy of specific devices and techniques. Interestingly, the STS NCD data has shown that although Medicare bypass patients have

become sicker, older, more overweight, and their expected mortality rate has increased by approximately 35%, both the observed and risk-adjusted mortality decreased by approximately 30%.

Most experts recommend that any pay-for-performance model must start with financial incentives to collect the necessary data, particularly for physicians where the cost burden, especially with regard to IT investments, can be overwhelming. STS database participants pay an average of \$50,000 per practice to submit and analyze clinical data. They must purchase software and hire a data manager. These costs are not reimbursed in any way, and they are not currently recognized by Medicare. Compounding this issue is the uncertainty brought by the lack of standards for electronic health records.

Despite the start-up costs involved, most large health care organizations have been very receptive to CMS efforts to identify quality standards, since it mirrors the growing emphasis within the industry. Since 2003, CMS has operated the Hospital Quality Initiative, which is designed to stimulate improvements in hospital care by standardizing hospital data, data transmission, and performance measures to ensure that all payers, providers, oversight and accrediting entities use the same measures when publicly reporting hospital activities. Initially, a set of 10 quality indicators are being focused on. Hospitals that submit the required data receive a market basket increase of 0.4 percentage points higher than facilities that do not. For FY 2005, virtually every hospital in the country that is eligible to participate (98.3 percent) has submitted the required data and received the higher payment. Financial incentives will likely be even more important when focus shifts towards smaller providers and physician groups. For example, Bridges to Excellence has initiated a program that measures the extent to which a practice has implemented information technology (IT)

systems that track and educate patients, maintain medical records, prescribe medicines and ensure appropriate follow up. These are all IT systems that have been shown to dramatically improve patient care and prevent mistakes. Some initiatives are also providing technical assistance to physician groups in order to make the IT issues less daunting

MEASURING QUALITY

CMS has been working with other major players such as professional associations, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Agency for Healthcare Research and Quality (AHRQ), consumer groups, major payers, representatives of health care purchasers, and the National Quality Forum to develop standardized quality measures. The National Quality Forum (NQF) has been indispensable in developing a consensus around quality measures and their endorsement gives these measures credibility. So far they have endorsed performance measures in the areas of acute hospital care, nursing homes, home health, diabetes, nursing-sensitive care, and cardiac surgery. Other projects are underway to address cancer, deep vein thrombosis, and ambulatory care. In addition, NQF has endorsed a set of reportable events for mandatory adverse event reporting and a set of 30 safe practices designed to reduce the risk of medical error. Another major project is underway to develop performance measures for outpatient care focusing on the areas of patient experience with care, coordination of care, asthma, prevention, medication management, heart disease, diabetes, hypertension, depression, and obesity.⁷

One policy questions that emerges is whether quality standards should be process or outcome-based. In many cases, it is easier to develop a consensus around process measures.

However, some providers, especially physicians, argue that the use of national process-oriented standards stifles innovation. Physicians are no longer allowed to follow their own intuition or innovations in care plans. This is why many advocate for a move to outcome measures or at least a combination of the two—in order to encourage providers to keep striving to bring their care and as a result the clinical standards to the next level. Of course, if outcome measures are used, they must be risk-adjusted to minimize “cherry-picking” and to ensure fairness for providers who treat the sickest patients.

TO REPORT OR NOT TO REPORT?

Many providers are hesitant to allow performance data to be reported to the public. In addition to the obvious PR concerns, there is a fear that it will become fodder for plaintiff's attorneys. No one debates whether providers should have access to this information. It is key to let everyone know where they stand, so they can work towards improvement. It is also useful to see who the leaders are, so we can learn from them. The prior head of the Veterans Administration testified before Congress about how the VA undertook a major transformation in the late 90s to reach where it is outperforming Medicare on essentially all standardized quality indicators.⁸ Much of that change was accomplished by implementing a performance measurement system in which standardized measures of quality were regularly assessed and the results made available for everyone to see. In this case, no changes in physician payment were associated with performance measurement.

If the VA can do this just based on collecting quality data and reporting it internally, imagine the improvements that could result in the private market if consumers and payors

were given the information they need to make better choices. The possible repercussions to reputation would no doubt be an important motivator for quality improvement. Medicare took an important first step in public quality reporting in the hospital and nursing home arenas, and it has an obligation to continue to provide the public with this kind of information as it is collected.

INCENTIVIZING QUALITY AND COST-EFFICIENCY

There is a developing body of evidence linking quality improvement to cost containment. One study found that in Virginia the lowest spending hospital had the lowest observed to expected mortality ratio.⁹ This is, of course, the goal behind pay-for-performance: achieving high quality while saving money. Pay-for-performance rewards providers that can achieve these results. CMS is undertaking a number of demonstration projects linking reimbursement to quality, many of which also require demonstrated cost savings. For instance, CMS is partnering with Premier Inc., a nationwide alliance of not-for-profit hospitals, to conduct a demonstration program in which about 300 hospitals are voluntarily providing data on 34 quality measures related to five clinical conditions: heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. Using the quality measures, CMS will identify hospitals in the demonstration with the highest clinical quality performance for each of the five clinical areas. Hospitals scoring in the top 10 percent for a given set of quality measures will receive a 2 percent bonus payment in addition to the normal payment for the service provided for Medicare beneficiaries. Hospitals in the next highest 10 percent will receive a 1 percent bonus payment. In the third year of the demonstration project, hospitals that do not improve above the demonstration baseline will be subject to reductions in payments.

CMS also recently announced a demonstration project to test pay-for-performance with Medicare physicians. Ten large (200+ physicians), multi-specialty physician groups across the country will participate in the demonstration, which is scheduled to begin operations this month. Participating physician groups will continue to be paid on a fee-for-service basis, but they will be able to earn performance-based payments for implementing care management strategies that anticipate patients' needs, prevent chronic disease complications, avoid hospitalizations, and improve the quality of care. The performance payment will be derived from savings achieved by the physician group and paid out in part based on the quality results, which CMS will assess.

Another pay-for-performance initiative is being tested regarding the treatment of chronically ill Medicare beneficiaries in small- and medium-sized physician practices. In this demonstration (which will be implemented in Arkansas, California, Massachusetts, and Utah), physicians who meet or exceed performance standards in clinical delivery systems and patient outcomes will receive bonus payments. The recent Medicare Bill also mandated a five-year initiative designed to reduce the variation in utilization of health care services by encouraging the use of evidence-based care and best practice guidelines.

CMS has a number of other demonstration projects that focus on coordinating care and disease management for chronically ill patients which incorporate some performance-based incentives. However, generally the performance incentive in these is a negative incentive, i.e. they do not receive reimbursement unless they meet certain quality measures. Also these programs require providers to show a cost savings.

As noted above, there are approximately 90 pay-for-performance initiatives—many of which were undertaken by the private sector. Leapfrog Group, who has been in the forefront of the quality improvement trend, has launched a Hospital Rewards Program to provide incentives and rewards for hospitals that are both high quality and demonstrate efficient use of resources. The program initially focuses on five clinical areas that represent a significant proportion of hospital admissions and expenditures among the commercially-insured population: coronary artery bypass graft (CABG), percutaneous coronary intervention (PCI), acute myocardial infarction (AMI), community-acquired pneumonia (CAP) and deliveries/newborn care.

Bridges to Excellence is another organization composed of employers, providers, and health care plans that has undertaken a number of pay-for-performance initiatives focusing on specific diagnoses which monopolize a large amount of health care resources such as diabetes and cardiac disease. The programs focus heavily on preventive and regular treatment.

A number of large private payors have begun to implement pay-for-performance models because they are faced with double digit costs increases. For example, the UNITE-HERE Labor Management Trust Fund provides health care to 120,000 hotel workers and their families in Las Vegas. The Trust measured all of its network physicians using a cost-efficiency tool that assesses the longitudinal efficiency of care provided, as well as measuring the quality of care based on process guidelines. The Trust used this information to exclude 50 of the 1,800 network physicians. The Trust also identified “Gold Star” physicians based on their quality of care. The “Gold Star” physicians were highlighted in the physician directory and were eligible for performance bonuses of up to 10% of their compensation

based on both quality and cost-efficiency. The Trust has seen a medical trend reduction of over ten percentage points.

It seems that the physician-based initiatives that have seen the best success seem to take into account some basic rules of human nature. First, the rewards or incentives must be meaningful to the physician. In most cases, rewards and incentives will be financial, but another effective incentive is to find a way to reduce the amount of paperwork that the physician has to complete in order to get paid. It is also important to remember that, like most people, physicians respond much more favorably to positive rewards than to punitive measures.

FINANCIAL ISSUES

While all of these demonstration programs or small initiatives are great first steps, they have not yet begun to achieve critical mass and momentum. Moreover, while we don't know what level of performance-based payment is necessary to affect quality, most experts believe that the small percentages being tested, especially by CMS, are inadequate. Performance-based payment really needs to make up a substantial portion of the reimbursement – likely at least 20% as is currently being paid in the United Kingdom.

One of the key questions then becomes how pay-for-performance can be implemented in the current budget environment. Many proponents argue that these programs pay for itself. Incentives to reduce costly complications have immediate savings potential for the healthcare system. However, most models have seen cost savings over time with some additional funding needed on the front end. Some have recommended repealing or cutting the sustainable growth rate and replacing it with incentive payments to physicians.

However, if physicians face fee reductions in excess of 5 percent per year, then they will likely not be in a position to invest in new technology.

Another concern is implementation of a “tournament model” where the funds are taken from the lower performers and given to the best. There is a real possibility that this approach could limit access to care by vulnerable populations, if providers are forced out of the system. In addition, the creation of winners and losers discourages everyone from sharing best practices with others. Moreover, the largest cost savings are likely to be seen through quality improvement focusing on the lowest performers.

CONCLUSION

If we really want to fix our system, pay-for-performance must become a top priority. Medicare should lead in this area as it did with the prospective payment system for hospitals. In contrast to the 90 programs currently operating across the country, Medicare not only has a national geographic reach, but it has works with so many providers that it is in the best position to provide a clear picture of the performance of most providers.

Undoubtedly there will be some uneasiness in implementing pay-for-performance on a wide-scale basis. The policy concerns mirrors what we have seen in the education field. Can we really compensate based on grades? Will there be cherry-picking, where no one wants to take the “tough” cases—as we have definitely seen in education? These issues will undoubtedly have to be ironed out. However, these concerns should not be allowed to hold up progress in this area, because pay-for-performance seems to hold the best chance of turning around our health care crisis.

¹ The most recent was “Measuring Physician Quality and Efficiency of Care for Medicare Beneficiaries,” Testimony Before the Subcommittee on Health of the House Committee on Ways and Means, March 15, 2005.

² This study compared treatment for cystic fibrosis. Gawande, Atul “The Bell Curve,” *The New Yorker*, December 6, 2004.

³ McGlynn, E.A. “The Quality of Health Care Delivered to Adults in the United States,” *New England Journal of Medicine*, June 26, 2003.

⁴ Peter Lee, President and CEO of Pacific Business Group on Health, Testimony Before the Subcommittee on Health of the House Committee on Ways and Means, March 15, 2005.

⁵ Pacific Northwest Regional Economic Conference, “Health Care Systems: An International Comparison,” May 2001.

⁶ Dr. Jeffery Rich, Chairman of the Society for Thoracic Surgeon’s Task Force on Pay for Performance, Testimony Before the Subcommittee on Health of the House Committee on Ways and Means, March 15, 2005.

⁷ Dr. Kenneth Kizer, President and CEO, The National Quality Forum, Testimony Before the Subcommittee on Health of the House Committee on Ways and Means, March 15, 2005.

⁸ *Id.*

⁹ Rich testimony, see note 6.